Documents Produced by

Cigna Corporation

(Express Scripts)

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CONFIDENTIAL

April 16, 2019

VIA COURIER AND ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: April 2, 2019 Information Request, First Response

Dear Chairman Grassley and Ranking Member Wyden:

We represent Cigna Corporation ("Cigna") and are writing in response to your letter dated April 2, 2019 ("Letter") requesting information and the production of certain materials. We appreciate the Committee on Finance's ("Committee") focus on health care costs, and particularly the cost of prescription drugs, as these issues are central to our mission of making prescription drugs safer and more affordable.

As you know, Cigna completed a merger with Express Scripts, Inc. ("Express Scripts" or "the Company") in December 2018. The combined companies bring together approximately 74,000 employees around the world with a joint mission to drive predictable and high-quality care through connected, personalized solutions. Express Scripts manages prescription drug benefits for more than 80 million Americans, including those in health plans, union-sponsored plans, state employee health plans, and public programs, including TRICARE, Medicare Part D, and Medicaid. Its services include providing network-pharmacy claims processing, home delivery pharmacy care, specialty pharmacy care, benefit-design consultation, drug utilization review, formulary management, and medical and drug data analysis services. For the purposes of this letter, we are responding exclusively on behalf of Express Scripts.

Insulin affordability and access are issues that have long been a concern of Express Scripts, and the Company is pleased that the Committee is addressing this important issue. In May 2017, Express Scripts launched Inside Rx, a prescription savings program expanding affordable access to medications for patients with no insurance or those experiencing high out-

of-pocket costs. Insulins are among the brand drugs for which Inside Rx offers more affordable options to those in need. Inside Rx has partnered with 8 manufacturers to lower prices on 36 brand diabetes products, of which 21 products are insulins. The average patient savings on brand insulin products through the Inside Rx savings program is $150 per claim. Savings on branded diabetes products averaged 47 percent in 2018. Savings on all diabetes products, brands and generics, averaged 52 percent. Inside Rx continues to expand relationships with pharmaceutical manufacturers to provide savings to consumers who may be uninsured or underinsured.

Additionally, when Cigna and Express Scripts announced the merger, the overarching objective was to improve choice, affordability, and predictability. To that end, Express Scripts launched a new Patient Assurance Program within the first 100 days of the combination, which will bring additional affordability and predictability to eligible customers who rely on insulin to manage their diabetes. This program establishes a lower fixed out-of-pocket cost for covered insulins, ensuring customers will pay no more than $25 out-of-pocket when filling a 30-day insulin prescription at a retail pharmacy or through home delivery.

As we have discussed with your staffs, we are pleased to assist the Committee with this important inquiry and will be providing responsive information and related materials on a rolling basis. In this, our first response, we are responding to certain of the questions in your Letter, which we have reproduced below. Responses to additional questions in your Letter will be forthcoming as the Company works to gather responsive information.

Certain of the information contained in this response is sensitive and nonpublic. Given the nature of this information, we have marked this response "Confidential" and request that the information contained herein not be disclosed beyond your staffs and not be made public. Further, we request that you treat this response as a confidential committee record under Standing Rule of the Senate XXIX, clause 5. We also request that you inform us of any proposed use of the information by the Committee and first provide Express Scripts with an opportunity to be heard.

* * *

Request 1
Regarding your business relationships with insulin manufacturers:

a. **Please provide a list of all insulin manufacturers with which your company has had contracts, agreements or business relationships at any time since January 1, 2013. Please explain the nature and scope of your company's business relationships with each manufacturer, including but not limited to, the size of the insulin business and any ancillary, consulting or other services, such as patient**

on-boarding, that your company provided these manufacturers. In addition to rebates, please list all other discounts and price concessions your company receives from insulin manufacturers—with respect to their insulin products—and fees collected that were based upon each price concession. Please also describe all other benefits that were agreed to as part of the price concession negotiation including, but not limited to, elimination of prior authorization, step therapies, and other utilization management methods.

b. Please provide all contracts between your company and each of these insulin manufacturers that are or have been in effect at any time since January 1, 2013. Examples of the types of contracts include, but are not limited to, supply agreements, pricing agreements, rebate agreements, other types of pricing concession agreements, and all agreements involving the performance of services or the providing of data.

c. What cost inflation or growth rate limits does your company require from insulin manufacturers, specifically, and other manufacturers, generally? Are such limits based on list price, net price or both? What penalties, fees, rebates, or other payments, if any, must manufactures make if they exceed such commitments? How does your company account for such penalties, fees, rebates or payments from manufacturers? That is, are they kept separate from other rebate revenue, or accounted for together?

d. Please provide a list of all instances in which a contract was terminated before its expiration date. In each instance, please provide the reason for such termination, and identify the party responsible for such termination.

***Response*:**

Express Scripts negotiates retrospective rebate discounts with manufacturers of all major insulin products. The amount of rebate discounts varies significantly based on utilization and a plan's benefit design. The overall value extracted from manufacturers through rebates has increased over time, as has the value shared with our clients, which include plan sponsors such as employers.

Express Scripts recently launched a new Patient Assurance Program that ensures eligible customers will pay no more than $25 out-of-pocket when filling a 30-day insulin prescription at a retail pharmacy or through home delivery.

In addition to price discounts, Express Scripts offers clients various utilization management options to further reduce costs for members—those individuals enrolled in Express Scripts-managed prescription benefit plans. We provide an option for plans not implementing exclusion formularies to utilize step therapies to encourage use of preferred insulin products. Step therapies require the trial of a clinically appropriate preferred product before the patient can try a non-preferred drug. A medical exception process is always available for the prescribing physician to pursue if a patient's unique health situation requires a non-preferred product to be the only option. Due to the unique individualized dosing of insulins and their clinical capabilities, Express Scripts does not currently offer any quantity level limits or prior authorizations on these products.

As for inflation or growth rate limits, some of our contracts with manufacturers include provisions requiring payment of certain amounts if the manufacturer increases the price of a particular product above a specified point. Nothing in our agreements prohibits any manufacturer from decreasing the wholesale acquisition cost ("WAC"), also referred to as list price, of a drug. Clients that choose to enroll in our Inflation Protection program are offered a guarantee capping inflation across their entire brand drug utilization costs. The program is not designed or managed based on individual drugs within competitive product categories, and the underlying economics of the inflation caps are separate and apart from the client's rebates. This means that any payments to clients under the Inflation Protection program are in addition to rebates received.

Request 2
Regarding your business relationship with health plans and programs:

a. **Please provide a list of all payers for which your company has been responsible for negotiating insulin products at any time since January 1, 2013. This list should include Part D plans, Medicare Advantage, Medicaid programs or Medicaid managed care plans, Qualified Health Plans under the Affordable Care Act, and commercial group, self-insured employers and individual health plans. Please also provide a list all "classes", i.e., groups of plans for which rebates are negotiated *en bloc*.**

b. **For each plan and class, please provide the number of covered lives, the number of covered lives believed to have diabetes, the number of covered lives who made claims for insulin, and the number of insulin claims on an annual basis. In providing these data, please include lives who were covered for only a portion of the calendar year. To the extent this information is reportable on a class level,**

please provide a list of the plans that are included in each respective class. In all cases, please delineate whether the plan is a Medicare or Medicaid plan.

c. **What assurances, if any, does your company make to health plans or programs regarding cost inflation, growth rate limits and trend agreements for insulin specifically, and prescription drug prices, generally? What, if any, penalties, fees, or payments is your company required to pay if these limits are exceeded? How are these penalties accounted for?**

***Response*:**

Express Scripts manages prescription drug benefits for more than 80 million Americans, including those in health plans, union-sponsored plans, state employee health plans, and public programs, including TRICARE, Medicare Part D, and Medicaid. Our services include providing network-pharmacy claims processing, home delivery pharmacy care, specialty pharmacy care, benefit-design consultation, drug utilization review, formulary management, and medical and drug data analysis services.

Regarding inflation or growth rate limits, as we noted in our response to Request 1, some of our contracts with manufacturers include provisions requiring payment of certain amounts if the manufacturer increases the price of a particular product above a specified point, and nothing in our agreements prohibits any manufacturer from decreasing the list price of a drug. Clients that choose to enroll in our Inflation Protection program are offered a guarantee capping inflation across their entire brand drug utilization costs. The program is not designed or managed based on individual drugs within competitive product categories, and the underlying economics of the inflation caps are separate and apart from the client's rebates. This means that any payments to clients under the Inflation Protection program are in addition to rebates received.

Request 3

Please explain your process for making pricing and rebate determinations. Please provide the names of the departments, divisions and key employees involved in rebate and pricing decisions. Please provide the names and positions of all members of your company's manufacturer contracting group, and all policies, procedures and guidelines to which that group adheres. Please explain how the manufacturer contracting group interacts with the PBM's Pharmacy and Therapeutics (P&T) Committee. Who has final approval of pricing and rebate decisions, and how are these decisions communicated to plans, manufacturers, and other entities within the insulin supply chain? Has your company ever had discussions with insulin manufacturers about the list prices they set for insulin products? If so, what were the nature of those discussions?

***Response*:**

Express Scripts does not play any role in setting list prices of insulin or any other medication and welcomes manufacturers lowering their list prices so that patients can have greater access to medications.

To increase affordability and access, Express Scripts negotiates retrospective rebate discounts with manufacturers of all major insulin products. The amount of rebate discounts varies significantly based on utilization and a plan's benefit design. In the commercial market, rebates are an effective tool that employers and health plans use to generate more savings for prescription drugs. Employers and other plan sponsors that work with Express Scripts choose how rebates are used. Some use them to lower premiums and cost sharing, others choose to expand access, fund wellness programs, or provide discounts to consumers at the point-of-sale. The overall value extracted from manufacturers through rebates has increased over time, as has the value shared with our clients. On average, Express Scripts passes approximately 95 percent of rebates, discounts, and price reductions back to its core PBM commercial and health plan clients and their customers. In Medicare Part D, 100 percent of the rebate value is passed through within the program.

Additionally, most drugs do not involve a rebate structure. For example, rebates are not typically offered for generic medications, for drugs without market competition (i.e., sole-source brand drugs), or for drugs administered by a physician. Approximately 90 percent of all prescriptions Express Scripts fills are generics. According to a study of drugs covered under Medicare Part D by the actuarial firm Milliman, 81 percent of all drugs analyzed do not offer rebates and 64 percent of brand drugs analyzed do not offer rebates.

Request 4

Please explain your process for making PBM-based formulary placement decisions for insulin products, including specifically answering the following questions:

a. **Please provide the names of the departments, divisions and key employees involved in formulary placement decisions. Who has final approval of formulary decisions, and how are these decisions communicated to plans, manufacturers, and other entities within the insulin supply chain?**

b. **What is the role of the PBM's P&T Committee? What is the process that the P&T Committee uses to determine pricing and rebate decisions? Does the P&T Committee have discretion to make decisions and recommendations independently? Please provide any policies, guidelines or other documents that**

set out the process for the P&T Committee generally and in relation to insulin products specifically. Please provide all names, positions and professional qualifications of P&T Committee members since January 1, 2013. If the company contracted, employed or otherwise consulted with any specialists or experts in regards to insulin placements, please provide their names as well as a description of the work they did and contributions they made in regard to such decisions. Please provide the minutes for any P&T Committee meeting since January 1, 2013 that included a discussion of any insulin products. Pleas also provide all recommendations, memoranda, reports or other communications the P&T Committee produced regarding insulin, whether for internal consideration or for clients.

c. **What, if any, analysis is conducted to gauge the impact of formulary placement decisions on patients, including, but not limited to, cost and clinical effects? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to patient or clinical impacts of insulin formulary placements since January 1, 2013. Please also provide any written communications that discuss patient or clinical impacts of insulin formulary placement decisions since January 1, 2013.**

d. **What, if any, analysis is conducted to gauge the impact of formulary placement decisions on your company's business, including, but not limited to revenue, gross profit per claim, rebate amounts, plan costs, and other financial metrics? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to the business impacts of insulin formulary placement since January 1, 2013. Please also provide any written communications that discuss the business impacts of insulin formulary placement decisions since January 1, 2013.**

e. **Please provide a list and describe any instances in which an insulin product was provided preferred formulary treatment when a therapeutic substitute was available for a lower net price. What was the reason for this decision? What was the difference in the rebate, discount or price concession between the two drugs?**

***Response*:**

Our formulary is a critical driver of both clinical efficacy and value. Formulary development involves guidance from three distinct committees: the Therapeutic Assessment

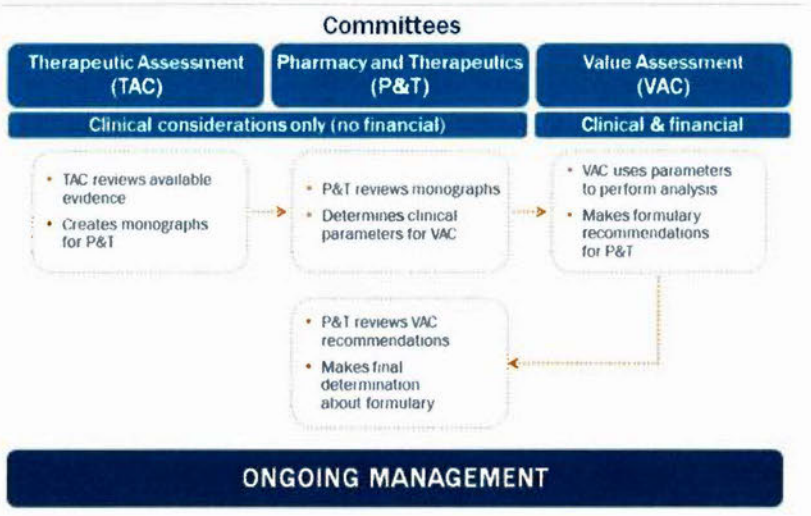
Committee ("TAC"); the Pharmacy and Therapeutics Committee ("P&T"); and the Value Assessment Committee ("VAC"). Each is described briefly below:

- TAC is an internal clinical review body consisting of clinical pharmacists and physicians, who review specific medications following FDA approval using medical literature and published clinical trial data.

- P&T consists of a group of 15 independent physicians and 1 pharmacist from active community and academic practices representing a broad range of medical specialties.

- VAC, which consists of Express Scripts' employees from formulary management, product management, finance, human resources, and clinical account management, considers the value of drugs by evaluating the net cost, market share, and drug utilization trends of clinically similar medications.

Our formulary development approach for all medications prioritizes clinical considerations first and foremost before evaluating net cost to clients. Financial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process. The financial impact to clients, however, is considered by the VAC, but only after all clinical considerations have been taken into account.



Clients are free to accept, reject, or modify Express Scripts' National Preferred Formulary ("NPF"), or create their own custom formulary. A formulary becomes part of a plan sponsor's benefit only after adoption by the client.

Prior to 2014, most clients had a 3-tiered formulary design: (1) generic, (2) formulary/ preferred, and (3) non-formulary/non-preferred. Members could obtain the non-formulary medications by paying a higher copay. Challenges arose when pharmaceutical manufacturers introduced copay cards that reduced patients' copays on more expensive brand drugs instead of the less expensive brand or generic drug on the client's benefit design. These manufacturer coupon programs undermined client plans' effort to guide patients to cost-effective medications, which eroded incentives for manufacturers to offer aggressive discounts through rebates, even in drug classes with significant competition.

In response to manufacturers' decisions to limit discounts in favor of higher net prices, and client demand to do something to help them control costs, we offered clients the option of excluding medications from the formulary when clinically appropriate. This meant that some medications would not be covered by the benefit unless: (1) a physician-authorized exception existed to start therapy on an excluded medication, or (2) patients were pre-existing users of excluded medications. Exclusions provided clients significant savings and the majority elected to continue using our NPF.

Since 2014, Express Scripts has continued to evaluate the financial opportunities that clinically-appropriate exclusions represent for our clients. Insulins are considered highly interchangeable by our P&T Committee of independent physicians. In fact, many competing insulin products contain the same active ingredient (e.g., Humulin vs. Novolin, Lantus vs. Basaglar), and we offer clients exclusions in certain categories. In August 2018, we announced our 2019 NPF changes, of which there are 48 new formulary exclusions. Less than 0.2 percent of members will see a change in coverage for a medication. These changes will save plans an estimated $3.2 billion; cumulative savings for plans leveraging the NPF since 2014 are estimated to reach $10.6 billion.

Request 6
Regarding negotiations with pharmaceutical companies:

a. **Please list all types of financial transactions, contracts, terms of service and other agreements that are contingent in any way upon the size of a rebate or other price concessions paid by insulin manufacturers. In regard to insulin transactions, how do the size of rebates and other price concessions from pharmaceutical manufacturers affect the financial compensation your company receives? How does the size of a rebate and other price concessions affect your**

company's revenue and gross profit per claim? How would it affect the cost to the plans on behalf of which you are negotiating? Are there situations in which a larger rebate or price concession would incentivize your company to select a higher-priced insulin over a lower-priced therapeutic equivalent? Why or why not?

b. Please provide a list of all revenue types that your company receives from manufacturers, including but not limited to rebates, other price concessions, fees for services, and any other payments. Please describe each type of revenue and the purpose for which your company receives it. How does your company account for each of these payments for reporting to the Securities and Exchange Commission? How does your company account for these payments for reporting to Part D plans and the Centers for Medicare and Medicaid Services? Is revenue derived from rebates or pharmacy reimbursements ever accounted for as fees? If so, does accounting for such payments as fees allow your company to not report and pass on these fees to Part D plan sponsors?

c. Please list and describe all instances since January 1, 2013 in which your company negotiated a rebate for an insulin product that was bundled with a rebate for another product produced by the manufacturer.

d. Please list and describe all instances since January 1, 2013 in which your company declined an insulin manufacturer's offer of a lower list price in the renegotiation of an existing contract or development of a new one.

***Response*:**

Express Scripts contracts with manufacturers for payment of gross rebates and administrative fees earned for the administration of our rebate programs that, per industry practice, are a percentage of the WAC, which, as noted previously, is exclusively controlled by drug manufacturers. Client contracts generally establish a client's pricing as a discounted percentage from drug products' average wholesale price ("AWP"), which is determined by the manufacturer's WAC. These discounts are typically backed by various guarantees that are individually negotiated and vary among clients. Express Scripts passes approximately 95 percent of rebates, discounts, and price reductions back to its core PBM commercial and health plan clients and their customers.

Client contracts contain financial disclosures in which Express Scripts provides a detailed overview of its principal revenue sources, including arrangements with pharmaceutical manufacturers, wholesale distributors, and retail pharmacies. These disclosures explain that

some of this revenue relates to utilization of prescription drugs by members of the clients receiving PBM services, and that Express Scripts may pass through certain manufacturer payments to its clients or may retain certain of those payments for itself, depending on the contract terms between Express Scripts and the client.

Our clients, which are sophisticated entities and are often represented by benefit consultants and advisors, negotiate the overall arrangement they believe best suits their pharmacy benefit needs. Terms vary across clients and contracts, and some clients negotiate to receive a portion of rebates, as well as manufacturer administrative fees collected by Express Scripts. Nearly half of Express Scripts' clients have opted for 100 percent pass-through of rebates.

Request 8

Please explain the health information your company—or any parent company, subsidiary or affiliates, including affiliated pharmacies—collects regarding patients who are pre-diabetic, have been diagnosed with diabetes and/or make claims for insulin. For example, does your company collect health information or maintain records for levels of blood sugar, HbA1c, or albumin in the urine? What information regarding diagnostic and procedure codes does your company maintain? What information is collected regarding patients' prescription adherence? Please detail any other types of diabetes-related health information that is tracked or collected. In each instance, please specify whether this information is collected on a patient level and how the information is collected.

***Response*:**

Express Scripts collects information regarding patients' prescription adherence, including information related to patients' insulin adherence and adherence to diabetic oral medications.

Despite industry demand for a uniform standard for measuring insulin adherence, no such standard exists due to wide variations in patients' medication administration directions and use. Typical industry methods of measuring adherence for other medications involve calculation of Medication Possession Ratio ("MPR") or Proportion of Days Covered ("PDC"). Both of these measures are commonly used to determine whether a patient has sufficient supply of medication on hand to maintain adherence to their prescribed drugs. Due to variable dosing of insulin based upon individual blood glucose levels, the number of units a patient should be taking is very difficult to calculate for an accurate MPR or PDC.

Contrary to insulins, diabetic oral medications are more easily tracked using traditional MPR and PDC methods. Express Scripts' Smart90 program, in which members are incentivized to fill 90-day diabetes oral prescriptions at retail pharmacies, has resulted in findings that suggest

diabetes patients are 20–33 percent more adherent. According to 2016 data, people who were adherent to their oral diabetes medications experienced 235 fewer emergency room visits and 50 fewer inpatient hospitalizations per 1000 patients, and they spent nearly $500 less on total healthcare costs compared to nonadherent patients, potentially avoiding more than $210 million in healthcare spending in 2016.

Please also answer the following questions:

a. **For what purposes is this information collected and used?**

b. **How is this information used in relationship to your company's analysis of plan costs?**

c. **How is this information used to track the health status of individual patients?**

d. **Does your company, or any parent company, subsidiary, or affiliates, including affiliated pharmacies, make decisions regarding an individual patient's coverage, treatment, or any other matter based on his or her collected information? If so, please provide detailed explanations of the types of decisions that would be based on collected information, and how the information influences the outcomes.**

e. **How does your company store the information it collects? What does your company define as authorized and unauthorized uses? What specific measures are taken to protect against an unauthorized breach or use of the information? For example, has your company implemented the National Institution of Standards and Technology Cybersecurity Framework or other safeguards? If not, why not? Has your company ever suffered a breach of this information? If so, please detail the time and scope of such a breach.**

f. **Does your company sell, profit from, or otherwise share any of the collected information with any third parties, including but not limited to, pharmaceutical manufacturers? Does your company sell, profit from, or otherwise share any of the collected information with any affiliated entities, including but not limited to, a parent company, subsidiary, or any other affiliate, including affiliated pharmacies? If so, please provide your privacy policy and any contractual restrictions your company impose on these parties' use or further sharing of such information. Please identify each entity to which such information is**

shared or has been shared since January 1, 2013. Please also explain the specific purposes behind any sharing of such information.

g. How is this information used to inform the work of diabetes management programs that your company runs?

h. Which of these data are collected by your company's diabetes management programs?

***Response*:**

Tracking patients' prescription adherence assists Express Scripts in developing tools to prevent or minimize nonadherence. In particular, predictive modeling uses proprietary models, in combination with personalized clinical services and interventions, to attempt to prevent or minimize nonadherence. Information is first gathered on patients' potential personal adherence obstacles, such as cost, clinical concerns, and/or personal behaviors or preferences. The predictive models are then used to assess which patients are at risk to be nonadherent in the future. Using this data, a tailored approach is developed—through personal clinical services and interventions, for example, consultations with licensed pharmacists—to attempt to prevent or minimize future nonadherence.

Late-to-fill logic takes an active approach to message members who are late to fill a medication. Upon login to the Express Scripts' website, the member will receive a message that prompts the member to act to fill the medication, speak with a specialist pharmacist, arrange for a follow-up reminder, or indicate that the medication is no longer needed. Pharmacy records are automatically updated with the member's selection. Members immediately react 45 percent of the time when receiving a late-to-fill message.

Express Scripts also utilizes a number of proactive adherence opportunities. Medication refill reminders are sent via standard mail, email, phone, the member website, and through mobile applications. Express Scripts also sends gap in care alerts and enhanced messaging to remind members about managing their care through standard mail, email, mobile applications, and electronic medical records. We also work with several healthcare technology partners to conduct real-time remote monitoring, which helps members and their pharmacists better manage chronic conditions, including diabetes, by immediately addressing adherence issues.

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We hope this information is helpful to the Committee. Please feel free to have your staff contact me with any questions.

Sincerely,

Michael D. Bopp

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HIGHLY CONFIDENTIAL

June 21, 2019

VIA COURIER AND ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

Re: April 2, 2019 Information Request, Second Response

Dear Chairman Grassley and Ranking Member Wyden:

We represent Cigna Corporation ("Cigna") and are writing in response to your letter to Mr. Timothy C. Wentworth, dated April 2, 2019, ("Letter") requesting information and the production of certain materials.

Please note that, as with our first response, for the purposes of this letter, we are responding exclusively on behalf of Express Scripts, Inc. ("Express Scripts," or "the Company").

As we have discussed with your Staffs, we are providing responsive information and related materials on a rolling basis. In this, our second response, please find below and enclosed on an encrypted CD documents and information responsive to a number of the Requests in your Letter, which we have reproduced below.

Certain of the information contained in this response is sensitive and nonpublic. Many Requests relate to Express Script's costs, prices, profits, and business strategy. Accordingly, providing certain information may raise competitive concerns. The FTC has explained that when competitors "exchang[e] price or other commercially sensitive information," this may "harm competition and consumers."[1] And the FTC has noted that "information relating to price, cost,

[1] Bloom, Michael, *Information Exchange: be reasonable*, FTC News & Events, Dec. 11, 2014, *available at* https://www.ftc.gov/news-events/blogs/competition-matters/2014/12/information-exchange-be-reasonable.

output, customers, [and] strategic planning" is the type of data most likely to be commercially sensitive and raise competition concerns when shared with competitors.[2] Responding to many of the Requests would require Express Scripts to disclose some of its most commercially sensitive information. Given the nature of this information, we have marked this response "Highly Confidential" and request that the information contained herein, as well as the documents produced as part of this response, not be disclosed beyond your Staffs and not be made public. Further, we request that you treat this response as a confidential committee record under Standing Rule of the Senate XXIX, clause 5. We also request that you inform us of any proposed use of the information by the Committee and first provide Cigna with an opportunity to be heard.

We are responding as follows:

Request 1
Regarding your business relationships with insulin manufacturers:

a. **Please provide a list of all insulin manufacturers with which your company has had contracts, agreements or business relationships at any time since January 1, 2013. Please explain the nature and scope of your company's business relationships with each manufacturer, including but not limited to, the size of the insulin business and any ancillary, consulting or other services, such as patient on-boarding, that your company provided these manufacturers. In addition to rebates, please list all other discounts and price concessions your company receives from insulin manufacturers—with respect to their insulin products—and fees collected that were based upon each price concession. Please also describe all other benefits that were agreed to as part of the price concession negotiation including, but not limited to, elimination of prior authorization, step therapies, and other utilization management methods.**

***Response*:**

Express Scripts has contracts with all major insulin product manufacturers—Eli Lilly and Company, Novo Nordisk, and Sanofi. The amount of rebates varies based on benefit design. Due to the unique individualized dosing of insulins and their clinical capabilities, Express Scripts does not currently offer prior authorization criteria on these products. Clients may adopt, modify or develop formularies that include or exclude certain therapeutically equivalent insulin products. Clients also have the option of utilizing step therapies to encourage the use of preferred insulin products, with an exception process available where a patient's unique health situation requires.

Please see Express Scripts' April 16, 2019 response for additional information.

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2 *Id.*

b. Please provide all contracts between your company and each of these insulin manufacturers that are or have been in effect at any time since January 1, 2013. Examples of the types of contracts include, but are not limited to, supply agreements, pricing agreements, rebate agreements, other types of pricing concession agreements, and all agreements involving the performance of services or the providing of data.

***Response*:**

Please see Express Scripts' April 16, 2019 response.

c. What cost inflation or growth rate limits does your company require from insulin manufacturers, specifically, and other manufacturers, generally? Are such limits based on list price, net price or both? What penalties, fees, rebates or other payments, if any, must manufacturers make if they exceed such commitments? How does your company account for such penalties, fees, rebates or payments from manufacturers? That is, are they kept separate from other rebate revenue, or accounted for together?

***Response*:**

Please see Express Scripts' April 16, 2019 response.

d. Please provide a list of all instances in which a contract was terminated before its expiration date. In each instance, please provide the reason for such termination, and identify the party responsible for such termination.

***Response*:**

Express Scripts is not aware of any instances in which a contract with an insulin manufacturer was terminated before its expiration date.

<u>Request 2</u>
Regarding your business relationship with health plans and programs:

a. Please provide a list of all payers for which your company has been responsible for negotiating insulin products at any time since January 1, 2013. This list should include Part D plans, Medicare Advantage, Medicaid programs or Medicaid managed care plans, Qualified Health Plans under the Affordable Care Act, and

commercial group, self-insured employers and individual health plans. Please also provide a list all "classes," i.e., groups of plans for which rebates are negotiated *en bloc*.

***Response*:**

Express Scripts has served and continues to serve thousands of clients, which include sponsors of pharmacy benefit plans in the commercial employer, union, public sector, exchange, Medicare Part D and Medicaid space, as well as TRICARE, the health program for 9.4 million uniformed service members, retirees, and their families. Express Scripts' clients make benefit design decisions, such as which pharmaceutical products to cover, for their member populations. Express Scripts negotiates with manufacturers to secure rebate discounts on insulins and other products attributable to utilization across a range of clients and develops standard formulary offerings, such as the National Preferred Formulary (NPF). While many clients adopt Express Scripts' NPF, others modify NPF or create their own custom formulary.

b. For each plan and class, please provide the number of covered lives, the number of covered lives believed to have diabetes, the number of covered lives who made claims for insulin, and the number of insulin claims on an annual basis. In providing these data, please include lives who were covered for only a portion of the calendar year. To the extent this information is reportable on a class level, please provide a list of the plans that are included in each respective class. In all cases, please delineate whether the plan is a Medicare or Medicaid plan.

***Response*:**

Express Scripts' clients sponsor a wide range of plan types and cover tens of millions of lives. As noted above, the TRICARE program alone provides coverage for 9.4 million people. The Company's combined commercial clients cover the largest number of lives at over 50 million, as well as the largest number of insulin claims in the last calendar year. In 2017, Express Scripts conducted an analysis of 26 million commercially insured members, noting that more than 5% used diabetes medication.[3] As the Committee is aware, insulins make up one category of pharmaceutical products available to treat diabetes. The 2017 analysis found that oral diabetes medications were used by more than 84% of people treated for diabetes, one in four people used

[3] Express Scripts, *Diabetes Dilemma: U.S. Trends in Diabetes Medication Use*, August 2017, pg. 3, *available at* https://lab.express-scripts.com/lab/insights/industry-updates/report-adherence-to-diabetes-rx.

insulin as part of their treatment regimen, and nearly one in 10 used insulin only.[4] Moreover, over 37% of patients used both long-acting and rapid-acting insulins for treatment.[5]

c. What assurances, if any, does your company make to health plans or programs regarding cost inflation, growth rate limits and trend agreements for insulin specifically, and prescription drug prices, generally? What, if any, penalties, fees or payments is your company required to pay if these limits are exceeded? How are these penalties accounted for?

***Response*:**

Please see Express Scripts' April 16, 2019 response.

Request 3

Please explain your process for making pricing and rebate determinations. Please provide the names of the departments, divisions and key employees involved in rebate and pricing decisions. Please provide the names and positions of all members of your company's manufacturer contracting group, and all policies, procedures and guidelines to which that group adheres. Please explain how the manufacturer contracting group interacts with the PBM's Pharmacy and Therapeutics (P&T) Committee. Who has final approval of pricing and rebate decisions, and how are these decisions communicated to plans, manufacturers and other entities within the insulin supply chain? Has your company ever had discussions with insulin manufacturers about the list prices they set for insulin products? If so, what were the nature of those discussions?

***Response*:**

Manufacturers alone set list prices; Express Scripts does not. Nor does the Company oppose manufacturers lowering list prices. In fact, Express Scripts has gone on record favoring lower list prices.[6]

Manufacturers ultimately decide whether to offer a rebate discount, and if so, what rebate to offer. When there are multiple therapies with similar clinical efficacy, the Company is able to leverage competition to drive lower costs for its clients and customers. Conversely, rebates are

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4 *Id.* at pg. 3 and pg. 12.

5 *Id.* at pg. 20.

6 Ramsey, Lydia, *The healthcare industry is starting to turn on itself as pressure over drug prices heats up*, Business Insider, March 7, 2017, *available at* https://www.businessinsider.com/express-scripts-responds-to-gilead-drug-pricing-comments-2017-3.

not typically offered for drugs without market competition (*i.e.,* sole-source brand drugs), drugs that have obtained "orphan" designation, or drugs administered by a physician. Rebates are typically only offered on brand drugs. According to a study of drugs covered under Medicare Part D, 81 percent of all drugs analyzed do not offer rebates and 64 percent of brand drugs analyzed do not offer rebates.[7] Many sole-source, highly expensive specialty drugs, like drugs to treat cancer, do not offer rebates today and continue to be priced higher and higher. Express Scripts welcomes additional competition and innovation in the marketplace that could reduce the cost of insulins and other products overall.

For additional information regarding Express Scripts' process for formulary development, please see Express Scripts' April 16, 2019 response and further responses below. Express Scripts also offers its National Preferred Flex Formulary to its clients to provide flexibility to take advantage of the possibility of a drug manufacturer choosing to lower the price of a drug by offering an authorized generic alternative. Should the manufacturer offer an authorized generic, that product can be added to the formulary.

Express Scripts' independent Pharmacy and Therapeutics (P&T) Committee does not consider price or rebates in making formulary decisions.

Request 4

Please explain your process for making PBM-based formulary placement decisions for insulin products, including specifically answering the following questions:

***Response*:**

Please see Express Scripts' April 16, 2019 response. Below, the Company has provided additional information regarding its formulary development process.

a. **Please provide the names of the departments, divisions and key employees involved in formulary placement decisions. Who has final approval of formulary decisions, and how are these decisions communicated to plans, manufacturers and other entities within the insulin supply chain?**

***Response*:**

Express Scripts' formulary development process, which is the same for insulins as for other pharmaceutical products, is based on the following principles:

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[7] Johnson, Nicholas, Mills, Charles, Kridgen, Matthew, *Prescription Drug Rebates and Part D Drug Costs*, Milliman, July 16, 2018, *available at* https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf. The Milliman analysis focused on approximately 1,300 drug and therapeutic class combinations, reflecting 97 percent of 2016 Part D gross drug spending.

1. Clinical appropriateness of the drug, not cost, is Express Scripts' foremost consideration.

2. The prescribing physician always makes the final decision regarding an individual patient's drug therapy.

3. Express Scripts will develop clinically sound formularies based on evaluations of independent physicians.

Express Scripts develops formularies through a four-step process involving the work of three distinct committees:

Therapeutic Assessment Committee — The Therapeutic Assessment Committee (TAC) is an internal clinical review body, consisting of clinical pharmacists and physicians who are employed by Express Scripts. From a formulary development perspective, the committee is tasked to review specific medications following approval by the Food and Drug Administration (FDA). Before discussing a new drug at TAC, Express Scripts' clinical team conducts a search of the medical literature, evaluates published data from clinical trials, and develops comprehensive drug evaluation summary documents. The drug evaluation documents are developed with the aid of a wide range of resources including, but not limited to: primary literature, clinical practice guidelines, and FDA-approved package inserts. The drug evaluation documents include, at a minimum: a summary of the pharmacology, safety, efficacy, dosage, mode of administration, and the relative place in therapy of the medication under review compared to other pharmacologic alternatives. Following a review of the drug evaluation summary document, TAC ultimately provides a formulary placement recommendation that is shared with the Express Scripts' Pharmacy and Therapeutics (P&T) Committee. TAC formulary recommendations are merely a suggestion and cannot be formally implemented without the approval of the P&T Committee.

Pharmacy & Therapeutics Committee — The Express Scripts P&T Committee is a group of independent, actively practicing physicians and pharmacists who are not employed by Express Scripts. The P&T Committee is tasked to review medications from a purely clinical perspective. The Committee does not have access to, nor does it consider, any information regarding Express Scripts' rebates/negotiated discounts, or the net cost of the drug after application of all discounts. The Committee does not use price, in any way, to make formulary placement decisions. Please refer to the response to Request 4b below for more information about the P&T Committee.

Value Assessment Committee — The Value Assessment Committee (VAC) considers the value of drugs by evaluating the net cost, market share, and drug utilization trends of clinically similar medications. VAC consists of Express Scripts employees from formulary management, product management, finance, human resources and clinical account management. No member of

VAC can serve in any capacity on TAC (and vice versa). VAC reviews drugs designated as optional by the P&T Committee, and develops a formulary placement recommendation.

Pharmacy & Therapeutics Committee (Annual Review) — On an annual basis, the P&T Committee will review the final formulary recommendations, by drug class, for the upcoming plan year. The Committee utilizes this opportunity to ensure adherence to previously established formulary placement recommendations, and to recommend any additional changes to ensure that the formulary is clinically appropriate. The Committee also ensures that all Express Scripts national formularies cover a broad distribution of therapeutic classes and categories, and that the formularies neither discourage enrollment by any group of enrollees nor discriminate against certain patient populations.

b. What is the role of the PBM's P&T Committee? What is the process that the P&T Committee uses to determine pricing and rebate decisions? Does the P&T Committee have discretion to make decisions and recommendations independently? Please provide any policies, guidelines or other documents that set out the process for the P&T Committee generally and in relation to insulin products specifically. Please provide all names, positions and professional qualifications of P&T Committee members since January 1, 2013. If the company contracted, employed or otherwise consulted with any specialists or experts in regards to insulin placements, please provide their names as well as a description of the work they did and contributions they made in regard to such decisions. Please provide the minutes for any P&T Committee meeting since January 1, 2013 that included a discussion of any insulin products. Please also provide all recommendations, memoranda, reports or other communications the P&T Committee produced regarding insulin, whether for internal consideration or for clients.

***Response*:**

The P&T Committee's mission is to establish and review lists of drugs known as Express Scripts Formularies in order to promote clinically sound drug therapy for the plan participants covered by the formularies. The P&T Committee is designed to ensure an unbiased clinical perspective for the formulary evaluation process from practicing physicians and pharmacists reflecting a variety of practice specialties. It has discretion to make decisions and recommendations independently.

As noted above, the P&T Committee is composed of independent, actively practicing physicians and pharmacists who are not employed by Express Scripts. P&T Committee members are selected based on contributions to the medical and pharmacy literature; national recognition in their specialty; involvement in clinical (patient care) practice—this is a membership prerequisite—

and previous experience with P&T committees. The following medical and pharmacy specialties are represented on Express Scripts' P&T Committee:

- Allergy & Asthma
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Geriatrics
- Geriatric Pharmacy
- Internal Medicine (2 members)
- Neurology
- Obstetrics & Gynecology
- Oncology
- Pediatrics
- Psychiatry
- Pulmonology
- Rheumatology

The P&T Committee has not formally contracted, employed or otherwise consulted with any additional experts regarding formulary decisions relating to insulin. The Committee is currently composed of independent, actively practicing physicians who regularly manage patients with diabetes and prescribe insulin.

As previously noted, the P&T Committee does not have access to, nor does it consider, any information regarding Express Scripts' rebates/negotiated discounts, or the net cost of the drug after application of all discounts. The P&T Committee does not use price in any way to make formulary placement decisions.

In addition to this response, the Company is providing summaries of P&T Committee meetings, from 2013 to present, that include discussion of insulin products, Bates numbered Cigna-SFC-00000001 - Cigna-SFC-00000020.

c. What, if any, analysis is conducted to gauge the impact of formulary placement decisions on patients, including, but not limited to, cost and clinical effects? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to patient or clinical impacts of insulin formulary placements since January 1, 2013. Please also provide any written communications that discuss patient or clinical impacts of insulin formulary placement decisions since January 1, 2013.

***Response*:**

Please see responses to Requests 4a and 4b, above. Additionally, the Company is providing insulin therapy class summaries for the Committee's review, Bates numbered Cigna-SFC-00000021 – Cigna-SFC-00000082, covering the following therapy classes: (1) basal, (2) human, and (3) rapid-acting analogues. These summaries analyze and compare the relevant insulin products within each therapy class, and include each drug's indications, composition, dosing, efficacy, adverse events, warning and precautions, and guidelines.

d. What, if any, analysis is conducted to gauge the impact of formulary placement decisions on your company's business, including, but not limited to revenue, gross profit per claim, rebate amounts, plan costs, and other financial metrics? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to the business impacts of insulin formulary placement since January 1, 2013. Please also provide any written communications that discuss the business impacts of insulin formulary placement decisions since January 1, 2013.

***Response*:**

Financial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process. Cumulative savings for plans leveraging the NPF since 2014 is estimated to reach $10.6 billion.

e. Please provide a list and describe any instances in which an insulin product was provided preferred formulary treatment when a therapeutic substitute was available for a lower net price. What was the reason for this decision? What was the difference in the rebate, discount or price concession between the two drugs?

***Response*:**

Express Scripts has maintained a clear, unwavering position that achieving the lowest net cost for a clinically appropriate prescription medication is its mission for its clients and their members, whether that is through a negotiated rebate or reduction in list price. As noted in Express Scripts' response letter dated April 16, 2019, clients are free to accept, reject, or modify Express Scripts' NPF, or create their own custom formulary. A formulary becomes part of a plan sponsor's benefit only after adoption by the client. Further, as mentioned above, the National Preferred Flex Formulary provides employers and health plans with the flexibility to take advantage of the

possibility of a drug manufacturer choosing to lower the price of a drug by offering an authorized generic alternative.

Request 5

For all FDA-approved insulin products since January 1, 2013, please provide a list of each PBM-based formulary placement positions, and the time periods when the formulary positions were in effect. If any FDA-approved insulin product was excluded at any time since January 1, 2013, please indicate the period when such exclusions were in effect. In addition, please provide:

a. **The number of claims for each FDA-approved product, by year, since January 1, 2013. To the extent that your company excluded an FDA-approved insulin product from its formulary, please provide for each product the number of claims that were made for the product in the calendar year before the exclusion was instituted;**

b. **On a unit basis, the size of all rebates, discounts and other price concessions for each FDA-approved product, by year, since January 1, 2013, including any intra-year changes of such rebates or concessions. Please also provide the aggregate amount of rebates, discounts, other price concessions and fees collected for each year since January 1, 2013, annually;**

c. **For each year since January 1, 2013, a breakdown of the total number of claims that fell into different formulary tiers, including but not limited to preferred, and non-preferred tiers;**

d. **The average gross profit per claim for each FDA-approved insulin product, by year, since January 1, 2013;**

e. **A description of the financial considerations, including but not limited to list price, rebates, other price concessions, price inflation agreements, and profit margins affected each FDA-approved product's formulary placement; and**

f. **A description of how clinical efficacy and patient outcomes affected the FDA-approved product's formulary placement.**

***Response*:**

Please see Appendix A below for a table that includes the formulary status for all insulin products since 2014. Additionally, the Company is providing copies of its NPF by year, Bates numbered Cigna-SFC-00000083 – Cigna-SFC-00000103.

Please note that Express Scripts does not measure the gross profit per claim for insulin products.

For more information related to this Request, please refer to Express Scripts' responses to Requests 4a and 4b.

Request 6
Regarding negotiations with pharmaceutical companies:

a. **Please list all types of financial transactions, contracts, terms of service and other agreements that are contingent in any way upon the size of a rebate or other price concessions paid by insulin manufacturers. In regard to insulin transactions, how do the size of rebates and other price concessions from pharmaceutical manufacturers affect the financial compensation your company receives? How does the size of a rebate and other price concessions affect your company's revenue and gross profit per claim? How would it affect the cost to the plans on behalf of which you are negotiating? Are there situations in which a larger rebate or price concession would incentivize your company to select a higher-priced insulin over a lower-priced therapeutic equivalent? Why or why not?**

***Response*:**

Express Scripts does not analyze how the size of rebates will affect the Company's revenue in making formulary decisions. Rather, rebates serve to lower the net cost of products for which they are offered. Express Scripts' formulary development process is based first and foremost on clinical factors, and secondarily involves consideration of net cost, market share, and drug utilization trends of clinically similar medications. As noted above, financial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process. Express Scripts does not track gross profit per claim for insulins.

b. **Please provide a list of all revenue types that your company receives from manufacturers, including but not limited to rebates, other price concessions, fees for services, and any other payments. Please describe each type of revenue and the purpose for which your company receives it. How does your company account**

for each of these payments for reporting to the Securities and Exchange Commission? How does your company account for these payments for reporting to Part D plans and the Centers for Medicare and Medicaid Services? Is revenue derived from rebates or pharmacy reimbursements ever accounted for as fees? If so, does accounting for such payments as fees allow your company to not report and pass on these fees to Part D plan sponsors?

***Response*:**

Revenues generated by Express Scripts segments can be classified as either tangible pharmacy revenues or other pharmacy service revenues. The Company earns tangible pharmacy revenues from the sale of prescription drugs by retail pharmacies in its retail pharmacy networks and from dispensing prescription drugs from its home delivery and specialty pharmacies. Other pharmacy service revenues include administrative fees associated with integrated medical benefit management solutions, the administration of retail pharmacy networks contracted by certain clients, informed-decision counseling services and certain specialty pharmacy services.

c. **Please list and describe all instances since January 1, 2013 in which your company negotiated a rebate for an insulin product that was bundled with a rebate for another product produced by the manufacturer.**

***Response*:**

Express Scripts does not initiate bundling as part of rebate negotiations.

d. **Please list and describe all instances since January 1, 2013 in which your company declined an insulin manufacturer's offer of a lower list price in the renegotiation of an existing contract or development of a new one.**

***Response*:**

Express Scripts analyzes offers based on its clinical guidance. Please refer back to the response to Request 4 for additional detail regarding Express Scripts' formulary development process.

Request 7
Regarding your insulin business:

a. **Please provide the average per member per month (PMPM) insulin costs for members who have made claims for insulin at any time since January 1, 2013.**

Please provide this information for each month of the year—i.e., there should be 12 values for each year—rather than an annual average.

As an initial matter, the Company does not track its "insulin business" as referenced in this Request. The Company is focused on reducing costs across drug products for its clients and members. Regarding clients' net prices for drug products, closely managed plans that adopt strong clinically driven benefit designs generally experience slower growth in their net cost, or in some cases even a flat or negative trend in net cost, even when the list prices change. Comparatively, plans that offer broader benefits generally experience higher rates of growth in net cost, whether calculated by average per member per month (PMPM) or some other measure.

Please refer to the response to Request 7b below for additional information.

b. Please provide the average per member per year (PMPY) insulin costs for members who have made claims for insulin at any time since January 1, 2013. Please provide this data for each of the last six calendar years.

***Response*:**

In 2018, commercial plans enrolled in Express Scripts' solution saw a 4.3% decline in spending for diabetes medications in 2018. Unit costs for diabetes drugs remained low in 2018, due in part to a -1.5% unit cost trend for insulins, while insulin utilization rose 1.8%. In total, 16.9% of insulin costs were paid by patients in 2018, with an average price of $43.19 per adjusted Rx.

In the diabetes therapy class, Express Scripts found that in 2018 the average per member per year (PMPY) spend was $114.85 for commercial plans.[8] For 2017, in the diabetes therapy class the average PMPY spend was $116.23 for commercial plans.[9] For 2016, 2015, 2014, and 2013, in the diabetes therapy class the average PMPY spend for commercial plans was $108.80[10],

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[8] Express Scripts, 2018 Drug Trend Report, pg. 10, *available at* https://lab.express-scripts.com/lab/drug-trend-report/2018-drug-trend-report.

[9] Express Scripts, 2017 Drug Trend Report, pg. 8, *available at* http://lab.express-scripts.com/lab/drug-trend-report/previous-reports.

[10] Express Scripts, 2016 Drug Trend Report, pg. 10, *available at* http://lab.express-scripts.com/lab/drug-trend-report/previous-reports.

$77.50[11], $97.68[12], and $83.53[13], respectively.

c. Please provide your annual gross profit per claim for each year since January 1, 2013.

Express Scripts does not measure gross profit at the claim level for insulins.

d. Please provide the average out-of-pocket expense per claim for each year since January 1, 2013. In providing these data, please show how much of the expense is attributable to direct-to-patient costs—i.e. cash, credit card, check, etc.—versus coupons or patient assistance programs. If you are unable to provide such a breakdown, please explain why.

Patient experience in terms of out-of-pocket costs related to insulin can vary widely due to multiple factors. First, as mentioned previously, the list price of the insulin that a patient is taking is wholly in the hands of manufacturers, which establish the list price and adjust it periodically. If, for example, the manufacturer increases the price of an insulin product effective July 1 of a given year, a patient whose plan includes a coinsurance responsibility will pay more for a prescription dispensed in September than one dispensed in May. An individual patient's experience will also depend on factors determined by his or her plan sponsor. Plan sponsors select the network of pharmacies they believe provide the right balance of access and value; adopt or create formularies they believe offer clinically appropriate and cost-effective options; and set copay tiers, coinsurance requirements, deductibles and out-of-pocket maximums.

Given the variables discussed above, a patient with a prescription for insulin could pay anything from $0 to an amount equal to some percentage less than the list price of the product. Factors include: list price of the particular insulin; dosage, quantity and days' supply; formulary and utilization management decisions by the plan sponsor; whether the plan design applicable to the patient specifies a flat copay for brand drugs (for example, $25 or $50) or a percentage coinsurance; whether the patient is in the deductible phase of his or her benefit and whether the plan combines pharmacy and medical coverage for purposes of meeting the deductible; whether the patient has reached his or her out-of-pocket maximum amount across all prescription drugs or

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[11] Express Scripts, 2015 Drug Trend Report, pg. 14, *available at* http://lab.express-scripts.com/lab/drug-trend-report/previous-reports.

[12] Express Scripts, 2014 Drug Trend Report, pg. 13, *available at* http://lab.express-scripts.com/lab/drug-trend-report/previous-reports.

[13] Express Scripts, 2013 Drug Trend Report, pg. 7., *available at* http://lab.express-scripts.com/lab/drug-trend-report/previous-reports.

medical services that patient has received; pricing negotiated by the plan sponsor; whether the patient uses a copay coupon or other assistance; and which pharmacy fills the prescription.

Average out-of-pocket costs for insulin drugs on the preventive drug list for patients in high-deductible plans was $40.69 in 2018.[14] Meanwhile, average out-of-pocket costs for insulin drugs not on the preventive drug list was $105.16.[15]

The Company is unable to provide a breakdown by cash, credit card, check, coupons or patient assistance programs, as the Company does not have access to that level of detail across all claims. When a member of a plan sponsored by one of Express Scripts' clients presents his or her identification card at a retail network pharmacy, the pharmacist sends certain specified member, prescriber and prescription information in an industry-standard format through Express Scripts' systems, which process the claim and send a response back to the pharmacy with relevant information to process the prescription. Pharmacies collect any applicable copay or coinsurance amounts as determined by Express Scripts' clients directly from the patient. The amount to be collected is messaged to the pharmacy at point of sale through Express Scripts' adjudication system, but the method of payment by the patient is generally not messaged back to Express Scripts. In addition, if the pharmacy accepts a manufacturer's coupon or other copay assistance from a third party on behalf of a member, this information is not passed back to the PBM. Accordingly, the Company does not have the ability to track or report on this information.

e. When your company sets co-pays for insulin products, is the co-pay linked to the list price or the rebated price?

Express Scripts does not set copays for insulin products. Benefit design decisions such as beneficiary cost share (whether in the form of flat dollar copay amounts or percentage-based coinsurance) are made by the Company's clients for the members they provide with coverage.

Request 8

Please explain the health information your company—or any parent company, subsidiary or affiliates, including affiliated pharmacies—collects regarding patients who are pre-diabetic, have been diagnosed with diabetes and/or make claims for insulin. For example, does your company collect health information or maintain records for levels of blood sugar, HbA1c, or albumin in the urine? What information regarding diagnostic and procedure codes does your company maintain? What information is collected regarding patients' prescription adherence? Please detail any other types of diabetes-related health information that is

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[14] Express Scripts, Drug Trend Report, pg. 8, *available at* https://lab.express-scripts.com/lab/drug-trend-report/2018-drug-trend-report.

[15] *Id.*

tracked or collected. In each instance, please specify whether this information is collected on a patient level and how the information is collected.

***Response*:**

Please see Express Scripts' April 16, 2019 response. Further responding, Express Scripts receives enrollment data from its clients, as well as pharmacy claims information on a member level. Express Scripts may also receive medical and laboratory data from its clients or their medical carriers as necessary to perform its services on behalf of its clients or in connection with its established client programs including the adherence programs outlined in its prior response. Additionally, Express Scripts may receive information from digital remote monitoring vendors, where real-time blood glucose monitoring data is shared by the patient and stored and tracked for purposes of care management and care coordination by its TRC specialized pharmacists when available. All patient health information collected and received by Express Scripts is collected, maintained, and used only in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Please also answer the following questions:

a. For what purposes is this information collected and used?

***Response*:**

For information specific to diabetes, please see Express Scripts' April 16, 2019 response. More generally, Express Scripts may collect and maintain information for multiple purposes and use that information in accordance with applicable federal and state law, including HIPAA. Express Scripts collects patient information in order to perform the agreements executed with its clients. This information may be collected in connection with specific programs as outlined in its prior response or more generally in order to complete pharmacy benefit management functions.

b. How is this information used in relationship to your company's analysis of plan costs?

***Response*:**

Please see Express Scripts' April 16, 2019 response. Further responding, Express Scripts' clients may request information and reporting to enable them to analyze and monitor plan costs.

c. How is this information used to track the health status of individual patients?

Response:

Please see Express Scripts' April 16, 2019 response.

d. Does your company, or any parent company, subsidiary, or affiliates, including affiliated pharmacies, make decisions regarding an individual patient's coverage, treatment, or any other matter based on his or her collected information? If so, please provide detailed explanations of the types of decisions that would be based on collected information, and how the information influences the outcomes.

Response:

Express Scripts provides data to its clients/plan sponsors, which ultimately make all benefit and plan design decisions for their membership. Decisions made by a pharmacy regarding a patient's care and treatment are made in accordance with applicable pharmacy practice requirements and based on information required for the operation of a licensed pharmacy. For example, a patient's health history is relevant for a pharmacist to determine whether it is safe to dispense.

e. How does your company store the information it collects? What does your company define as authorized and unauthorized uses? What specific measures are taken to protect against an unauthorized breach or use of the information? For example, has your company implemented the National Institution of Standards and Technology Cybersecurity Framework or other safeguards? If not, why not? Has your company ever suffered a breach of this information? If so, please detail the time and scope of such a breach.

Response:

Express Scripts maintains full compliance with applicable standards established by HIPAA. Information collected by affiliated pharmacies is maintained pursuant to a separate HIPAA compliant program from information collected by the PBM. Express Scripts has adopted information security measures in order to reasonably and appropriately implement the standards and specifications of the HIPAA Security Rule.

Industry standard encryption is in place where recommended and Express Scripts has implemented strict alternative measures, including rigorous, documented procedures that include:

- Logical access controls including protocols used for identification, authentication, authorization, and accountability;

- Physical security protocols, which include hyper-restricted access to physical servers to a very small number of individuals who have been rigorously vetted for such access, and for which enterprise-wide testing occurs by internal and external audit resources to test compliance with and validation of appropriate Express Scripts policies and relevant industry standards; and

- Technical security and boundary controls such as server room dual factor authentication and other designated high security areas.

Authorized uses are those permitted by HIPAA, or other applicable law, and in accordance with the Express Scripts Notice of Privacy Practices. Authorized uses are determined based on the type and holder of the applicable data in compliance with HIPAA. For example, the Company may use Protected Health Information (PHI) under HIPAA for treatment, payment or healthcare operation purposes. Unauthorized uses are those that are not permitted by HIPAA or not specified in the Express Scripts Notice of Privacy Practices. For example, using PHI for fundraising purposes would be an unauthorized use. Authorized uses by affiliated pharmacies differ from those of the PBM under these rules.

The Company has adopted policies and procedures requiring employees in all areas of its business to safeguard PHI at all times and to take steps necessary to prevent unauthorized uses. These policies address areas such as mandatory employee training, reporting of violations, system access controls and protections, mobile end-user devices, audit of information access, and use of the minimum PHI necessary. Express Scripts implements role-based access to confidential information and protection of electronic PHI to further prevent unauthorized use or disclosure of PHI.

Express Scripts is committed to safeguarding information through innovative processes and procedures. The Company has undertaken initiatives well beyond those required by the HIPAA Privacy and Security Standards to lower the practical risk of loss and currently continues to review and upgrade its technology and practices as the industry develops. Express Scripts has a dedicated Privacy Office responsible for its compliance with HIPAA and other data protection or privacy requirements, including overseeing how data is used and disclosed. Express Scripts' entire workforce is required to complete annual training, and reminders and awareness on Express Scripts' privacy, information security, and data protections policies are conducted throughout the year.

Express Scripts follows the National Institute of Standards and Technology (NIST) guidelines. The Company is also certified against the HITRUST Common Security Framework

and maintains HITRUST Certification. The Company is committed to protecting the confidentiality, integrity, and availability of client and member data through a vigilant focus on prevention, detection, and response. The Company has not been subject to any state or federal disciplinary actions for HIPAA violations.

To its knowledge, Express Scripts has not experienced a significant data or security breach involving PHI within the last five years. In particular, with regard to the information identified above, the Company has not experienced a significant data breach regarding information pertaining to insulin or diabetes diagnosis data.

f. Does your company sell, profit from, or otherwise share any of the collected information with any third parties, including but not limited to, pharmaceutical manufacturers and consultants? Does your company sell, profit from, or otherwise share any of the collected information with any affiliated entities, including but not limited to, a parent company, subsidiary, or any other affiliate, including affiliated pharmacies? If so, please provide your privacy policy and any contractual restrictions your company impose on these parties' use or further sharing of such information. Please identify each entity to which such information is shared or has been shared since January 1, 2013. Please also explain the specific purposes behind any sharing of such information.

Response:

Express Scripts receives individual member information from its clients as part of performing PBM services and may be required to provide such information as part of performing those services in compliance with applicable law including HIPAA. It accesses, uses and de-identifies data in accordance with its agreements with those clients, as well as in compliance with HIPAA. As a PBM, Express Scripts enters into appropriate business associate agreements with its clients to allow for the de-identification and other uses of client data. For example, Express Scripts may use aggregate de-identified data, to the extent permitted by the client, to improve the services offered by Express Scripts. Express Scripts does not sell member PHI.

g. How is this information used to inform the work of diabetes management programs that your company runs?

***Response*:**

Please see Express Scripts' April 16, 2019 response. Further responding, the Company regularly evaluates its pharmacy data and other respective data sources to inform its diabetes management approach. Express Scripts is constantly evaluating opportunities for improving the

health of members and has continued to innovate in this space over the last decade. Express Scripts has brought to the market several innovative programs that it has built itself in partnership with leading diabetes vendors. The goal is to bring best in class diabetes management to clients which they can adopt for their respective populations.

h. Which of these data are collected by your company's diabetes management programs?

***Response*:**

Various data may be leveraged as part of Express Scripts' diabetes management program offerings, including pharmacy claims, medical/lab data and blood glucose patient remote monitoring data.

Request 9
Regarding business relationships with pharmacies:

a. How does your company determine the reimbursement rate for pharmacies that dispense medications? In your answer, please explain whether and how your company considers overhead costs, profit margins, costs to obtain the prescription drugs from the manufacturers and/or wholesalers, and out-of-pocket costs to the patient when determining the reimbursement rate.

***Response*:**

Express Scripts negotiates reimbursements with more than 60,000 pharmacies across the country. Prescription drug acquisition costs, overhead, profit margins, as well as rates that competitors in the market offer, are all factors in these negotiations. Patient out of pocket costs are determined by individual plan sponsors and thus are not a factor in negotiations with pharmacies.

b. Does your company use a Maximum Allowable Cost (MAC) list? If so, please provide copies of that list relating to any insulin products on formularies your company created.

***Response*:**

Express Scripts uses Maximum Allowable Cost (MAC) to establish reimbursements for multisource products. MAC lists help ensure that pharmacies make prudent purchasing decisions for their pharmacies, as there can be great fluctuation between different manufacturers of the same

drug. Insulins are not generic drugs available from multiple sources. Accordingly, they are not part of the Company's MAC lists.

c. Does your company employ spread pricing contracts? If yes, please provide the following:

i. The number of contracts that operate under this structure, and the percent of volume across your book of business these contracts represent.

***Response*:**

Pharmacies charge Express Scripts amounts different from the prices at which they acquire drugs; hence, spread pricing appears in all or substantially all contracts. Express Scripts does not have access to the procurement contracts held by retail pharmacies. Any information related to the spread achieved and maintained by pharmacies would only be accessible by acquiring the information directly from the retail pharmacies.

ii. The gross profit per claim your company made on pass-through contracts on an annual basis for each year since January 1, 2013.

***Response*:**

Express Scripts does not measure gross profit at the claim level.

d. Does your company employ pass-through contracts? If yes, please provide the following:

i. The numbers of contracts that operate under this structure, and the percent of volume across your book of business these contracts represent.

***Response*:**

The Company is not aware of having entered into a pass-through contract with any Pharmacies.

ii. The gross profit per claim your company made on pass-through contracts on an annual basis for each year since January 1, 2013.

***Response*:**

Express Scripts does not measure gross profit at the claim level.

Request 10:
Does your company operate a mail order pharmacy service? If so, please provide the following:

a. The formula you use to price insulin purchased through this service, including whether you use a MAC or Average Wholesale Price and what discounts are applied in the calculation.

***Response*:**

Express Scripts offers convenient mail order pharmacy services to its clients and their members, with pharmacies located across the country. Reimbursement for insulins dispensed from its home delivery pharmacy is discounted off Average Wholesale Price (AWP). As noted above, insulins are not part of MAC lists.

b. The difference between the prices charged to plans for insulin products at preferred retailed pharmacies versus through mail order.

***Response*:**

The difference, or lack thereof, in pricing can depend on a number of factors. For example, the Company's clients can select some program offerings which result in the same average cost for the plan for insulins dispensed by preferred retail pharmacies as insulins dispensed by the Company's home delivery pharmacies. In other instances, clients may experience greater savings on insulin products dispensed to their members by the Company's home delivery pharmacies.

c. The difference in the gross profit per claim your company made on insulin product claims filled through your mail order pharmacy and insulin product claims filled through preferred retail pharmacies on an annual basis for each year since January 1, 2013.

***Response*:**

Express Scripts does not track this data.

* * *

We hope this information is helpful to the Committee in your investigation. Please do not hesitate to contact us if further information is needed.

Sincerely,

Michael D. Bopp
Appendix
Enclosure

Appendix A

Y = Preferred
N = Non Preferred
E-N = Excluded / Not Covered

CPC	Drug name	NPF FS 2014	NPF FS 2015	NPF FS 2016	NPF FS 2017	NPF FS 2018	NPF FS 2019
Insulin - Basal	Basaglar			N	Y	N	N
Insulin - Basal	LANTUS	Y	Y	Y	Y	Y	Y
Insulin - Basal	LANTUS Solostar	Y	Y	Y	Y	Y	Y
Insulin - Basal	Levemir Flexpen	Y	Y	Y	Y	Y	Y
Insulin - Basal	Levemir Vials	Y	Y	Y	Y	Y	Y
Insulin - Basal	Toujeo Solostar		Y	Y	Y	Y	Y
Insulin - Basal	Tresiba FlexTouch 100 unit/ml		N	Y	Y	Y	Y
Insulin - Basal	Tresiba FlexTouch 200 unit/ml		N	Y	Y	Y	Y
Insulin - Other	Humulin 3 mL vials	Y	Y	Y	Y	Y	Y
Insulin - Other	Humulin Pens	Y	Y	Y	Y	Y	Y
Insulin - Other	Humulin vials	Y	Y	Y	Y	Y	Y
Insulin - Other	Novolin vials	E-N	E-N	E-N	E-N	E-N	E-N
Insulin - Rapid Acting	Admelog					E-N	E-N
Insulin - Rapid Acting	Admelog Solostar						E-N
Insulin - Rapid Acting	Apidra Solostar	E-N	E-N	E-N	E-N	E-N	E-N
Insulin - Rapid Acting	Apidra Vial	E-N	E-N	E-N	E-N	E-N	E-N
Insulin - Rapid Acting	Fiasp FlexTouch 100 UNIT/ML				E-N	E-N	E-N
Insulin - Rapid Acting	Fiasp Subcutaneous Solution 100 UNIT/ML				E-N	E-N	E-N
Insulin - Rapid Acting	Humalog 3 mL vials	Y	Y	Y	Y	Y	Y
Insulin - Rapid Acting	Humalog Cartridge	Y	Y	Y	Y	Y	Y
Insulin - Rapid Acting	Humalog Pen	Y	Y	Y	Y	Y	Y
Insulin - Rapid Acting	Humalog U-200 KwikPen		Y	Y	Y	Y	Y

Insulin - Rapid Acting	Humalog Vials	Y	Y	Y	Y	Y	Y
Insulin - Rapid Acting	NovoLog Cartridge and FlexPen	E-N	E-N	E-N	E-N	E-N	E-N
Insulin - Rapid Acting	Novolog Mix	E-N	E-N	E-N	E-N	E-N	E-N
Insulin - Rapid Acting	Novolog Vials	E-N	E-N	E-N	E-N	E-N	E-N

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Michael D. Bopp
[redacted]

HIGHLY CONFIDENTIAL

September 25, 2019

VIA ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

Re: April 2, 2019 Information Request, Third Response

Dear Chairman Grassley and Ranking Member Wyden:

We represent Cigna Corporation ("Cigna") and are writing in response to your letter to Mr. Timothy C. Wentworth, dated April 2, 2019, ("Letter") requesting information and the production of certain materials.

Please note that, as with our prior responses, for the purposes of this letter, we are responding exclusively on behalf of Express Scripts, Inc. ("Express Scripts" or "the Company").

As we have discussed with your Staffs, we are providing responsive information and related materials on a rolling basis. In this, our third response, we are providing additional information in response to certain subparts of Request 4 of your Letter, which we have reproduced below.

Certain of the information contained in this response is sensitive and nonpublic. Many Requests relate to Express Scripts' costs, prices, profits, and/or business strategy. Accordingly, providing certain information may raise competitive concerns. The FTC has explained that when competitors "exchang[e] price or other commercially sensitive information," this may "harm competition and consumers."[1] And the FTC has noted that "information relating to price, cost, output, customers, [and] strategic planning" is the type of data most likely to be commercially sensitive and raise competition concerns when shared with competitors.[2] Responding to many of

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[1] Bloom, Michael, *Information Exchange: be reasonable*, FTC News & Events, Dec. 11, 2014, *available at* https://www.ftc.gov/news-events/blogs/competition-matters/2014/12/information-exchange-be-reasonable.

[2] *Id.*

the Requests would require Express Scripts to disclose some of its most commercially sensitive information.

Given the nature of the information we are providing today, we have marked this response "Highly Confidential" and request that the information contained herein not be disclosed beyond your Staffs and not be made public. Further, we request that you treat this response as a confidential committee record under Standing Rule of the Senate XXIX, clause 5. We also request that you inform us of any proposed use of the information by the Committee and first provide Cigna with an opportunity to be heard.

We are responding as follows:

Request 4

Please explain your process for making PBM-based formulary placement decisions for insulin products, including specifically answering the following questions:

[...]

b. What is the role of the PBM's P&T Committee? What is the process that the P&T Committee uses to determine pricing and rebate decisions? Does the P&T Committee have discretion to make decisions and recommendations independently? Please provide any policies, guidelines or other documents that set out the process for the P&T Committee generally and in relation to insulin products specifically. Please provide all names, positions and professional qualifications of P&T Committee members since January 1, 2013. If the company contracted, employed or otherwise consulted with any specialists or experts in regards to insulin placements, please provide their names as well as a description of the work they did and contributions they made in regard to such decisions. Please provide the minutes for any P&T Committee meeting since January 1, 2013 that included a discussion of any insulin products. Please also provide all recommendations, memoranda, reports or other communications the P&T Committee produced regarding insulin, whether for internal consideration or for clients.

***Response*:**

The Company's April 16, 2019 response described the composition of the P&T Committee (the "Committee"). *See* Cigna's April 16, 2019 Letter to Hon. Charles E. Grassley & Hon. Ron Wyden at 8-9 ("First Response"). The Company's June 21, 2019 response described the Committee's mission, noted the selection criteria used to select members, and listed the medical and pharmacy specialties represented on the Committee. *See* Cigna's June 21, 2019 Letter to Hon. Charles E. Grassley & Hon. Ron Wyden at 6-11 ("Second Response"). This response provides additional information on how the Committee operates—specifically, the

compensation Committee members receive, the terms members serve, how frequently the Committee meets, reviews of potential and actual conflicts of interest, etc.

As noted in the Company's First Response, the Committee consists of a group of fifteen independent physicians and one pharmacist from active community and academic practices representing a broad range of medical specialties. Each member of the Committee receives a stipend as compensation for preparation and participation in each of the Committee meetings, which occur at least quarterly. The stipend amount varies and is based on a reasonable estimate of the revenue that each Committee member forgoes as a result of not being able to see patients during Committee meeting attendance and preparation. Committee members serve for a three-year term and are eligible for re-appointment by the Committee. New members are elected by the current members of the Committee.

At the beginning of each Committee meeting, members disclose potential and actual conflicts of interest by declaring any relationships with pharmaceutical manufacturers and Part D plan sponsors, including membership on advisory boards, participation on speakers' bureaus, receipt of research grants, and stock ownership. Prior to each meeting, a subgroup of the Committee, the Membership Subcommittee, determines if a conflict of interest exists. Members who are determined to have conflicts of interest with a drug or manufacturer are prohibited from participating in the final discussion and voting process where a conflict exists. Committee Members are also prohibited from having direct interaction with pharmaceutical manufacturers in their role as P&T Committee Members.

On an annual basis, the Committee reviews policies and procedures mandated by CMS in the Code of Federal Regulations, and also undergoes training on Medicare Part D requirements.

As noted previously, the Committee does not access or consider financial information regarding specific manufacturers or pharmaceutical products, such as rebates, as part of the formulary development process. The Committee does not use price in any way to make formulary placement decisions. Like the Therapeutic Assessment Committee, the P&T Committee only considers clinical information.

With respect to insulins specifically, as explained in the Company's First Response, the Committee, from a clinical perspective, generally considers them to be interchangeable within their respective therapeutic categories.

[...]

d. What, if any, analysis is conducted to gauge the impact of formulary placement decisions on patients, including, but not limited to, cost and clinical effects? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to patient or clinical impacts of insulin formulary placements since January 1, 2013. Please also provide any written

communications that discuss patient or clinical impacts of insulin formulary placement decisions since January 1, 2013.

***Response*:**

The Company's Second Response included a production of therapy class summaries relating to basal insulins (Basaglar, Lantus, Levemir, Toujeo, Tresiba); human insulins (Afrezza, Humulin, Novolin); and rapid-acting analogues (Amdelog, Apidra, Fiasp, Humalog and NovoLog). *See* documents Bates numbered Cigna-SFC-00000021 – Cigna-SFC-00000082. Moreover, we refer the Committee to prior written responses and production of materials relating to the Company's formulary development process, which prioritizes clinical considerations first and foremost before evaluating net cost to clients, market share, and drug utilization trends of clinically similar medications. As previously explained, financial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process. The Value Assessment Committee ("VAC"), as described in the Company's First Response, considers financial impact to clients, but only after all clinical considerations have been taken into account. Indeed, the VAC is expressly charged with establishing formulary recommendations *within* the clinical parameters set by the P&T Committee. The Company's clients may choose to accept, reject, or modify the Company's national formularies, or create their own custom formulary.

The VAC is comprised of employees with diverse areas of expertise and deep industry experience, and three voting members are pharmacists. VAC members are from a number of departments within Express Scripts, including Formulary Management, Product Management, Finance, Human Resources, and Clinical Account Management. The VAC meets at least once per quarter. At least four of the five voting members must be present at each meeting. Formal recommendations from the VAC are determined based on a majority vote.

Each current VAC member has at least a decade or more of experience in the industry as well as significant tenure with Express Scripts. On average, the VAC members have approximately 13 years of experience at Express Scripts, and 19 years of experience in the industry.

* * *

We hope this information is helpful to the Committee. Please do not hesitate to contact us if further information is needed.

Sincerely,

Michael D. Bopp

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Michael D. Bopp
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CONFIDENTIAL

April 20, 2020

VIA ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

Re: April 2, 2019 Information Request, Sixth Response

Dear Chairman Grassley and Ranking Member Wyden:

We represent Cigna Corporation ("Cigna") and are writing in response to your letter to Mr. Timothy C. Wentworth, dated April 2, 2019 ("Letter"), requesting information and the production of certain materials, as well as your follow-up letter of February 25, 2020. Please note that, as with our prior responses, for the purposes of this letter, we are responding exclusively on behalf of Express Scripts, Inc. ("Express Scripts" or "the Company").

The Company has worked diligently to identify documents and information to supplement its prior responses to your Letter. In this, our sixth response, we are providing additional non-privileged documents and other information responsive to certain of the requests ("Requests") in the Letter. We are making these documents available via a secured electronic File Transfer Protocol (FTP) site. The documents are stamped Cigna-SFC-00016006 - 00048865.

Documents Produced. With this transmittal letter, we are producing unredacted copies of more than 3,800 documents in the following categories:

- Emails and other documents responsive to Requests 4c and 4d;
- Contracts between Express Scripts and insulin pharmaceutical manufacturers responsive to Request 1b;
- Documents responsive to Requests 2a and 2c;
- Documents responsive to Requests 5a, 5b, and 5c.

Please note that, pursuant to an understanding we reached with your staffs, we are providing slipsheets that contain the file name and page count for attachments to responsive

documents that do not include any discussion of insulin-related products and are therefore non-responsive.

In addition, we are providing narrative responses supplementing our prior responses to certain Requests, which are reproduced below.

Background/Context for Production Set. As we have discussed in previous submissions and in two briefings with staff, Express Scripts' formulary development process involves three distinct committees to create clinically appropriate formularies that deliver savings and the lowest net cost the Company can achieve for its clients. The emails we are producing include multiple exchanges between Value Assessment Committee (VAC) members and the Express Scripts staff supporting the VAC Committee. Some emails discuss assessments of insulin products for formulary placement and the reasons for those decisions. As part of the formulary development process, the VAC looks at multiple factors, many of which were described in detail during the December 12, 2019 briefing from Adam Kautzner, Chief Pharma Trade Relations Officer.

In the emails being produced today, the VAC Committee members and other Express Scripts staff who support the VAC Committee frequently employ terms and phrases related to formulary decision-making whose meanings might be ambiguous or unclear to third parties. As a result, we felt it would be helpful to the Committee to provide additional context around these commonly used terms and phrases. For example, some emails discuss "targeting" products. While the intent of that term can vary depending on the context, Express Scripts often uses the word "target" to refer to focusing on a product for possible removal from the formulary. This may also be referred to as "blocking" or "excluding" the product.

There are also discussions of products being "expensive" or "high cost." Products are often referred to as "expensive" or "high cost" when the product has a high average wholesale price (AWP) or list price. Hence, a product with the lowest net price may still be discussed as being the "most expensive" or "high cost" in certain contexts. In some situations, a product with a higher list price (but lower net cost) is selected for preferred formulary status on an Express Scripts' standard formulary. While many clients adopt Express Scripts' National Preferred Formulary (NPF), others modify the NPF or create their own custom formulary. Plan sponsors also select the network of pharmacies they believe provide the right balance of access and value, and set copay tiers, coinsurance requirements, and out-of-pocket maximums.

As discussed in our June 21, 2019 response ("Second Response"), patient experience in terms of out-of-pocket costs related to insulin can vary widely due to multiple factors. A patient with a prescription for insulin could pay anywhere from $0 to an amount equal to some percentage less than the list price of the product. Factors include: list price of the particular insulin; dosage, quantity, and days' supply; formulary and utilization management decisions by the plan sponsor; whether the plan design applicable to the patient specifies a flat copay for brand drugs (for example, $25 or $50) or a percentage coinsurance; whether the patient is in the deductible phase of his or her benefit and whether the plan combines the medical and pharmacy coverage for purposes of meeting the deductible; whether the patient has reached his or her out-of-pocket

maximum amount across all prescription drugs or medical services received; pricing negotiated by the plan sponsor; whether the patient uses a copay coupon or other assistance; and which pharmacy fills the prescription.

Another commonly used phrase by Express Scripts staff when discussing formulary development is "CPC," which refers to "Competitive Product Category." The process for naming, defining, and selecting drug products for inclusion in CPCs is overseen by Express Scripts' Clinical Integrity Council, and the Company follows strict protocols to ensure that drug product inclusion is justifiable, consistent, unbiased, and clinically sound.

The email discussions will also include references to "utilization management," "UM," "add-back," and various other phrases to describe the criteria or processes that plans will put in place to support formulary decisions. As it relates to Express Scripts' standard offerings (NPF, etc.), any clinical criteria or utilization management offered under the Company's standard formularies must conform with the Pharmacy & Therapeutic (P&T) Committee's clinical guidance.

In addition to formulary placement, Express Scripts actively negotiates with pharmaceutical manufacturers to allow appropriate utilization management strategies to be deployed by its clients. For example, two drugs may fall in the same CPC. If both drugs are deemed clinically interchangeable by the P&T Committee, Express Scripts may offer clinically appropriate utilization management to clients to prefer one product prior to the usage of another product. Another example is management of drugs based on the indications approved by the Food and Drug Administration (FDA). For products with multiple indications approved by the FDA, the Company is able to offer UM programs to prefer different products for specific indications. These UM strategies allow Express Scripts to drive competition and help lower the overall net cost of products to its clients. These decisions can sometimes influence which rebate a claim will qualify for under a rebate agreement, as long as the management decisions first align with the P&T Committee's recommendations. Importantly, the use of utilization management, and how to best manage the benefit, is always the client's decision.

Sensitivity of Information Provided and Request for Confidential Treatment. The information contained in this response is sensitive and non-public. Many of the Requests call for non-public business sensitive information that, if disclosed publicly, would cause competitive harm to Express Scripts. Further, many of the Requests relate to Express Scripts' costs, rebate structure, and overall business strategy. Accordingly, disclosing certain information may raise competitive concerns. The FTC has explained that, when competitors "exchang[e] price or other commercially sensitive information," this may "harm competition and consumers." And the FTC has noted that "information relating to price, cost, output, customers, [and] strategic planning" is the type of data most likely to be commercially sensitive and raise competition concerns when shared with competitors. Responding to many of the Requests requires Express Scripts to disclose some of its most commercially sensitive information. In its efforts to be accommodating, the Company is sharing a significant amount of non-public sensitive information with the Committee.

Given the business-sensitive nature of the information we are providing today, we have marked this response and the documents on the secured site "Confidential" and request that the information contained herein not be disclosed beyond your staffs and not be made public. Further, we request that you treat this response as a confidential committee record under Standing Rule of the Senate XXIX, clause 5 and afford it and the accompanying documents the maximum protection available to information provided to the Committee. We also request that you inform us of any proposed use of the information by the Committee and first provide the Company with an opportunity to be heard.

The information contained in this response is based on the Company's best efforts undertaken within the timeframe provided and based on its understanding of the terms of the Letter. The representations made in this response are based on information reasonably available to the Company and may not reflect all existing relevant information. The Company reserves the opportunity to supplement information in this response and will do so as warranted by the identification of additional information. In providing information and materials responsive to the Letter, Express Scripts does not waive any rights or legal options relating to the Committee's inquiry.

In this production, we are supplementing our prior responses to the following Requests in your Letter:

Request 1

[…]

a. Please provide a list of all insulin manufacturers with which your company has had contracts, agreements or business relationships at any time since January 1, 2013. Please explain the nature and scope of your company's business relationships with each manufacturer, including but not limited to, the size of the insulin business and any ancillary, consulting or other services, such as patient on-boarding, that your company provided these manufacturers. In addition to rebates, please list all other discounts and price concessions your company receives from insulin manufacturers—with respect to their insulin products—and fees collected that were based upon each price concession. Please also describe all other benefits that were agreed to as part of the price concession negotiation including, but not limited to, elimination of prior authorization, step therapies, and other utilization management methods.

***Response*:**

In addition to traditional formulary rebates, Express Scripts negotiates with pharmaceutical manufacturers for the payment of additional amounts if the manufacturer raises list prices beyond a certain point ("Inflation Protection"), as more fully reflected in the agreements being produced with this response. While the terms and conditions for Inflation

Protection in the manufacturer agreements have evolved over time and were subject to negotiation, Express Scripts has generally included Inflation Protection language in pharmaceutical manufacturer agreements since before 2013. Express Scripts holds Inflation Protection agreements that cover insulin products with Sanofi, Eli Lilly, and Novo Nordisk. Express Scripts does not collect any fees from pharmaceutical manufacturers relating to Inflation Protection.

Express Scripts has also contracted with Novo Nordisk, Sanofi, and Eli Lilly for discounts on insulin as part of the Diabetes Care Value Program since 2017. Fees are not collected by Express Scripts from pharmaceutical manufacturers relating to these discounts. Express Scripts has negotiated with the same insulin manufacturers for additional amounts as part of the Patient Assurance Program. The Patient Assurance Program became effective for enrolled clients in 2020. Express Scripts does not collect any fees from pharmaceutical manufacturers relating to the Patient Assurance Program.

Lastly, Express Scripts' affiliated mail order pharmacies hold agreements with pharmaceutical manufacturers relating to drug procurement. It is worth noting that these agreements are not held by the pharmacy benefit manager. Rather, they are procurement agreements held by affiliated pharmacies that dispense insulin to patients. In searching its contract database, the Company identified that Express Scripts' affiliated pharmacies have held purchase discount contracts relating to insulin products with Eli Lilly since 2014 and with Sanofi since 2017. Express Scripts' affiliated pharmacies have not held purchase discount contracts relating to insulin products with Novo Nordisk since 2013. Fees are not collected by Express Scripts' pharmacies from pharmaceutical manufacturers relating to purchase discounts.

b. Please provide all contracts between your company and each of these insulin manufacturers that are or have been in effect at any time since January 1, 2013. Examples of the types of contracts include, but are not limited to, supply agreements, pricing agreements, rebate agreements, other types of pricing concession agreements, and all agreements involving the performance of services or the providing of data.

c. What cost inflation or growth rate limits does your company require from insulin manufacturers, specifically, and other manufacturers, generally? Are such limits based on list price, net price or both? What penalties, fees, rebates or other payments, if any, must manufacturers make if they exceed such commitments? How does your company account for such penalties, fees, rebates or payments from manufacturers? That is, are they kept separate from other rebate revenue, or accounted for together?

***Response*:**

Please see contracts and amendments thereto responsive to these requests at Cigna-SFC-00016006 – 00017507.

Request 2

[…]

a. Please provide a list of all payers for which your company has been responsible for negotiating insulin products at any time since January 1, 2013. This list should include Part D plans, Medicare Advantage, Medicaid programs or Medicaid managed care plans, Qualified Health Plans under the Affordable Care Act, and commercial group, self-insured employers and individual health plans. Please also provide a list of all "classes," i.e., groups of plans for which rebates are negotiated *en bloc*.

***Response*:**

Please see a list of all clients invoiced by Express Scripts from 2014 to 2019, at Cigna-SFC-00017508.

[…]

c. What assurances, if any, does your company make to health plans or programs regarding cost inflation, growth rate limits and trend agreements for insulin specifically, and prescription drug prices, generally? What, if any, penalties, fees or payments is your company required to pay if these limits are exceeded? How are these penalties accounted for?

***Response*:**

Please see information responsive to this request at Cigna-SFC-00017509 - 00017518.

Request 3

Please explain your process for making pricing and rebate determinations. Please provide the names of the departments, divisions and key employees involved in rebate and pricing decisions. Please provide the names and positions of all members of your company's manufacturer contracting group, and all policies, procedures and guidelines to which that group adheres. Please explain how the manufacturer contracting group interacts with the PBM's Pharmacy and Therapeutics (P&T) Committee. Who has final approval of pricing and rebate decisions, and how are these decisions communicated to plans, manufacturers and other entities within the insulin supply chain? Has your company ever had discussions

with insulin manufacturers about the list prices they set for insulin products? If so, what were the nature of these discussions?

***Response*:**

As discussed in the formulary development white paper and the Formulary Development Firewall Policy produced as part of our March 10, 2020 response, the Company's manufacturer contracting team does not interact with the P&T Committee. Adam Kautzner is the current team lead for the manufacturer contracting team.

Request 4

[…]

c. What, if any, analysis is conducted to gauge the impact of formulary placement decisions on patients, including, but not limited to, cost and clinical effects? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to patient or clinical impacts of insulin formulary placements since January 1, 2013. Please also provide any written communications that discuss patient or clinical impacts of insulin formulary placement decisions since January 1, 2013.

d. What, if any, analysis is conducted to gauge the impact of formulary placement decisions on your company's business, including, but not limited to revenue, gross profit per claim, rebate amounts, plan costs, and other financial metrics? Please provide all analyses, memoranda, presentations, data and other information that has been used in relation to the business impacts of insulin formulary placement since January 1, 2013. Please also provide any written communications that discuss the business impacts of insulin formulary placement decisions since January 1, 2013.

***Response*:**

Please see additional email communications responsive to these requests at Cigna-SFC-00017519 - 00048864. As noted in our Second Response, "[f]inancial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process." *See* June 21, 2019 response at 10. Additional information and documents responsive to this Request were provided to the Committee in our April 16, 2019, June 21, 2019 and March 10, 2020 responses as well as in the November 7, 2019 briefing by Andrew Behm, Vice President of Clinical Evaluation and Policy, and the December 12, 2019 briefing by Adam Kautzner, Chief Pharma Trade Relations Officer.

[…]

Request 5

[…]

a. The number of claims for each FDA-approved product, by year, since January 1, 2013. To the extent that your company excluded an FDA-approved insulin product from its formulary, please provide for each product the number of claims that were made for the product in the calendar year before the exclusion was instituted;

***Response*:**

As part of this response, the Company is providing, at Cigna-SFC-00048865, the number of each FDA-approved insulin products processed by Express Scripts per year since 2014 for its Medicare and Commercial standard formularies. Data prior to 2014 is not readily accessible by Express Scripts and would take significant manual effort to collect and provide. Express Scripts previously provided information relating to formulary status for FDA-approved insulin products in our Second Response, at Cigna-SFC-00000083 - 00000103.

The numbers in this response do not include claims filled under client-managed formularies, sometimes referred to as customs or clones. It is also important to note that the claim count data is reflective of unadjusted actual claims.

b. On a unit basis, the size of all rebates, discounts and other price concessions for each FDA-approved product, by year, since January 1, 2013, including any intra-year changes of such rebates or concessions. Please also provide the aggregate amount of rebates, discounts, other price concessions and fees collected for each year since January 1, 2013, annually;

***Response*:**

Cigna-SFC-00048865 provides average wholesale acquisition cost (WAC) net of rebates for a 30 day supply of insulin products by CPC filled under Express Scripts' standard formularies between 2014-2019. Data from 2013 and prior is not readily available for data reporting. The numbers in this response do not include claims filled under client-managed formularies, sometimes referred to as customs or clones.

The amounts identified in the WAC net of rebates column for each section was calculated as the then-current WAC price, less rebates and administrative fees collected by Express Scripts during the identified period. This amount does not include other discounts, like network discounts offered by pharmacy providers based on the networks selected by the individual client.

It is important to remember that the WAC net of rebate amount reflected in these documents does not take into account individual patient cost sharing obligations. As discussed in

our previous submissions, clients determine appropriate benefit design including cost share obligations. Accordingly, a patient with a high deductible plan may pay out-of-pocket something closer to the full cost of these products at the beginning of the year regardless of formulary placement, whereas a patient with a flat copay will only pay the copay amount. These client decisions have a significant impact on how the patient and plan experience the cost of these products.

It should also be noted that not every claim is rebate eligible. Claims that are not rebate eligible are still reflected in total claim counts but Express Scripts does not receive rebates on those claims. For example, manufacturers typically exclude claims filled through the 340B program from rebate eligibility. Similarly, claims that involve a coordinated benefit are not always rebate eligible. Details about excluded claims can be found in the rebate agreements previously produced.

c. For each year since January 1, 2013, a breakdown of the total number of claims that fell into different formulary tiers, including but not limited to preferred, and non-preferred tiers;

***Response*:**

As part of this response, the Company is providing, at Cigna-SFC-00048865, the number of each FDA-approved insulin products processed by Express Scripts per year since 2014 for its Medicare and Commercial standard formularies, broken down by preferred, non-preferred, and excluded formulary status. Data prior to 2014 is not readily accessible by Express Scripts and would take significant manual effort to collect and provide. Express Scripts previously provided information relating to formulary status for FDA-approved insulin products in our Second Response, at Cigna-SFC-00000083 - 00000103.

The numbers in this response do not include claims filled under client-managed formularies, sometimes referred to as customs or clones. It is also important to note that the claim count data is reflective of unadjusted actual claims.

[…]

Request 9

[…]

a. How does your company determine the reimbursement rate for pharmacies that dispense medications? In your answer, please explain whether and how your company considers overhead costs, profit margins, costs to obtain the prescription drugs from the manufacturers and/or wholesalers, and out-of-pocket costs to the patient when determining the reimbursement rate.

***Response*:**

As stated in our Second Response, a number of factors including acquisition cost and overhead factor into the negotiations Express Scripts has with pharmacy providers for reimbursement rates. To further clarify, Express Scripts generally does not negotiate insulin-specific rates with pharmacies. Instead, these products are reimbursed under the "brand rate" in place for a given network. These brand rates cover all brand drugs, not just insulin products. In the course of negotiations, Express Scripts consistently tries to reach the lowest reimbursement rate that network pharmacies will accept. Express Scripts does this in order to remain competitive as a pharmacy benefit manager but also to ensure that clients and members have access to a robust network of low cost providers. While Express Scripts' primary focus is driving down cost across its networks, issues such as overhead, drug acquisition cost, profit margins, and front of store sales are often themes raised by pharmacy providers as rates are negotiated and ultimately contractually agreed upon. Importantly, Express Scripts does not have access to an individual pharmacy's acquisition cost data, overhead costs, or front of store sales. Further, Express Scripts is not aware of any contract with a pharmacy that is based on the pharmacy's actual acquisition cost. Because of that, Express Scripts believes pharmacies are being reimbursed in excess of their drug acquisition costs plus proportional overhead expenses in all or substantially all circumstances pursuant to the contracts between pharmacies and Express Scripts.

* * *

We hope this information is helpful to the Committee in its investigation.

Sincerely,

Michael D. Bopp

Kristin Julason Damato
Vice President
Global Public Policy & Government Affairs

701 Pennsylvania Avenue
Suite 720
Washington, DC 20004
[redacted]

December 7, 2020

VIA ELECTRONIC MAIL

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20002

Re: Context Regarding Cigna-SFC-00015159

Dear Chairman Grassley and Ranking Member Wyden:

As you know, Cigna has been cooperating with the Senate Finance Committee's ("Committee") investigation into the costs of Insulin drugs. Pursuant to recent conversations with members of the Committee staff, we are writing to provide additional detail and context to a document we previously provided to the Committee titled "Formulary Exclusions Activity and Savings Book of Business," which is appended hereto, and is Bates-stamped Cigna-SFC-00015159.

This document, dated July 23, 2014, was created as part of Express Scripts' ("ESI") routine monitoring of the prescription drug activities of clients subscribed to ESI's National Preferred Formulary ("NPF").[1] Some background on the design and implementation of the NPF will help place the document in context.

Recognizing the need to mitigate increasing drug prices, ESI launched a redesigned NPF in 2014 with the primary purpose of reducing the aggregate net costs patients pay for prescription drugs. At the time, drug manufacturers were raising prices multiple times per year as significant patent expirations neared, and the more than 11% annual price inflation[2] for brand

[1] Cigna acquired ESI in 2018.

[2] National Academies of Sciences, Engineering, and Medicine (Sharyl J. Nass, Guru Madhavan, and Norman R. Augustine eds.), Making Medicines Affordable: A National Imperative (2017) at 3, Factors Influencing Affordability. Available at: https://www.ncbi nlm nih.gov/books/NBK493090/

drugs was unsustainable for both clients and patients. Additionally, the increasing use of copay discount cards, while helpful to patients in the short term, ultimately added to costs for both patients and clients by steering patients to higher-cost brand drugs over generics.

Though not the first Pharmacy Benefit Manager to exclude drugs from a formulary, ESI recognized that limited exclusions could create competition among therapeutically equivalent pharmaceuticals by forcing drug manufacturers to lower the net costs in order to achieve preferential placement on the NPF. Preferential placement, in turn, was designed to transition our clients' members to lower net-price drugs that were therapeutically equivalent to higher net-price alternatives. The higher net-price alternatives were either placed on a higher formulary tier or excluded from the NPF. Because of ESI's scale and client base, the redesigned NPF strongly incentivized drug manufacturers to compete against each other to gain preferential formulary placement and market share by offering the lowest net-price drug in a therapy class. The NPF has lowered, and today still lowers, the net costs for payers across therapy classes so that, in the aggregate, a payer will spend less on its full basket of a drug class like insulins, while still providing comprehensive coverage between the three insulin therapy classes: Human, Basal, and Rapid-Acting. This results in lower premiums and out-of-pocket costs for consumers.

In order to lower the net price of drugs for our clients and their members, ESI negotiates with drug manufacturers a rebate amount, or price discount, on the cost of drugs. The higher the rebate a drug manufacturer is willing to provide for a particular drug, the lower the net price of the drug. Given the significant price inflation we have seen in recent years of brand name drugs, the rebates we are able to secure play a vital role in keeping these drugs affordable for patients. We pass approximately 95% of rebates, discounts, and price reductions back to our clients, which results in sizable cost savings to both our clients and their members. Recognizing the potential for cost savings for themselves and for patients, more than 90% of ESI's clients who chose the NPF in 2013 opted to accept the redesigned NPF in 2014. That figure increased to 94% in 2015. Since 2014, we calculate that the redesigned NPF has saved our clients approximately $19 billion in costs. *See* Appendix A.

* * *

With that background, we wish to explain the purpose and meaning of the document identified above and that we have attached to this letter.

ESI undertook a massive client, consumer, physician, and pharmacist outreach campaign months in advance of and during the 2014 launch of the redesigned NPF. ESI understood that excluding 1% of utilized drugs would require a significant amount of time to implement appropriately, despite the availability of therapeutically equivalent alternatives.[3] As a result of this outreach campaign, through which ESI detailed to its clients the cost-saving benefits the NPF provided, ESI received very few calls into its call centers.

[3] 48 products were excluded from the 2014 NPF.

The document identified above and attached to this letter was one of a number of weekly internal reports that tracked aggregate prescriptions filled after the launch of the redesigned NPF, including preferred prescriptions filled ("Fill Preferred"), non-preferred prescriptions filled ("Fill Non Preferred"), and prescriptions not filled ("No Fill") as the NPF was implemented. This tracking sheet aided in sustained outreach to consumers and physicians to ensure awareness of the therapeutically-equivalent alternatives available at a lower cost, in an effort to reduce the number of prescriptions not filled ("No Fill"). ESI also implemented a formulary exception process for those unique instances where a customer, physician, or pharmacist requested coverage of an excluded drug, and ESI approved the majority of exception requests.

This tracking document was updated weekly from January 1, 2014 and indicates that, as of July 23, 2014, the majority of individuals seeking excluded drugs successfully transitioned to preferred drugs. For individuals specifically seeking excluded insulin products, 70% transitioned to preferred products and 6% to non-preferred products. As these aggregate figures only represent a point in time, they do not capture the ongoing actions of patients and physicians to receive future fills based on new prescriptions or clinical exceptions. It is important to note the vast majority of physician requests for medical exceptions for patients to remain on excluded drugs were approved, including 77% of requests for excluded insulin products. In total, across all claims for covered and excluded insulin products over January 2014 through July 23, 2014, approximately 1% of insulin claims on the formulary received a reject of an excluded insulin product and were counted in the "No Fill" column.

Importantly, many of the individuals whose claims were counted in the 1% "No Fill" column actually received medications. Because the figures in this document were updated weekly, the rolling figures are inclusive of historical "No Fill" claims that could have been filled through one of several exception categories. For example, if the prescriber determined to move the patient to an insulin product in a different therapy class as opposed to the preferred product in the originally prescribed therapy class, the claim would continue to appear in the "No Fill" column on the spreadsheet. Similarly, there are other scenarios where the patient could have received medication without Express Scripts receiving the claim, and thereby continuing to count as a "No Fill." For example, the patient could have had secondary coverage with another payer that ultimately paid for the original prescription, the patient could have received the prescription through a pharmaceutical manufacturer-funded program, or the patient could have paid cash for certain products. Additionally, a patient could be counted as a "No Fill" for an extended period of time simply because the patient has an adequate amount of medication on hand. Lastly, even after all prescriptions are adjudicated, roughly 10% of all prescriptions may not be picked up at a pharmacy for a variety of reasons. These too would appear in the "No Fill" column on the spreadsheet.

We feel this context is important for interpreting the spreadsheet. To that end, while the "No Fill" percentages were used by ESI as indications of needs for additional patient, pharmacy, or prescriber outreach, they should not be assumed to reflect gaps in care.

# # #

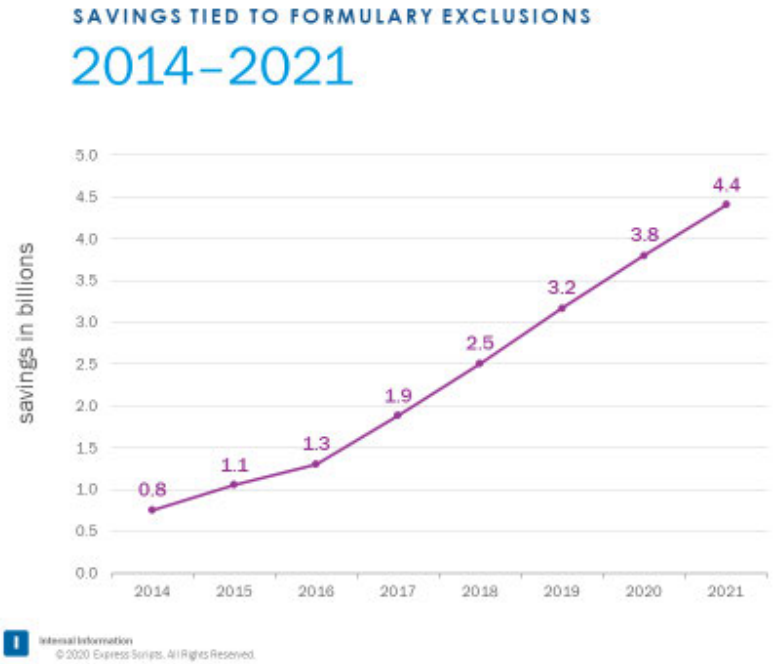
Should the Committee decide to make public the attached document, Bates-stamped Cigna-SFC-00015159, we ask that this letter be appended at the beginning of that document so that readers will have the benefit of the context provided in this letter.

Thank you for your consideration.

Sincerely,

Kristin Julason Damato
Vice President

APPENDIX A



White Paper: Formulary Development at Express Scripts

Express Scripts works with health-benefit plan sponsors and individual members of health plans to provide affordable access to clinically sound, high-quality pharmaceutical products. Drug formularies are one method of achieving this result.

From time to time, Express Scripts receives questions about how it develops formularies that are both clinically sound and cost-effective. This white paper is designed to answer those questions. The Express Scripts' formulary development process is based on the following principles:

1. *Clinical appropriateness* of the drug, not cost, is Express Scripts' foremost consideration.

2. The prescribing *physician always makes the final decision* regarding an individual patient's drug therapy.

3. Express Scripts will develop clinically sound formularies *based on evaluations of independent physicians.*

Consistent with these principles, Express Scripts offers a variety of standard formularies. Plan sponsors, based on their own unique situation, can select a formulary that is most appropriate for their members.

How Express Scripts Develops Formularies

Express Scripts has many years of formulary development expertise and an extensive clinical pharmacy department. Express Scripts develops formularies through a four-step process involving the work of three distinct committees:

1. Therapeutic Assessment Committee
2. National Pharmacy & Therapeutics Committee
3. Value Assessment Committee
4. National Pharmacy & Therapeutics Committee (annual formulary review)

Therapeutic Assessment Committee — The Therapeutic Assessment Committee (TAC) is an internal clinical review body, consisting of clinical pharmacists and physicians who are employed by Express Scripts. From a formulary development perspective, the committee is tasked to review specific medications following approval by the Food and Drug Administration (FDA). Before discussing a new drug at TAC, Express Scripts' clinical team conducts a search of the medical literature, evaluates published data from clinical trials, and develops comprehensive drug evaluation summary documents. The drug evaluation documents are developed with the aid of a wide range of resources including, but not limited to: primary literature, clinical practice guidelines, and FDA-approved package inserts. The drug evaluation documents include, at a minimum: a summary of the pharmacology, safety, efficacy, dosage, mode of administration, and the relative place in therapy of the medication under review compared to other pharmacologic alternatives. Following a review of the drug evaluation summary document, TAC ultimately provides a formulary placement recommendation which is shared with the Express Scripts' National Pharmacy and Therapeutics (P&T) Committee. TAC formulary recommendations are merely a suggestion and cannot be formally implemented without the approval of the P&T Committee.

National Pharmacy & Therapeutics Committee — The Express Scripts' National P&T Committee is a group of independent, actively practicing physicians and pharmacists who are not employed by Express Scripts. The P&T Committee is tasked to review medications from a purely clinical perspective. **The Committee does not have access to, nor does it consider, any information regarding Express Scripts' rebates/negotiated discounts, or the net cost of the drug after application of all discounts. The Committee does not use price, in any way, to make formulary placement decisions.** The Express Scripts' P&T Committee reviews a much broader range of formulary placement topics than TAC, including: new drug evaluations, new FDA-approved indications for existing drugs, new clinical line extensions, and new published or clinical practice trends that may impact previous formulary placement decisions.

For new drug evaluations, the P&T Committee reviews the relevant drug evaluation summary documents as well as the formulary placement recommendation from TAC. In addition, members of the P&T Committee provide their insight into the quality of the published literature, share their clinical practice experience, and assess the relative place in therapy of the medication and therapy class. The P&T Committee can establish one of the following three formulary placement designations: *include*, *exclude*, or *optional* from a formulary. Drugs with a designation of ***include*** are recommended for placement on all formularies. Drugs may be given an *include* designation for one or more of the following clinical reasons: unique indication for use addressing a clinically significant unmet treatment need, efficacy superior to that of existing therapy alternatives, a safety profile superior to that of existing therapy alternatives, a unique place in therapy, and/or drugs which treat medical conditions that necessitate individualized therapy and for which there are multiple treatment options. Drugs with an ***exclude*** designation are not recommended for formulary inclusion. Drugs may be given an *exclude* designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Medications recalled from the market for safety reasons take an automatic *exclude* status, and are formally reviewed at the next P&T Committee meeting. Drugs may also be designated as ***optional*** on a formulary. Drugs may be given an *optional* designation based on the conclusion that they are clinically similar to other currently available drug alternatives. Optional medications are forwarded to the Value Assessment Committee for further analysis.

Value Assessment Committee — The Value Assessment Committee (VAC) considers the value of drugs by evaluating the net cost, market share, and drug utilization trends of clinically similar medications. VAC consists of Express Scripts' employees from formulary management, product management**,** finance**,** and clinical account management. No member of VAC can serve in any capacity on TAC (and vice-versa). VAC reviews drugs designated as *optional* by the P&T Committee, and develops a formulary placement recommendation. VAC is required to add medications with an *include* designation to formulary, while drugs with an exclude designation are not added to formulary. In both cases, economic considerations are superseded by the clinical requirements of the P&T Committee. Once complete, formulary placement recommendations are then forwarded to the P&T Committee for final approval.

National Pharmacy & Therapeutics Committee (Annual Review) — On an annual basis, the National P&T Committee will review the final formulary recommendations, by drug class, for the upcoming plan year. The Committee utilizes this opportunity to ensure adherence to previously established formulary placement recommendations, and to recommend any additional changes to ensure that the formulary is clinically appropriate. The Committee also ensures that all Express Scripts national formularies cover a broad distribution of therapeutic classes and categories, and that the formularies neither discourage enrollment by any group of enrollees nor discriminate against certain patient populations.

National Pharmacy & Therapeutics Committee: Overview

The Express Scripts National P&T Committee consists of 15 physicians and one pharmacist from active community and academic-based practices representing a broad range of medical specialties. The Committee is chaired by an elected member. Two Express Scripts registered pharmacists, an Express Scripts Medical Director, and the Chief Medical Officer provide staff support to the Committee.

The following medical and pharmacy specialties are represented on Express Scripts' P&T Committee:

- Allergy & Asthma
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Geriatrics
- Geriatric Pharmacy
- Internal Medicine (two members)
- Neurology
- Obstetrics & Gynecology
- Oncology
- Pediatrics
- Psychiatry
- Pulmonology
- Rheumatology

Members are selected by the Committee based on:

1. contributions to the medical and pharmacy literature
2. national recognition in their specialty
3. involvement in clinical (patient care) practice (membership prerequisite)
4. previous experience with P&T committees

Members of the Express Scripts' National P&T Committee receive a stipend for preparation for and participation in the meetings. The stipend amount is based on a reasonable estimate of revenue lost by not seeing patients while out of the office for meeting attendance and preparation. New committee members are elected by current members of the Committee. Members serve for a three-year term and are eligible for re-appointment by the Committee. At the beginning of each Committee meeting, members disclose potential and actual conflicts of interest by declaring any relationships with pharmaceutical manufacturers and Part D plan sponsors, including membership on advisory boards, participation on speakers' bureaus, receipt of research grants, and stock ownership. Prior to each meeting, a subgroup of the P&T Committee or Membership Subcommittee reviews all member disclosure information and determines if a conflict of interest exists. Members who are determined to have conflicts of interest are prohibited from participating in the final discussion and voting process for medications or manufacturers where a conflict exists. In the event a conflict of interest is determined to be so significant that a member of the Committee is unable to participate in most proceedings, the member will be asked to resign from the Committee.

The P&T Committee meets at least quarterly to evaluate drugs for addition to or deletion from the formulary. If necessary, mail ballots may be used to seek committee member comments and approval for new clinical designations between meetings (e.g., following FDA approval of a therapeutic-breakthrough drug).

How Express Scripts Plan Sponsors Manage Their Formularies

Express Scripts' plan sponsors often adopt Express Scripts-developed formularies as their own or use them as the foundation for their own custom formularies. Among the more than 70 therapeutic categories, custom formularies can vary in the number of brand-name drugs per category and in the extent to which the pharmacy benefit is managed in each category.

Formulary control levels are specified through benefit design. At one end of the spectrum is the open formulary. With an open formulary, the plan sponsor pays a portion of the cost for all drugs, regardless of formulary status, although a plan sponsor may choose to exclude certain products, such as 'lifestyle' drugs, from coverage. At the other end of the spectrum is the closed formulary. With a closed formulary, non-formulary drugs are not covered unless approved via a formulary exclusion override process. Between these two alternatives, a plan sponsor can implement differential copays (as with a three-tier benefit design) or other financial incentives to encourage participants to use preferred formulary drugs, but will still pay a portion of the cost of the non-preferred drug.

For example, a plan sponsor using a three-tier benefit design may elect to manage a particular therapeutic category by making all generics in that category available at the first-tier copay level and preferred branded products available at the second-tier copay level. Non-preferred, non-formulary products could be placed on the third tier — available, but at a higher copay.

After first taking into account clinical considerations, plan sponsors consider cost in making their formulary choices. Generally, the fewer the drugs offered on the formulary and the greater the incentives to use the formulary's preferred drugs, the higher the discounts available from manufacturers and, therefore, the lower the cost to the plan sponsor. All formularies offer generics at the lowest cost and typically include the vast majority of available generic products.

Express Scripts is able to administer lower-cost prescription drug benefits for plan sponsors in part because of the rebates that ESI receives from manufacturers. A rebate is simply a retrospective payment that is paid to ESI pursuant to rebate contracts negotiated independently by ESI with pharmaceutical manufacturers and directly attributable to the utilization of certain pharmaceuticals by our client's members. Many factors can affect the amount of the rebate, but in general, higher rebates are achieved when a plan sponsor adopts a formulary and plan design that provides greater incentives to its participants to use a formulary (preferred) drug.

Accessing Non-Formulary Medications

Express Scripts encourages plan sponsors to develop formulary systems that enable individual patient needs to be met with non-formulary drug products when demonstrated to be clinically justified by the physician or other prescriber. Generally speaking, plan sponsors should offer an efficient process for the timely procurement of non-formulary drug products, impose minimal administrative burdens, and provide access to a formal appeal process if request for a non-formulary drug is denied.

Due to the variability in plan sponsor benefit design, Express Scripts encourages individual patients who are attempting to access a non-formulary medication for clinical purposes to contact the phone number, mailing address or website outlined on their prescription drug card. The decision to cover non-formulary medications, as well as the mechanism by which it is administered, is entirely determined by the plan sponsor; not Express Scripts.

Express Scripts Formulary Compliance Programs

Express Scripts' plan sponsors also achieve formulary management through participation in one of Express Scripts' Formulary Compliance programs. These programs help plan sponsors reduce overall prescription

drug costs by encouraging utilization of preferred drugs (generics and formulary brand name medications) through intervention strategies.

Express Scripts never recommends changing to a higher-cost drug, but it may suggest an equally-effective, lower-cost drug (typically, a generic) before a more expensive brand name alternative. The Express Scripts formulary compliance programs provide clear information about formulary drugs to all of the participants in the prescription-dispensing process. For example, when a prescription for a drug that is not on the member's formulary is taken to a retail pharmacy in our network, the **claims processing system** notifies the pharmacist of comparable drugs that are covered by the member's plan. The pharmacist can then work with the member and the prescriber to replace the originally-prescribed drug with an appropriate formulary product, if possible. A second example is our **formulary notification program**. The formulary notification program sends targeted letters to members who are taking a maintenance medication that will soon become non-formulary. These notifications frequently include a list of clinically similar, formulary alternatives. The member can take this type of communication to their physician, and determine if a formulary alternative is right for them. The third type of formulary support tool includes Express Scripts' **web-based tools**. Express Scripts and/or the members' plan sponsor provides a suite of online resources including: copies of the formulary, relative price comparisons of therapeutic alternatives, and information about which drugs have a generic equivalent.

Conclusion

Prescription drug costs, which represent more than 10 percent of the overall healthcare dollar, continue to increase for a variety of complex reasons. As a result, the job of managing the pharmacy benefit has become an essential element of the overall healthcare management equation. Left unmanaged, plan sponsors' costs would rise at faster rates, with the likely ultimate result of reduced benefits and higher costs to consumers.

Affordable access to a clinically sound, high-quality pharmacy benefit depends on sophisticated, carefully constructed cost-control strategies — strategies that always place patients and their physicians first. The processes Express Scripts uses to develop formularies have been constructed to ensure that clinical considerations are paramount and fully taken into account *before* cost considerations. Express Scripts has also implemented one of the industry's most unique cost-lowering rebate policies — one which ensures that each drug is considered individually on its own merits with the active involvement of our plan sponsors. Finally, Express Scripts' has a number of tools (formulary, plan design, and clinical programs) to ensure that plan sponsors maximize the use of lower cost, clinically-equivalent generic medications. By combining the solutions above, plan sponsors can continue to offer a fair, clinically appropriate, and financially responsible pharmacy benefit.

Revised October 2016

EXPRESS SCRIPTS, INC.
AMENDMENT TO THE
PREFERRED SAVINGS GRID REBATE PROGRAM AGREEMENT

2014/2015 Rebate Cycle Bid Enhancement Opportunity

THIS AMENDMENT ("Amendment"), effective January 1, 2014, is made to the Preferred Savings Grid Rebate Program Agreement dated effective February 1, 2010, by and between Express Scripts, Inc. ("ESI") and Novo Nordisk Inc. ("Company") (the "Agreement").

Recitals

WHEREAS, ESI has offered Company an opportunity to participate in the 2014/2015 Preferred Savings Grid Bid Enhancement Opportunity (the "2014/2015 Commercial Bid"); and

WHEREAS, Company has reviewed the conditions under which the bid enhancements offers will be considered and desires to participate in 2014/2015 Commercial Bid, for purposes of providing competitive pricing terms, on the utilization of certain Products by Participants under a Plan, in accordance with this Amendment.

NOW, THEREFORE, the parties agree as follows:

Terms of Agreement

1. Exhibit A. With respect to the 2014/2015 Rebate Cycle and all subsequent Rebate Cycles, any pre-existing Exhibit A to the Agreement is hereby deleted in its entirety and replaced with a new Exhibit A, as set forth on Attachment 1 to this Amendment.

2. Rebate Bid Offers. Exhibit A of the Agreement is amended to restate Attachment A-1 of Exhibit A in the form attached to this Amendment as Attachment 2. Company shall provide Rebate bid offers for (i) retail utilization, and (ii) utilization dispensed from home delivery/specialty pharmacies owned by ESI or its Affiliates ("ESI Home Delivery/Specialty Pharmacy Utilization"). Any Rebate bid offer not providing Rebates for both (i) retail utilization, and (ii) ESI Home Delivery/Specialty Pharmacy Utilization shall be considered non-compliant and the applicable Products rejected from consideration for Formulary placement.

   The Rebate bids, as offered on the Attachment 2 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of certain Products by Participant. Attachment 2 attached hereto shall supersede and replace Attachment A-1 to Exhibit A of the Agreement. Company acknowledges that Rebate bids offered by Company and accepted by ESI under this Amendment shall be effective as of January 1, 2014, and shall remain in effect through the term of the Agreement, except to the extent replaced by a revised rebate bid mutually agreed to in writing by Company and ESI at a later date.

3. Rebate Enhancement Options. The Rebate Enhancement Options offered on Attachment 2 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of certain Products by Participant. For purposes of this Amendment and the Agreement, the term "Rebate Enhancement Options" shall mean those opportunities designated as such in Table 1 of Exhibit A attached hereto and additional Rebate opportunities outside of the intersecting Benefit Control/Formulary Positions cells (as defined in Exhibit A of Attachment 1 attached hereto) including, but not limited to, Select Client Options as defined below. Company acknowledges that Rebate Enhancement Options offered by Company and accepted by ESI under this Amendment shall be effective as of January 1, 2014 and shall remain in effect through the term of the Agreement. Rebate Enhancement Options accepted by ESI shall replace only the corresponding and existing Rebate Enhancement Options, if any. Except as amended herein, any previously contracted Rebate Enhancement Options currently in place shall remain in effect through the term of the Agreement, except to the extent modified in writing by mutual agreement of the parties at a later date. Enhanced Rebates for utilization of Products by Participants of specific Plans ("Select Client Options") currently in place shall continue in effect through the term of the Agreement.

4. Affiliate Rebates and Administrative Fees. For calendar year 2014 and thereafter, ESI shall submit to Company Eligible Utilization from all its affiliates, including, but not limited to, Medco Health Solutions, Inc. ("Medco"), for payments of Rebates and Administrative Fees and Company is obligated to pay ESI such Rebates and Administrative Fees for Eligible Utilization, in accordance with the Agreement. Such utilization submission for Rebates and Administrative Fees shall not be duplicative across this Agreement and any agreement with ESI's affiliates.

5. Other Agreements. Company acknowledges and agrees, for calendar year 2014 and thereafter, that this Agreement and the Rebates and Administrative Fees contained in the Agreement, and amended herein, shall supersede all agreements and related Formulary Rebates and associated Administrative Fees that have been agreed upon by Company and Medco ("Original Medco Formulary Rebate Agreements") in other agreements; provided, however, that any and all Plan-specific rebate and administrative fee agreements between Company and Medco currently in effect as of the execution date of the Amendment (as noted below) shall remain in effect until the earlier of the expiration date of such Plan-specific rates or when added to this Agreement through a mutual written amendment. For purposes of clarity, the Agreement shall not apply to rebates Medco receives from Company during calendar year 2013 or any prior calendar year. In such instance, the Original Medco Formulary Rebate Agreement shall apply.

6. Price Protection. In accordance with the terms set forth on Attachment 3 to this Amendment and the applicable terms of the Agreement, including Attachment A-1 to Exhibit A, Company may elect to pay Price Protection Rebate, with respect to Eligible Utilization for Company Products, as indicated on the Rebate matrix.

7. Term. Company acknowledges and agrees that effective upon the execution of this Amendment by Company, the term of the Agreement shall be extended through December 31, 2015, subject to earlier termination as provided in the Agreement.

8. Except as amended herein, all terms and conditions of the Agreement shall remain in effect.

Company represents that the following signature is that of an authorized representative of Company.

Novo Nordisk Inc.

By: _____
Signature

Name: JESPER KOEILAND
(please print)

Title: PRESIDENT
(please print)

Date: 1/17/2014

NOVO
DATE 1/24/13
INITIAL KEH

Except to the extent ESI has specifically indicated otherwise on the attached matrices, ESI accepts the Rebates offered by Company on the attached matrix.

Express Scripts, Inc.

By: _____
Signature

Name: E. Everett Neville

Title: Chief Trade Relations Officer

Date: 01-23-2014

APPROVED AS TO LEGAL FORM
1/22/14
LEGAL DEPT.

Attachment 1

EXHIBIT A

Preferred Savings Grid Rebate Program
Rebates – January 1, 2014 and Thereafter

Bidding Process:

For purposes of evaluating applicable Formulary determinations, ESI will solicit new Rebate offers and/or enhancements to existing Rebates for Company's Products in connection with each Rebate Cycle. At any time during the term of this Agreement, ESI may solicit new or enhanced Rebate offers with respect to any CPC based on changes in the marketplace.

In connection with a re-bidding process, Company may submit revised Rebate offers for an applicable Product at the time of ESI's solicitation. If Company does not respond by submitting a revised Rebate offer with respect to a Product, then the previously accepted Rebate, including any previously accepted enhancements, shall be deemed to be Company's Rebate offer for purposes of the bidding process. Company shall provide Rebates for both (i) retail utilization, and (ii) ESI Home Delivery/Specialty Pharmacy Utilization. Any Rebate bid offer not providing Rebates for both (i) retail utilization, and (ii) ESI Home Delivery/Specialty Pharmacy Utilization shall be considered non-compliant and the applicable Products rejected from consideration for Formulary placement.

Products are grouped by ESI based on Competitive Product Categories ("CPCs"). Manufacturer products in the same CPC compete against each other for participation in the PSG Rebate Program and for formulary status with respect to each Formulary. For purposes of this Agreement, classification of a product as a "brand" or "branded" product shall be as reasonably determined by ESI.

The number of manufacturers' products within a CPC designated as Preferred for each Plan differentiates one Formulary from another in terms of the "Formulary Positioning" (described more specifically below). For purposes of this Bid Amendment, the term "Preferred" refers to a Product that adjudicates at the lowest co-pay or coinsurance tier for branded products within its designated CPC.

ESI also categorizes each Plan in the PSG Rebate Program according to the Plan's benefit design attributes. The "Benefit Control" (defined more specifically below) determines the relative level of formulary compliance control affecting product utilization by Participant under the applicable Plan.

As shown on the following diagram, a matrix (or "Grid") is used to plot the Rebates for each Product based on the intersecting points on the Grid (each such intersection is often referred to as a "cell") reflecting the foregoing elements, as applicable to each Participant's utilization:

Table 1

CURRENT PSG[1]

		Formulary Positioning			
		1 of Many	1 of 3	1 of 2	Exclusive
Benefit Control	Open	%	%	%	%
	Controlled	%	%		
	Closed	%	%	%	%
Rebate Enhancement Options	PST/Closed No Grandfathering[2]	%	%	%	%
	Unrestricted Enhancement[3]	%	%	%	%
			Restricted[4a]		Unrestricted[4b]
	Non-Preferred Formulary Access[4]	%		%	

[redacted]

Formulary Positioning:

With respect to each Formulary, ESI or the applicable Plan, in conjunction with the oversight and approval of the applicable Pharmacy and Therapeutics ("P&T") Committee, will determine the appropriate product (or products) to be designated as Preferred. In this way, the Plan will ultimately determine the applicable "Formulary Positioning" for each designated CPC, either based on a Formulary developed by ESI or the Plan's customized Formulary design. The Formulary Positioning used within the PSG Rebate Program will be defined as follows:

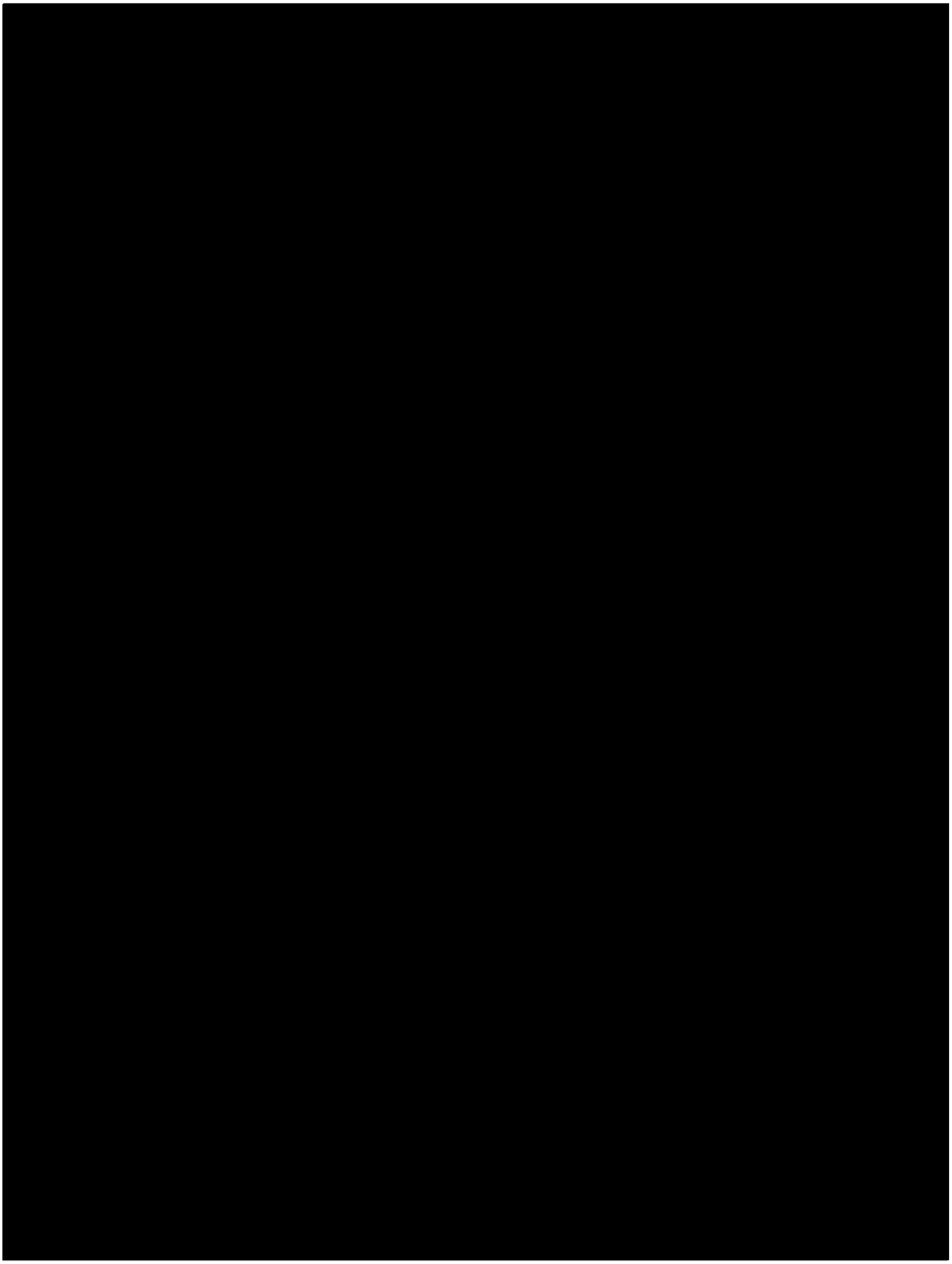
1 of Many	Designates those CPCs within a Formulary for which four (4) or more branded manufacturers whose products are competing in the CPC as Preferred.
1 of 3	Designates those CPCs within a Formulary for which three (3) branded manufacturers whose products are competing in the CPC as Preferred.
1 of 2	Designates those CPCs within a Formulary for which two (2) branded manufacturers whose products are competing in the CPC as Preferred.
Exclusive	Designates a CPC within a Formulary for which only one (1) branded manufacturer whose products is Preferred.

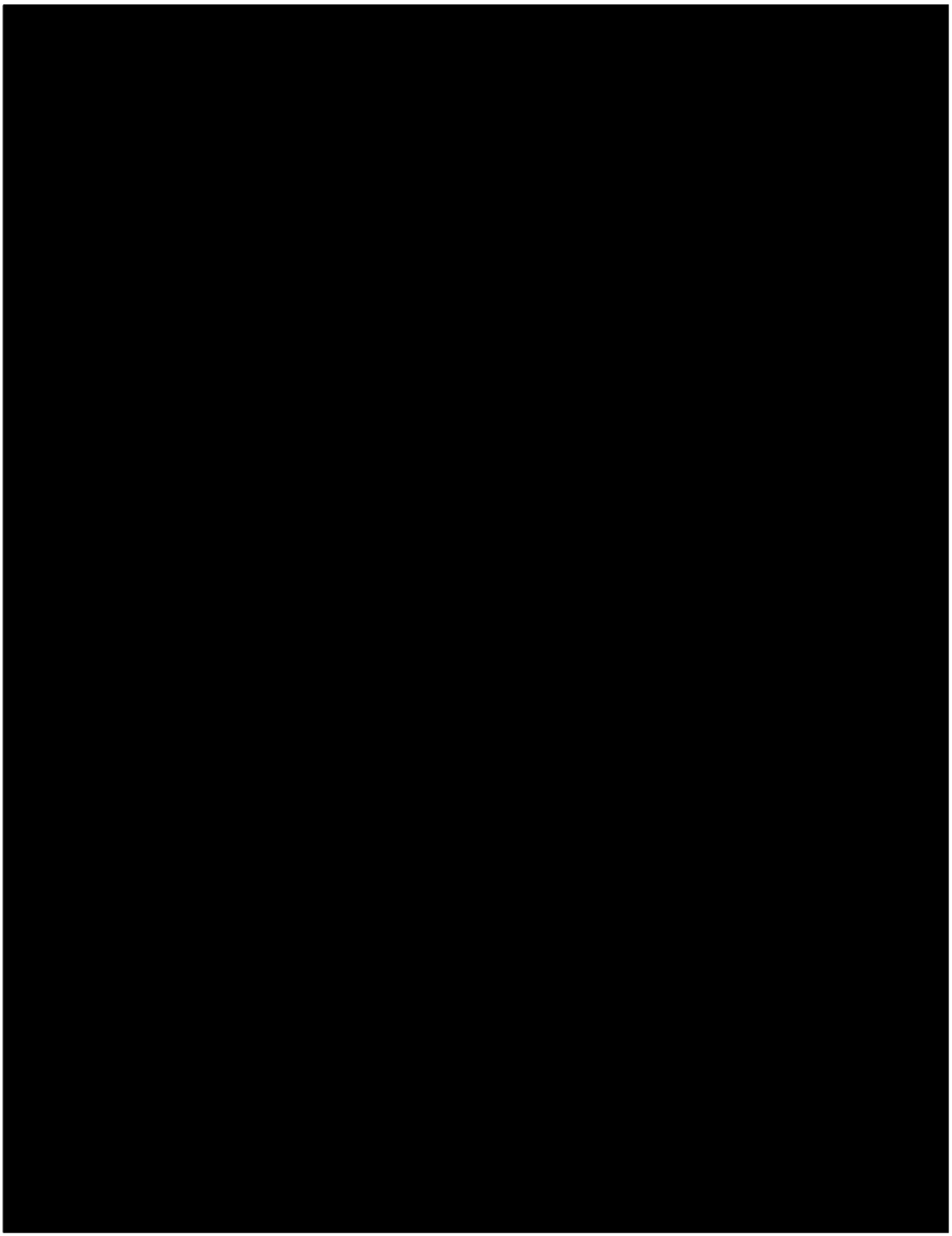
Benefit Control:

As referenced above, "Benefit Control" shall mean a certain set of Formulary compliance control mechanisms that are imposed with respect to each Plan. The Benefit Control that will differentiate the level of Rebates due are defined as follows:

Open	Refers to a benefit design under which the Product is Preferred.
Controlled	Refers to a benefit design under which the Product is Preferred and under which a higher co-payment or coinsurance percentage for non-Preferred products applies when the Plan provides reimbursement.
Closed	Refers to a benefit design under which the Product is Preferred; however, with respect to any non-Preferred products, the Plan also (i) requires use of Preferred over non-Preferred brand, through step therapy or a similar intervention process; or (ii) requires the Participant to pay 100% of the applicable price of such products regardless of whether any applicable deductible has been satisfied; or (iii) imposes an NDC block against coverage benefits for such products. Provided, however, in each case Participant may obtain the non-Preferred or non-covered product when medically necessary. Existing users of non-Preferred product shall be allowed to continue to receive the non-Preferred product.

When a Product is dispensed or administered to a Participant, the "cell" that corresponds to both the applicable Formulary Positioning and the Plan's Benefit Control will determine the Rebate amount due.





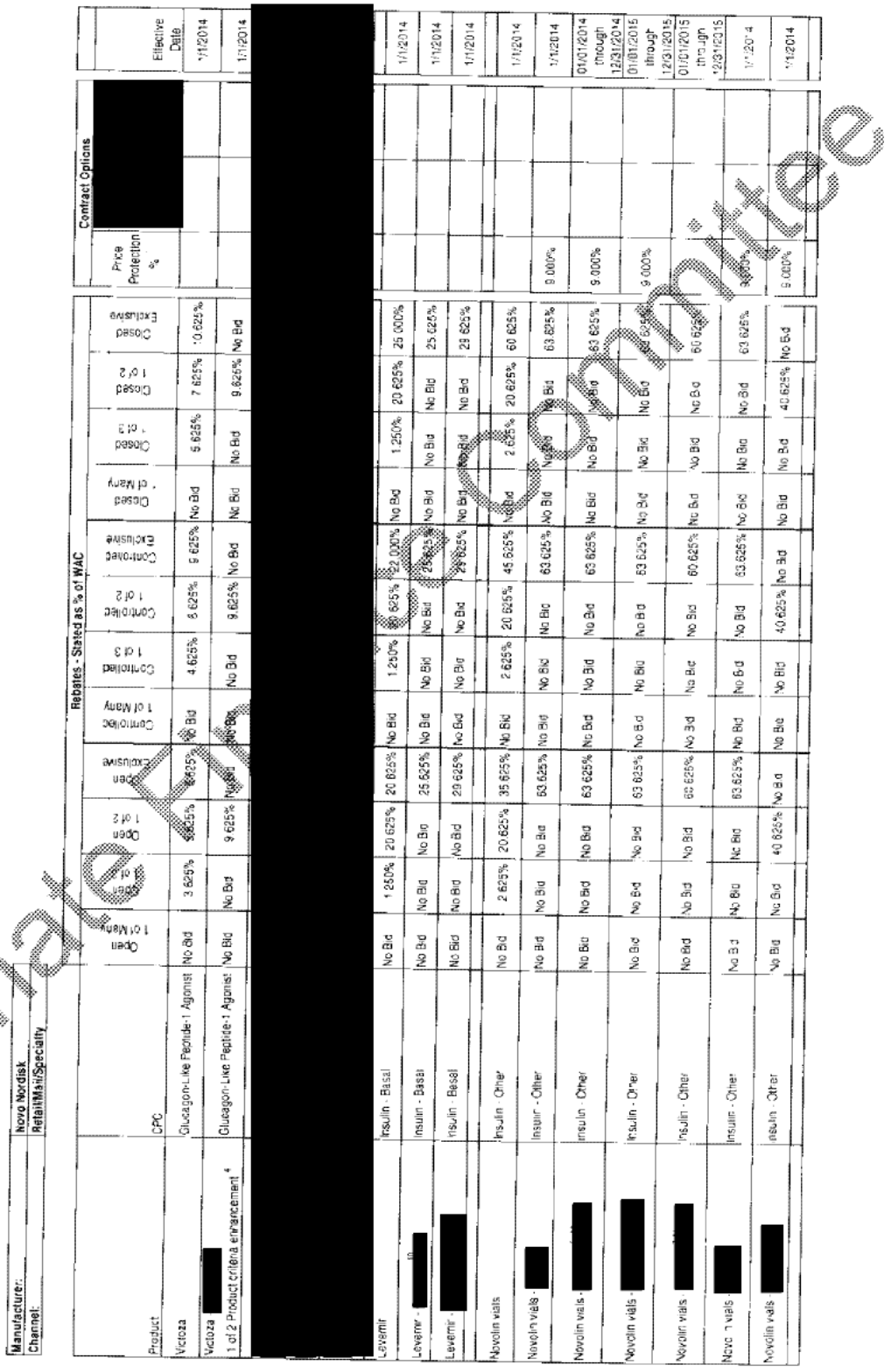
Rebate Calculations:

Rebates will be calculated on a per unit basis of a single tablet, capsule, milliliter or gram dosage, as applicable. Rebates for each Product will be billed to Company on a monthly basis as described in the Section of this Agreement titled "Billing and Payment." Rebates will be based upon Product utilization and the corresponding Formulary Positioning and the Benefit Control, or Client Classification, (each as defined above) applicable to each Plan and in place on the date the applicable Product is dispensed or administered. Rebates for a Product shall be calculated using the Rebate percentages set forth in the Rebate matrices attached to and incorporated in this Agreement as Attachment(s) to this Exhibit A, and the Product's WAC as of the date a Product is dispensed or administered to a Participant by a Participating Pharmacy. All Rebate percentages shall be stated as a percentage of WAC. Company agrees to pay the Rebate amounts determined in accordance with this Exhibit A regardless of the number of Plans that include Company's Product(s) on Formulary. Rebate eligibility shall be determined and Rebates shall be calculated on a channel specific basis (e.g. retail, home delivery/specialty pharmacy).

Company shall pay Rebates to ESI for all newly introduced package sizes of any Product unless Company promptly notifies ESI in writing that such newly introduced package sizes are not eligible for Rebates. Notwithstanding the foregoing, the parties agree that repackager and private label Products are not eligible for Rebates. No Rebates shall be due from Company for any Product dispensed or administered to a Participant enrolled in or covered by a Plan which subjects such Product to maximum allowable cost reimbursement limitations.

Attachment 2 to the Amendment

Product Bid Rebate Matrix
(Individual matrices will be incorporated as Attachment A-1 to Exhibit A of the Agreement)



Manufacturer: Novo Nordisk
Channel: Retail/Mail/Specialty

Express Scripts, Inc.
Rebate Matrix Issues For Year 1 of the 2014-2016 Commercial Rebate Cycle

Product	CPC	Rebates - Stated as % of WAC												Contract Options		
		Open 1 of Many	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection %	[redacted]	Effective Date
Victoza	Glucagon-Like Peptide-1 Agonist	No Bid	3.625%	3.625%	No Bid	4.625%	6.625%	6.625%	No Bid	5.625%	7.625%	10.625%			1/1/2014
Victoza [redacted] 1 of 2 Product criteria enhancement [4]	Glucagon-Like Peptide-1 Agonist	No Bid	No Bid	9.625%	No Bid	No Bid	9.625%	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
[redacted]															
Levemir	Insulin - Basal	No Bid	1.250%	20.625%	No Bid	1.250%	20.625%	25.000%	No Bid	1.250%	20.625%	25.000%			1/1/2014
Levemir [redacted]	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
Levemir [redacted]	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
Novolin vials	Insulin - Other	No Bid	2.625%	20.625%	35.625%	No Bid	2.625%	20.625%	45.625%	No Bid	20.625%	60.625%			1/1/2014
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	63.625%	63.625%	No Bid	No Bid	63.625%	9.000%		1/1/2014
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	63.625%	63.625%	No Bid	No Bid	63.625%	9.000%		01/01/2014 through 12/31/2014
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	63.625%	63.625%	No Bid	No Bid	63.625%	9.000%		01/01/2015 through 12/31/2015
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	63.625%	63.625%	No Bid	No Bid	63.625%	9.000%		01/01/2015 through 12/31/2015
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	63.625%	63.625%	No Bid	No Bid	63.625%	9.000%		1/1/2014
Novolin vials [redacted]	Insulin - Other	No Bid	No Bid	40.625%	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%		1/1/2014

Express Scripts, Inc.
Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Manufacturer:	**Novo Nordisk**
Channel:	**Retail/Mail Specialty**

Product	CPC	Rebates - Stated as % of WAC												Contract Options			Effective Date
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection %	[redacted]		
NovoLog Cartridge/FlexPen/Vials	Insulin - Rapid Acting	No Bid	2.625%	12.625%	35.625%	No Bid	8.000%	22.625%	45.625%	No Bid	10.000%	24.625%	60.625%				1/1/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2014 through 12/31/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2015 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2015 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2014 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%			1/1/2014
Novolog Mix Flex Pen/Vial	Insulin - Rapid Acting	No Bid	2.625%	12.625%	35.625%	No Bid	8.000%	22.625%	45.625%	No Bid	10.000%	24.625%	60.625%				1/1/2014
Novolog Mix Flex Pen/Vial- [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolog Mix Flex Pen/Vial [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2014 through 12/31/2014
Novolog Mix Flex Pen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2015 through 12/31/2015
Novolog Mix Flex Pen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2015 through 12/31/2015
Novolog Mix Flex Pen/Vial [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2014 through 12/31/2015
Novolog Mix Flex Pen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolog Mix Flex Pen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%			1/1/2014

Express Scripts, Inc.

Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Manufacturer: Novo Nordisk

Channel: Retail/Mail/Specialty

Product	Rebates - Stated as % of WAC										Contract Options	
	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Contracted 1 of Many	Contracted 1 of 3	Contracted 1 of 2	Contracted Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection %	Effective
CPC														

Footnotes:

- Unspecified CPC = Contracted Products currently not in a CPC, formulary positioning not applicable

1) This % will establish the annual Price Protection maximum allowable price

2)

3)

4) Victoza utilization is eligible for this level of Rebate when Victoza is 1 of 2 Products on formulary

5) Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.

6) In order for utilization to earn this level of Rebate, competitive products are subject to NDC block and no grandfathering is permitted

Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.

7) For the individual plans that have not implemented the NDC blocking grandfathering option outlined in Footnote #6, utilization will earn this level of Rebate provided competitive products are subject to NDC block, prior authorization and/or step edit.

Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.

8) In order for utilization to earn this level of Rebate, competitive products are subject to step edit to Novo Nordisk product

9) Victoza utilization is eligible for this level of Rebate provided Victoza is on formulary at the lowest branded copay/coinsurance tier and not subject to step edits or prior authorizations with the sole exception of an electronic step edit through metformin provided the selection step edit is applied to all products excluding metformin combination drugs in the branded NAD1 therapeutic class**.

** Branded NAD1 therapeutic Class includes: Victoza, Byetta, Bydureon, Januvia, Janumet, Juvisync, Onglyza, Kombiglyze XR, Tradjenta, Jentadueto, Nesina, Oseni, Kazano, Liraglutide and any new brand/generic NAD1 market entrants.

10) Covered "new patients" means that Levemir trials and "ExPen are 1 of 1 in the basal analog insulin class and all new patients are subject to NDC Block, Step Edit or Prior Authorization requiring demonstrated failure of the preferred brand product, or otherwise not eligible for this level of Rebate. Plan shall not solicit a rebate of manufacturer's product Rebates and shall commit to the mutually agreed upon formulary status of all contracted products during the term of this agreement, which will result in an immediate loss of any unpaid Rebates on utilization on a Product by Product basis, for the month in which the violation is resolved

Express Scripts, Inc.

Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Manufacturer:	Novo Nordisk - Managed Medicaid
Channel:	Retail/Mail/Specialty

		Rebates - Stated as % of WAC										Contract Options		
Product	CPC	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]		Effective Date
Victoza	Glucagon-like Peptide-1 Agonist	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%			1/1/2014
[redacted]																
Levemir	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
Novolin vials	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
NovoLog Cartridge and FlexPen	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
Novolog Mix	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
Novolog Vials	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid			1/1/2014
[redacted]																

- Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning and appropriate

[1] This % will establish the annual Price Protection maximum allowable price

[redacted]

Attachment 3
Price Protection

1. Definitions

"Allowed Net WAC" with respect to any Price Protection Product, for (a) the calendar year beginning January 1, 2014 is calculated by multiplying Net WAC as of December 31 of the prior calendar year by one (1) plus the Price Protection Factor, and (b) each calendar year thereafter, is calculated by multiplying the Allowed Net WAC for the prior calendar year by 1 plus the Price Protection Factor.

"Net WAC" shall mean, with respect to each Price Protection Product, the WAC net of Rebate and calculated as the WAC of such Product multiplied by one (1) minus the applicable Rebate percentage set forth on Exhibit A.

"Price Protection Percentage" shall mean the amount stated in Exhibit A-1, expressed as a percentage of WAC, that each contract year's Allowed Net WAC is permitted to increase prior to the effectuation of a Price Protection Rebate.

"Price Protection Rebate" shall mean the amount, expressed in dollars, by which the Net WAC for the applicable Price Protection Product exceeds the applicable Allowed Net WAC for the applicable Price Protection Period.

"Price Protection Period" shall mean each twelve (12) month calendar year period for which Rebates are being calculated.

"Price Protection Product" shall mean each Product for which Price Protection is offered as indicated on the matrix.

2. Eligibility for and Calculation of Price Protection Rebate

A. During a Price Protection Period, if Company increases the WAC of the applicable Price Protection Product above the applicable Allowed Net WAC, Company shall pay ESI the Price Protection Rebate and Rebate ("Total Rebate") on all Eligible Utilization of the Price Protection Product, including rebate enhancements and select client enhancements, occurring on and after the effective date of the Price Protection Rebate. Each subsequent WAC adjustment occurring during a Price Protection Period shall result in a new calculation of the applicable Price Protection Rebate Percentage. In no event shall the Rebates be adjusted downward below the amounts specified in Exhibit A of the Agreement.

B. The Total Rebate shall be effective on the later of (i) the day ESI updates its systems, or (ii) the first day following the applicable price increase.

C. Payment of the Total Rebate, shall be calculated, invoiced and paid pursuant the Billing and Payment Section of the Agreement.

D. For illustrative purposes only, below are hypothetical examples of a Price Adjustment Percentage calculation.

ALLOWED NET WAC									
DRUG	WAC as of 12/31/13	Rebate %	Starting Net WAC	Price Protection Percentage	Year 1 Allowed Net WAC	Price Protection Percentage	Year 2 Allowed Net WAC	Price Protection Percentage	Year 3 Allowed Net WAC
A	$100.00	5%	$95.00	8%	$102.60	8%	$110.81	8%	$119.67
B	$110.00	10%	$99.00	8%	$106.92	8%	$115.47	8%	$124.71
C	$150.00	15%	$127.50	8%	$137.70	8%	$148.72	8%	$160.61
D	$50.00	20%	$40.00	8%	$43.20	8%	$46.66	8%	$50.39
E	$225.00	25%	$168.75	8%	$182.25	8%	$196.83	8%	$212.58

PRICE PROTECTION CALCULATION								
DRUG	Applicable WAC for the QTR	Rebate %	Rebate $	Net WAC	Allowed Net WAC	Price Protection Rebate	Total Rebate	Total Rebate %
A	$110.00	5%	$5.50	$104.50	$102.60	$1.90	$7.40	6.73%
B	$112.00	10%	$11.20	$100.80	$106.92	$0.00	$11.20	10.00%
C	$155.00	15%	$23.25	$131.75	$137.70	$0.00	$23.25	15.00%
D	$60.00	20%	$12.00	$48.00	$43.20	$4.80	$16.80	28.00%
E	$225.00	25%	$56.25	$168.75	$182.25	$0.00	$56.25	25.00%

AMENDMENT TO THE
PREFERRED SAVINGS GRID
REBATE PROGRAM AGREEMENT

THIS AMENDMENT (the "Amendment") is to the Preferred Savings Grid Rebate Program Agreement (the "Agreement") dated effective February 1, 2010, by and between Express Scripts, Inc. ("ESI") and Novo Nordisk, Inc. ("Company") and shall become effective April 1, 2014, unless otherwise indicated herein.

RECITALS

WHEREAS, ESI has offered Company an opportunity to enhance Rebates paid in connection with the Agreement for utilization of Novolin vials, NovoLog Cartridge/FlexPen/Vials, and Novolog Mix 70/30 FlexPen/Vials by North Carolina State Employee Participants (the "NC State Employee Novolin and NovoLog Select Client Options");

WHEREAS, Company, recognizing the value of the NC State Employee Novolin and NovoLog Select Client Options, has elected to participate in such options, during the period April 1, 2014 through June 30, 2014;

WHEREAS, ESI and Company have agreed to revise the terms of the NC State Employee Novolin and NovoLog Select Client Options, which revised terms shall become effective during the period July 1, 2014 through December 31, 2016;

WHEREAS, ESI has offered Company an opportunity to enhance Rebates paid in connection with the Agreement for utilization of Novolin vials, NovoLog Cartridge/FlexPen/Vials, and Novolog Mix 70/30 FlexPen/Vials by [redacted]

WHEREAS, Company, recognizing the value of the [redacted] has elected to participate in such options, during the period July 1, 2014 through December 31, 2015;

WHEREAS, Company participates in [redacted] and now desires to further enhance the applicable Rebates, effective August 1, 2014;

WHEREAS, ESI and Company agreed to the terms of the aforementioned Select Client Options prior to the Amendment effective date, but have yet to execute the Amendment due to administrative reasons; and

WHEREAS, ESI and Company now wish to enter into this Amendment in order to memorialize the agreed upon terms, as set forth herein.

NOW, THEREFORE, the parties agree as follows:

TERMS OF AMENDMENT

1. **Attachment A-1 to Exhibit A.** The base Rebate matrix, as set forth on Attachment A-1 to Exhibit A of the Agreement, is hereby deleted in its entirety and replaced with a new base Rebate matrix, as attached to this Amendment.

2. For purposes of clarity, the applicable Select Client Option shall become effective on the date indicated on the "Effective Date" column of Attachment A-1 to Exhibit A. The Managed Medicaid

Rebate matrix, as set forth under Attachment A-1 to Exhibit A, remains unchanged by this Amendment.

3. Except as provided herein, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives effective as of the date first written above.

EXPRESS SCRIPTS, INC.

By: Janine Burkett

Janine Burkett
Vice President, Chief Drug Sourcing Officer

NOVO NORDISK, INC.

By: _____

Print Name: Jesper Høiland

Title: President

APPROVED AS TO LEGAL FORM
EJO 6/19/14
LEGAL DEPT.

Attachment A-1 to Exhibit A of the Agreement

Express Scripts, Inc.

Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Novo Nordisk
Channel:	Retail/Mail/Specialty

		Rebates - Stated as % of WAC												Contract Options			
Product	CPC	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection [5] [1]	[redacted]	[redacted]	Effective Date
Victoza	Glucagon-Like Peptide-1 Agonist	No Bid	3.625%	5.625%	6.625%	No Bid	4.625%	6.625%	9.625%	No Bid	5.625%	7.625%	10.625%				1/1/2014
Victoza - [redacted] 1 of 2 Product criteria enhancement [4,6]	Glucagon-Like Peptide-1 Agonist	No Bid	No Bid	9.625%	No Bid	No Bid	No Bid	9.625%	No Bid	No Bid	No Bid	9.625%	No Bid				1/1/2014
[redacted]																	
Levemir®FlexPen®/FlexTouch/Vial	Insulin - Basal	No Bid	1.250%	20.625%	20.625%	No Bid	1.250%	20.625%	22.000%	No Bid	1.250%	20.625%	25.000%				1/1/2014
Levemir FlexPen®/FlexTouch/Vial - [redacted]	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	46.625%				8/1/2014 through 12/31/2016
Levemir® FlexPen®/FlexTouch/Vial - 3ML- [redacted] [10]	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	46.625%				8/1/2014 through 12/31/2016
Novolin vials	Insulin - Other	No Bid	2.625%	20.625%	35.625%	No Bid	2.625%	20.625%	45.625%	No Bid	2.625%	20.625%	60.625%				1/1/2014
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2014 through 12/31/2014
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2015 through 12/31/2015
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2015 through 12/31/2015
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolin vials - Wellpoint [11]	Insulin - Other	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%			01/01/2014 through 12/31/2015
Novolin vials – NC State Employees [11]	Insulin - Other	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid				04/01/2014 through 6/30/2014
Novolin vials - NC State Employees [11]	Insulin - Other	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			07/01/2014 through 12/31/16
Novolin vials - [redacted]	Insulin - Other	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid				07/01/2014 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials	Insulin - Rapid Acting	No Bid	2.625%	12.625%	35.625%	No Bid	8.000%	22.625%	45.625%	No Bid	10.000%	24.625%	60.625%				1/1/2014

Attachment A-1 to Exhibit A of the Agreement

Product	CPC	Rebates - Stated as % of WAC												Contract Options			Effective Date
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	[redacted]		
NovoLog Cartridge/FlexPen/Vials - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2014 through 12/31/2014
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2015 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2015 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2014 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
NovoLog Cartridge/FlexPen/Vials Wellpoint [11]	Insulin - Rapid Acting	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%			01/01/2014 through 12/31/2015
NovoLog Cartridge/FlexPen/Vials - NC State Employees [11]	Insulin - Rapid Acting	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid				04/01/2014 through 6/30/2014
NovoLog Cartridge/FlexPen/Vials - NC State Employees [11]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			07/01/2014 through 12/31/16
NovoLog Cartridge/FlexPen/Vials - [redacted]	Insulin - Other	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid				07/01/2014 through 12/31/2015
Novolog Mix 70/30 FlexPen/Vial	Insulin - Rapid Acting	No Bid	2.625%	12.625%	35.625%	No Bid	8.000%	22.625%	45.625%	No Bid	10.000%	24.625%	60.625%				1/1/2014
Novolog Mix 70/30 FlexPen/Vial- [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolog Mix 70/30 FlexPen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2014 through 12/31/2014
Novolog Mix 70/30 Flex Pen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			01/01/2015 through 12/31/2015
Novolog Mix 70/30 FlexPen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2015 through 12/31/2015
Novolog Mix 70/30 FlexPen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%	No Bid	No Bid	No Bid	60.625%				01/01/2014 through 12/31/2015
Novolog Mix 70/30 FlexPen/Vial - [redacted]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			1/1/2014
Novolog Mix 70/30 FlexPen/Vial - Wellpoint [11]	Insulin - Rapid Acting	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	No Bid	No Bid	40.625%	No Bid	9.000%			01/01/2014 through 12/31/2015
Novolog Mix 70/30 FlexPen/Vial - NC State Employees [11]	Insulin - Rapid Acting	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid				04/01/2014 through 6/30/2014
Novolog Mix 70/30 FlexPen/Vial - NC State Employees [11]	Insulin - Rapid Acting	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	No Bid	No Bid	No Bid	63.625%	9.000%			07/01/2014 through 12/31/16

Attachment A-1 to Exhibit A of the Agreement

Product	CPC	Rebates - Stated as % of WAC											Contract Options		Effective Date
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	
Novolog Mix 70/30 FlexPen/Vial - [redacted]	Insulin - Other	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	No Bid	No Bid	27.625%	No Bid	[redacted]	07/01/2014 through 12/31/2015
[redacted]															

Footnotes:

- Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable.

1) This % will establish the annual Price Protection maximum allowable price.
2) [redacted]
3) [redacted]
4) Victoza utilization is eligible for this level of Rebate when Victoza is 1 of 2 Products on formulary [redacted]
5) Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.
6) In order for [redacted] utilization to earn this level of Rebate, competitive products are subject to NDC block and no grandfathering is permitted.
   Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.
7) For the [redacted] individual plans that have not implemented the NDC block/no grandfathering option outlined in Footnote #6, utilization will earn this level of Rebate provided competitive products are subject to NDC block, prior authorization and/or step edit.
   Humulin RU-500 must be available at the highest brand copay/coinsurance tier and only disadvantaged by copay/coinsurance with no requirement for NDC block, prior authorization and/or step edit.
8) In order for [redacted] utilization to earn this level of Rebate, competitive products are subject to step edit to Novo Nordisk product [redacted]
9) Victoza utilization is eligible for this level of Rebate provided Victoza is on formulary at the lowest branded copay/coinsurance tier and not subject to step edits or prior authorizations with the sole exception of an electronic step edit through metformin provided the electronic step edit is applied to all products, excluding metformin combination drugs in the branded NIAD therapeutic class**.
   ** Branded NIAD therapeutic Class includes: Victoza, Byetta, Bydureon, Januvia, Janumet, Janumet XR, Juvisync, Onglyza, Kombiglyze XR, Tradjenta, Jentadueto, Nesina, Oseni, Kazano, Invokana, Farxiga, and any new branded NIAD market entrants.
10) [redacted] Exclusivity means that Levemir® vials and FlexPen are 1 of 1 in the basal analog insulin class and all new patients are subject to NDC block, step edit or prior authorization, requiring demonstrated failure of the preferred brand product, or otherwise Not Covered; No grandfathering is allowed with the sole exception of one, 30 day, transition script for existing patients. Plan, including affiliated Plans whether under this Agreement or another agreement, shall not solicit a rebid of manufacturer's product Rebates and shall commit to the mutually agreed upon Formulary status of all contracted products during the term of this Agreement or as otherwise indicated in this Attachment A-1; violation will result in an immediate loss of any unpaid Rebates on utilization on a Product by Product basis, for the month in which the violation is resolved.
11) In order for [redacted] to earn this level of Rebates Plan shall not solicit a rebid of manufacturer's product Rebates and shall commit to the mutually agreed upon Formulary status of all contracted products during the term of this Agreement or through the end date as otherwise indicated in this Attachment A-1; violation will result in an immediate loss of any unpaid Rebates on utilization on a Product by Product basis, for the month in which the violation is resolved.

Attachment A-1 to Exhibit A of the Agreement

Express Scripts, Inc.
Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Novo Nordisk - Managed Medicaid
Channel:	Retail/Mail/Specialty

		Rebates - Stated as % of WAC												Contract Options			
Product	CPC	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	[redacted]		Effective Date
Victoza	Glucagon-Like Peptide-1 Agonist	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%				01/01/2014
[redacted]																	
Levemir	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				01/01/2014
Novolin vials	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				01/01/2014
NovoLog Cartridge and FlexPen	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				01/01/2014
Novolog Mix	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				01/01/2014
Novolog Vials	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				01/01/2014
[redacted]																	

- Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable

1) This % will establish the annual Price Protection maximum allowable price.
2) [redacted]
3) [redacted]

06/18/2014

EXPRESS SCRIPTS, INC.
AMENDMENT TO THE
PREFERRED SAVINGS GRID REBATE PROGRAM AGREEMENT

2016/2017 Rebate Cycle Commercial Bid Enhancement
Year 2

THIS AMENDMENT ("Amendment"), effective January 1, 2017, ("Amendment Effective Date") is made to the Preferred Savings Grid Rebate Program Agreement dated effective February 1, 2010, (the "Agreement"), by and between Express Scripts, Inc. ("ESI") and Novo Nordisk Inc. ("Company").

Recitals

WHEREAS, Company is a participant in the 2016/2017 Rebate Cycle Commercial Bid for ESI's PSG Rebate Program (the "2016/2017 Commercial Bid"), and ESI has offered Company an opportunity to revise Rebates in 2017 ("Year 2"); and

WHEREAS, Company has reviewed the conditions herein and set forth in the Agreement and desires to revise or otherwise amend the Agreement in Year 2, for purposes of providing competitive pricing terms on the utilization of certain Products by Participants under a Plan, in accordance with this Amendment.

NOW, THEREFORE, the parties agree as follows:

Amendment to Terms of Agreement

1. Rebate Bid Offers and Rebates Options. Exhibit A of the Agreement is amended to restate Attachment A-1 to Exhibit A in the form attached to this Amendment as Attachment 1. Company shall provide Rebate bid offers ("Rebate Bid Offers") for (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization. Any Rebate Bid Offer not providing Rebates for both (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization shall be considered non-compliant and such Rebate Bid Offer will not be considered for Formulary placement purposes. The term "Rebate Options" shall mean those opportunities which represent additional Rebate opportunities outside of the intersecting Benefit Control/Formulary Positions cells (as defined in Exhibit A of the Agreement) including, but not limited to, Rebates for utilization of Products by Participants of specific Plans ("Select Client Options").

   The Rebate Bid Offers and Rebate Options, as set forth on the Attachment 1 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of the Products set forth therein by Participants. Attachment 1 attached hereto shall supersede and replace Attachment A-1 to Exhibit A of the Agreement. Company acknowledges that Rebate Bid Offers and Rebate Options as offered by Company and accepted by ESI under this Amendment, shall be effective as of the Amendment Effective Date, and shall remain in effect through the term of the Agreement.

2. Enhanced Data Services. Section III.B. (Services), Subsections 5 and 9 of the Agreement shall be deleted in their entirety and replaced with the following:

   5. maintaining and making available to Company, evidence of Formulary status of a Product through ESI's data access products. Company acknowledgers that not all Clients print a Formulary, or may only print a guide listing a portion of the therapeutic categories of Products. In such cases, if drug is not listed on a paper Formulary, ESI may confirm Formulary status through an available electronic format including a CPC detail report, or

links to Client's websites, or point of sale adjudication screens showing evidence of the applicable Product's Formulary status and any applicable Formulary controls at the time such Product was dispensed for purposes of calculation Rebates hereunder. In the event that ESI is unable to validate the Formulary status of any Product, including any applicable restrictions, of a Client through either a paper or electronic format, upon written request by Company, ESI shall not be eligible for Rebates on Product utilization specific to that Client.

9. providing information (i) applicable to Eligible Utilization, and the Plan with respect to which Product utilization is applicable, for calculation of Rebates hereunder and for purposes of verifying and evaluating the invoiced amount of Rebates and Administrative Fees, (ii) applicable to Excluded Utilization or other utilization that is or may not be Eligible Utilization, and (iii) applicable to Eligible Utilization for which Rebates are otherwise not payable, such (i)-(iii) data to be provided through the data access products more specifically described on Exhibit B to this Agreement (and, in addition, as otherwise made available by ESI to Company in connection with this Agreement), and subject to any applicable laws prohibiting the disclosure of any such information from ESI to Company (collectively, "PSG Rebate Program Data");

3. Notices. Section XI of the Agreement is amended to provide for notice delivery by email in addition to the other methods listed. Notices sent to ESI shall be sent to the attention of Edward J. Adamcik. For convenience the ESI address for notice in its entirety is restated below:

"To Express Scripts, Inc. at:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
Attn: Edward J. Adamcik, Vice President, Pharma Strategy & Contracting
Fax #: 201-269-1137

With a copy to:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
Attn: General Counsel
Fax #: 800-417-8163"

4. Unrestricted Enhancement. The definition of Unrestricted Enhancement, as stated in Note 3 to Table 1 of the Section titled "Bidding Process" of Exhibit A to the Agreement, shall be deleted in its entirety and replaced with the new definition stated below.

"**Note 3 – "Unrestricted Rebate"** shall mean where Company agrees to pay a Rebate for Products when the applicable Product is not subject to a step edit, or a prior authorization that is more restrictive than the Product's package insert."

5. The parties shall work in good faith to negotiate written terms and conditions relating to "Clone Formularies".

6. Except as amended herein, all terms and conditions of the Agreement shall remain in effect.

SIGNATURE PAGE IMMEDIATELY FOLLOWING

Company represents that the following signature is that of an authorized representative of Company.

Novo Nordisk Inc.

DocuSigned by:

By: _____ Signature
D60674FFD0444402

Name: Jakob Riis (please print)

Title: EVP North America (please print)

Date: 05-Feb-2017

REVIEWED
NOVO NORDISK LEGAL
DATE: 1/31/17
INITIALS: LKMO

DocuSigned by:

Lars Green
81E44E5261DB4DF...

SVP, Finance and Operati

DS
PS

02-Feb-2017

Except to the extent ESI has specifically indicated otherwise on the attached matrices, ESI accepts the Rebates offered by Company on the attached matrix.

Express Scripts, Inc.

By: _____ Signature

Name: Edward J. Adamcik

Title: Vice President,
Pharma Strategy & Contracting

Date: 1·20·17

APPROVED AS TO LEGAL FORM
LEGAL DEPT.
1/18/17

Attachment 1

Attachment 1 to the Amendment

Product Bid Rebate Matrix

(Individual matrices will be incorporated as Attachment A-1 to Exhibit A of the Agreement)

(See Attached)

Attachment A-1 to Exhibit A of the Agreement

Rebate Program: Commercial

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Novo Nordisk
Channel:	Retail/Mail/Specialty

Product *	Rate Type	Footnotes	CPG **	Rebates - Stated as % of WAC												Rebates - Stated as % of WAC		Footnotes	Effective Date
				Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive				
Victoza		1	Glucagon-Like Peptide-1 Agonist	No Bid	3.625%	8.625%	8.625%	No Bid	10.125%	12.125%	12.125%	No Bid	10.125%	12.125%	12.125%				1/1/2017
Victoza		1	Glucagon-Like Peptide-1 Agonist	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	17.125%	No Bid				1/1/2017
Victoza		2, 14	Glucagon-Like Peptide-1 Agonist	No Bid	18.125%	18.125%	18.125%	No bid	18.125%	18.125%	18.125%	No bid	18.125%	18.125%	18.125%				1/1/2017
Victoza		3	Glucagon-Like Peptide-1 Agonist	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No bid	No Bid	No Bid	18.125%	No bid				1/1/2017
[redacted]																			
Levemir			Insulin - Basal	No Bid	39.125%	39.125%	No Bid	No Bid	47.125%	47.125%	47.125%	No Bid	47.125%	47.125%	47.125%				1/1/2017
Levemir			Insulin - Basal	No Bid	No Bid	33.625%	33.625%	No Bid	40.125%	40.125%	40.125%	No Bid	40.125%	40.125%	40.125%				1/1/2017
Levemir		15	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	43.125%	43.125%	43.125%	No Bid	43.125%	43.125%	43.125%				1/1/2017
Levemir		5	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	45.125%	45.125%	No Bid	No Bid	45.125%	45.125%	No Bid				1/1/2017
Levemir		5	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	46.125%				1/1/2017
Tresiba			Insulin - Basal	No Bid	36.125%	36.125%	No Bid	No Bid	45.125%	45.125%	45.125%	No Bid	45.125%	45.125%	45.125%				1/1/2017
Tresiba			Insulin - Basal	No Bid	36.125%	36.125%	36.125%	No Bid	40.125%	40.125%	40.125%	No Bid	40.125%	40.125%	40.125%				1/1/2017
Tresiba		15	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	43.125%	43.125%	43.125%	No Bid	43.125%	43.125%	43.125%				1/1/2017
Tresiba		7	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	40.125%				1/1/2017
Tresiba		7	Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	45.125%				1/1/2017
Novolin vials		8	Insulin - Other	No Bid	No Bid	12.125%	35.125%	No Bid	No Bid	35.125%	45.125%	No Bid	No Bid	25.125%	60.125%				1/1/2017
Novolin vials		8	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	63.125%				1/1/2017
Novolin vials		8, 9	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	65.125%				1/1/2017
Novolin vials		8, 10	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	29.125%	No Bid	No Bid	No Bid	29.125%	No Bid				1/1/2017
Novolin vials		8, 11	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	55.125%				1/1/2017
NovoLog		8	Insulin - Rapid Acting	No Bid	2.125%	12.125%	35.125%	No Bid	7.500%	25.125%	45.125%	No Bid	9.500%	25.125%	60.125%				1/1/2017
NovoLog		8	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	63.125%				1/1/2017
NovoLog		8, 9	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	65.125%				1/1/2017
NovoLog		8, 10	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	29.125%	No Bid	No Bid	No Bid	29.125%	No Bid				1/1/2017

Attachment A-1 to Exhibit A of the Agreement

Product*	Rate Type	Footnotes	CPC**	Rebates - Stated as % of WAC: Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Rebates - Stated as % of WAC: [redacted]	Footnotes	Effective Date
NovoLog	[redacted]	8, 11	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	65.125%			1/1/2017
Novolog Mix 70/30		8	Insulin - Rapid Acting	No Bid	2.125%	12.125%	35.125%	No Bid	7.500%	25.125%	45.125%	No Bid	9.500%	25.125%	60.125%			1/1/2017
Novolog Mix 70/30		8	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	63.125%			1/1/2017
Novolog Mix 70/30		8, 9	Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	65.125%			1/1/2017
Novolog Mix 70/30		8, 10	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	29.125%	No Bid	No Bid	No Bid	29.125%	No Bid			1/1/2017
Novolog Mix 70/30		8, 11	Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	65.125%			1/1/2017

[redacted]

** Unspecified CPC = Contracted Product is currently not in a CPC; Formulary Positioning is not applicable.

FOOTNOTES:

1) Victoza®is available at the Preferred brand co-pay or co-insurance tier, and neither restricted nor disadvantaged to any product in the Branded NIAD Therapeutic Class. Victoza® is not subject to any step edits or prior authorizations, or other additional restrictions with the sole exception of an electronic step edit through metformin so long as the electronic step edit is applied to all products in the Branded NIAD Therapeutic Class, excluding metformin combination drugs.

2) [redacted] All presentations of Victoza® must be on all [redacted] formularies as 1 of 3 manufacturers in the GLP-1 Therapeutic Class, Victoza® is available at the lowest Preferred brand co-pay or co-insurance tier, and neither restricted nor disadvantaged to any product in the Branded NIAD Therapeutic Class. Victoza® is not subject to any step edits or prior authorizations, or other additional restrictions with the sole exception of an electronic step edit through metformin so long as the electronic step edit is applied to all products in the Branded NIAD Therapeutic Class, excluding metformin combination drugs. In order to earn this level of Rebates, the applicable Plan shall not solicit a rebid of manufacturer's Product Rebates and shall commit to the mutually agreed upon Formulary status of the applicable Product during the term of this Agreement; violation will result in an immediate loss of any unpaid Rebates on utilization from the date utilization is ineligible for Rebates through the date(s) in which the violation is resolved.

3) [redacted] In order to earn this level of Rebates, the applicable Plan shall not solicit a rebid of manufacturer's Product Rebates and shall commit to the mutually agreed upon Formulary status of the applicable Product during the term of this Agreement; violation will result in an immediate loss of any unpaid Rebates on utilization on a Product-by-Product basis, from the date utilization is ineligible for Rebates through the date(s) in which the violation is resolved.

4) [redacted] Patient is responsible for 70% of the cost of a non-Preferred product; Grandfathering is not permitted.

5) [redacted] All presentations of Levemir® must be available on all [redacted] formularies as 1 of 2 or 1 of 3 manufacturers at the Preferred brand co-pay or co-insurance tier, and neither restricted nor disadvantaged to any product in the respectiveCPC. In order to earn this level of Rebates, the applicable Plan shall not solicit a rebid of manufacturer's Product Rebates and shall commit to the mutually agreed upon Formulary status of the applicable Product during the term of this Agreement; violation will result in an immediate loss of any unpaid Rebates on utilization, from the date utilization is ineligible for Rebates through the date(s) in which the violation is resolved.

6) [redacted] For the purposes of this Rebate only, "Exclusivity" means that (i) [redacted] (ii) all non-Preferred products utilized by new Participants (e.g., those Participants who have not previously utilized products in the CPC) are subject to NDC block (except when medically necessary), step edit or prior authorization, requiring demonstrated failure of the Preferred brand product, or otherwise not covered; and (iii) grandfathering is not permitted with the sole exception of a single 30 day transition prescription for existing Participants. Additionally, utilization shall not be eligible for Rebates unless [redacted] including affiliated Plans whether under this Agreement or another agreement, refrain from soliciting a rebid of manufacturer's Product Rebates and commit to the mutually agreed upon Formulary status of the applicable Product during the term of this Agreement; violation will result in an immediate loss of any unpaid Rebates on utilization, from the date utilization is ineligible for Rebates through the date(s) in which the violation is resolved.

7) [redacted] (including State Health Exchanges): For the purposes of this Rebate only, "Exclusive means that (i) [redacted] (ii) all non-Preferred products utilized by new Participants (e.g., those Participants who have not previously utilized products in the CPC) are subject to NDC block (except when medically necessary), step edit or prior authorization, requiring demonstrated failure of the Preferred brand product, or otherwise not covered; and (ii) grandfathering is not permitted with the sole exception of a single 30 day transition prescription for existing Participants. Non Company Insulin-Basals market share (i.e. Lantus and Toujeo market share) must decline at least 80% or higher of the Tresiba market share, otherwise Tresiba Rebate increases +5% (5 percentage points). For example, if Tresiba market share is 5%, then [redacted] market share must decline by 4% or greater; otherwise, Tresiba Rebate increases from 40.125% to 45.125%. Market share measurement will be done by comparing to previous quarter's market share to current market share.

8) For any formulary where Novolog and/or Novolin is the exclusive Preferred Product, Humulin u-500 is permissible on lowest brand co-pay or co-insurance tier provided clinical prior authorization is met, consistent with label, whereby patient requires daily doses of more than 200 units. Novolog and/or Novolin Utilization will be eligible for the Exclusive Rebates.

[redacted]

1/18/2017

Product*	Rate Type	Footnotes	CPC**	Rebates - Stated as % of WAC: Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Rebates - Stated as % of WAC: [redacted]	Footnotes	Effective Date

9) All presentations of NovoLog®, NovoLog® Mix 70/30, Novolin®, Levemir®, Tresiba® and Victoza® must be on Formulary available at the lowest brand co-pay or co-insurance tier, and neither restricted nor disadvantaged to any product in each respective CPC.

10) [redacted] - Utilization is eligible for this level of Rebate provided NovoLog®, NovoLog Mix 70/30® and Novolin® are all on [redacted] preferred formulary.

11) [redacted] Utilization is eligible for this level of Rebate when (i) all competitive products are subject to NDC block, Prior Authorization and/or stepedit (i.e. must step through the NNI product before competitive product), (ii) grandfathering is not permitted, and (iii) NovoLog®, NovoLog® Mix 70/30, Novolin®, Levemir®, Tresiba®, and Victoza® being on formulary at the lowest branded co-pay or co-insurance tier, and neither restricted nor disadvantaged to any product in the respective Therapeutic Class.

[redacted]

13) A clinical priorputhorization applied to Novoeight® is permitted provided it is applied to all of the brand or biosimiler pharmaceutical products in Novoeight®'s therapeutic class. The therapeutic class includes: Advate, Helixate FS, Kogenate FS, KOVALTRY, Nuwiq, Recombinate, XYNTHA, Adynovate, Eloctate, Alphanate, Hemofil M, Humate-P, Koate-DVI, Monoclate-P).

14) [redacted] All competing brands shall be subject to NDC block, or Prior Authorization and/or step edit where permitted by applicable law, either of which must require failure of the preferred brand before a non-preferred competing brand may be dispensed at a higher co-pay or coinsurance tier. Grandfathering is not permitted (unless where mandated by applicable law).

15) All presentations of Levemir® and Tresiba® must be available at the lowest brand co-pay or co-insurance, and neither restricted no disadvantaged to any product in the respective Competitive Product Category

Attachment A-1 to Exhibit A of the Agreement

Rebate Program: Commercial

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Novo Nordisk - Managed Medicaid
Channel:	Retail/Mail

Product	Rate Type	Footnotes	CPC**	Rebates - Stated as % of WAC												Rebates - Stated as % of WAC			Effective Date
				Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	[redacted]		Footnotes	
Victoza	Unrestricted Rebate		Glucagon-Like Peptide-1 Agonist	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%	No Bid	5.625%	5.625%	5.625%				1/1/2017
Norditropin	Unrestricted Rebate		Growth hormones	No Bid	3.625%	7.625%	15.625%	No Bid	3.625%	7.625%	15.625%	No Bid	3.625%	7.625%	15.625%				1/1/2017
Levemir			Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				1/1/2017
Tresiba	Unrestricted Rebate		Insulin - Basal	No Bid	No Bid	5.125%	5.125%	No Bid	No Bid	5.125%	5.125%	No Bid	No Bid	5.125%	5.125%				1/1/2017
Novolin vials			Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				1/1/2017
NovoLog			Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				1/1/2017
Novolog Mix 70/30			Insulin - Other	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid				1/1/2017
[redacted]																			

** Unspecified CPC = Contracted Product is currently not in a CPC; Formulary Positioning is not applicable.

FOOTNOTES:

EXPRESS SCRIPTS, INC.
EIGHTEENTH AMENDMENT TO THE
PREFERRED SAVINGS GRID REBATE PROGRAM AGREEMENT

2016/2017 Rebate Cycle Commercial Bid Enhancement
Year 2

THIS EIGHTEENTH AMENDMENT ("Amendment"), effective January 1, 2017, ("Amendment Effective Date") is made to the Preferred Savings Grid Rebate Program Agreement dated effective January 1, 2010, by and between Express Scripts, Inc. ("ESI") and Sanofi-Aventis U.S. LLC, on behalf of itself and its affiliate Genzyme ("Company") (the "Agreement").

Recitals

WHEREAS, Company is a participant in the 2016/2017 Rebate Cycle Commercial Bid for ESI's PSG Rebate Program (the "2016/2017 Commercial Bid"), and ESI has offered Company an opportunity to enhance Rebates in 2017 ("Year 2") by offering the Rebate Bid Enhancement Offers described below; and

WHEREAS, Company has reviewed the conditions herein and set forth in the Agreement and desires to enhance or otherwise amend the Agreement in Year 2, for purposes of providing competitive pricing terms on the utilization of certain Products by Participants under a Plan, in accordance with this Amendment.

NOW, THEREFORE, the parties agree as follows:

Amendment to Terms of Agreement

1. Rebate Bid Enhancement Offers and Rebates Enhancement Options. Exhibit A of the Agreement is amended to restate Attachment A-1 to Exhibit A in the form attached to this Amendment as Attachment 1. Company shall provide Rebate bid enhancement offers ("Rebate Bid Enhancement Offers") for (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization. Any Rebate Bid Enhancement Offer not providing Rebates for both (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization shall be considered non-compliant and such Rebate Bid Enhancement Offer will not be considered for Formulary placement purposes. The term "Rebate Enhancement Options" shall mean those opportunities which represent additional Rebate opportunities outside of the intersecting Benefit Control/Formulary Positions cells (as defined in Exhibit A of the Agreement) including, but not limited to, enhanced Rebates for utilization of Products by Participants of specific Plans ("Select Client Options"). The Rebates under this Agreement are not intended as discounts on purchases made by retail pharmacies, home delivery providers or specialty pharmacies.

   The Rebate Bid Enhancement Offers and Rebate Enhancement Options, as set forth on the Attachment 1 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of the Products set forth therein by Participants. Attachment 1 attached hereto shall supersede and replace Attachment A-1 to Exhibit A of the Agreement. Company acknowledges that Rebate Bid Enhancement Offers and Rebate Enhancement Options as offered by Company and accepted by ESI under this Amendment, shall be effective as of the Amendment Effective Date, and shall remain in effect through the term of the Agreement.

2. [redacted]

3. Enhanced Data Services. Section III.B. (Services), Subsections 6 and 9 of the Agreement shall be deleted in their entirety and replaced with the following:

> 6. maintaining and making available to Company, evidence of the Formulary status of a Product at the Client or Plan level (i) during the first calendar quarter of each year for Formularies that represent a minimum of 85% of ESI's covered lives (ii) for each new Client or Plan that are added after the first calendar quarter of each year, and (iii) Formulary changes for a Client or Plan that occur after the first calendar quarter of each year, upon request from Company. Upon reasonable written request, ESI shall provide evidence of the Formulary status of a Product at the Client or Plan level for Formularies that represent the remaining percentage of covered lives not made available in (i) above. ESI represents that not all Plans print a Plan Formulary, or may only print a guide listing a portion of the therapeutic categories of covered drugs. In such cases, if there is no paper form of the Formulary, ESI shall provide, upon written request, the Formulary status through an available electronic format, including links to Plan's websites, through the data access products or point of sale adjudication screens showing the applicable Product's Formulary status at the time such Product was dispensed for purposes of calculating Rebates hereunder;

4. Notices. Section XIV of the Agreement is amended to provide for notice delivery by email in addition to the other methods listed. Notices sent to ESI shall be sent to the attention of Edward J. Adamcik. For convenience the ESI address for notice in its entirety is restated below:

"To Express Scripts, Inc. at:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
Attn: Edward J. Adamcik, Vice President, Pharma Strategy & Contracting
Fax #: 201-269-1137

With a copy to:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
Attn: General Counsel
Fax #: 800-417-8163"

5. Unrestricted Enhancement. The definition of Unrestricted Enhancement, as stated in Note 3 to Table 1 of the Section titled "Bidding Process" of Exhibit A to the Agreement, shall be deleted in its entirety and replaced with the new definition stated below.

"**Note 3 – "Unrestricted Rebate"** shall mean where Company agrees to pay a Rebate for Products when the applicable Product is not subject to a generic step edit, or a prior authorization that is more restrictive than the Product's package insert."

6. Except as amended herein, all terms and conditions of the Agreement shall remain in effect.

SIGNATURE PAGE IMMEDIATELY FOLLOWING

Company represents that the following signature is that of an authorized representative of Company.

Sanofi-Aventis U.S. LLC

By: _____
Signature

Name: James Bornoman
Vice President
Strategic Pricing & Contracting
(please print)

Title: _____

Date: 1/3/17

By: _____
Signature

Name: Ching Jaw
CFO & North America
(please print)

Title: _____

Date: 1/4/17

Except to the extent ESI has specifically indicated otherwise on the attached matrices, ESI accepts the Rebates offered by Company on the attached matrix.

Express Scripts, Inc.

By: _____
Signature

Name: Edward J. Adamcik

Title: Vice President,
Pharma Strategy & Contracting

Date: 12.20.16

APPROVED AS TO LEGAL FORM
12-20-16
LEGAL DEPT.

Attachment 1

Attachment 1 to the Amendment

Product Bid Rebate Matrix

(Individual matrices will be incorporated as Attachment A-1 to Exhibit A of the Agreement)

(See Attached)

Attachment A-1 to Exhibit A of the Agreement

Rebate Program: Commercial

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Sanofi-Aventis
Channel:	Retail/Mail/Specialty

Product*	Rate Type	Footnotes	CPG*	Rebates - Stated as % of WAC												Rebates - Stated as % of WAC		Footnotes	Effective Date
				Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	[redacted]			
[redacted]																			
Lantus			Insulin - Basal	No Bid	33.125%	35.125%	36.125%	No Bid	50.125%	50.125%	52.125%	No Bid	50.125%	50.125%	52.125%	No Bid	No Bid		1/1/2017
Lantus			Insulin - Basal	No Bid	33.125%	35.125%	36.125%	No Bid	46.125%	46.125%	48.125%	No Bid	50.125%	50.125%	52.125%	No Bid	No Bid		1/1/2017
Lantus		1	Insulin - Basal	No Bid	33.125%	37.125%	38.125%	No Bid	52.125%	52.125%	54.125%	No Bid	52.125%	52.125%	54.125%	No Bid	No Bid		1/1/2017
Lantus		1	Insulin - Basal	No Bid	33.125%	37.125%	38.125%	No Bid	48.125%	48.125%	50.125%	No Bid	52.125%	52.125%	54.125%	No Bid	No Bid		1/1/2017
Lantus		2	Insulin - Basal	No Bid	No Bid	35.125%	36.125%	No Bid	48.125%	51.125%	51.125%	No Bid	48.125%	51.125%	51.125%	No Bid	No Bid		1/1/2017 through 12/31/2017
Lantus			Insulin - Basal	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid		1/1/2017
Toujeo			Insulin - Basal	No Bid	33.125%	35.125%	36.125%	No Bid	50.125%	50.125%	52.125%	No Bid	50.125%	50.125%	52.125%	No Bid	No Bid		1/1/2017
Toujeo			Insulin - Basal	No Bid	33.125%	35.125%	36.125%	No Bid	46.125%	46.125%	48.125%	No Bid	50.125%	50.125%	52.125%	No Bid	No Bid		1/1/2017
Toujeo		3	Insulin - Basal	No Bid	33.125%	37.125%	38.125%	No Bid	52.125%	52.125%	54.125%	No Bid	52.125%	52.125%	54.125%	No Bid	No Bid		1/1/2017
Toujeo		3	Insulin - Basal	No Bid	33.125%	37.125%	38.125%	No Bid	48.125%	48.125%	50.125%	No Bid	52.125%	52.125%	54.125%	No Bid	No Bid		1/1/2017
Toujeo		2	Insulin - Basal	No Bid	No Bid	35.125%	36.125%	No Bid	48.125%	51.125%	51.125%	No Bid	48.125%	51.125%	51.125%	No Bid	No Bid		1/1/2017 through 12/31/2017
Toujeo			Insulin - Basal	No Bid	No Bid	4.125%	7.125%	No Bid	No Bid	4.125%	7.125%	No Bid	No Bid	4.125%	7.125%	No Bid	No Bid		1/1/2017
Apidra Vial/Solostar			Insulin - Rapid Acting	No Bid	35.125%	45.125%	55.125%	No Bid	35.125%	45.125%	55.125%	No Bid	35.125%	45.125%	55.125%	No Bid	No Bid		1/1/2017
Apidra Vial/Soloster			Insulin - Rapid Acting	No Bid	7.125%	7.125%	9.125%	No Bid	7.125%	7.125%	9.125%	No Bid	7.125%	7.125%	9.125%	No Bid	No Bid		1/1/2017

Attachment A-1 to Exhibit A of the Agreement

Product*	Rate Type	Footnotes	CPC**	Rebates - Stated as % of WAC: Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	[redacted]	[redacted]	Footnotes	Effective Date
Apidra Vial/Solostar	Managed Medicaid only		Insulin - Rapid Acting	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid	No Bid		1/1/2017
[redacted]																			

* All NDCs of Products must be of Formulary and meet the requirements of Eligible Utilization.

** Unspecified CPC = Contracted Product is currently not in a CPC; Formulary Positioning is not applicable.

FOOTNOTES:

1) Lantus criteria based enhancement: Notwithstanding Section II(H) in the Agreement, in order for a Plan to be eligible for Rebates for Lantus under this Rate Type beginning January 1, 2017, the Plan must have all NDCs of Lantus and Toujeo on the Plan's Formulary in the preferred or lowest branded copay tier with unrestricted access, consistent with the Product's package insert and in accordance with Section II(E) of the Agreement and this Attachment A-1.

2) [redacted] In order for any utilization of Lantus or Toujeo, regardless of NDC, to be eligible for the Rebates identified above, each of the following conditions must be met for which ESI claims a Rebate with respect to [redacted] utilization: (i) All Lantus and Toujeo NDCs must be on [redacted] Preferred brand Formulary tier at the lowest co-pay or co-insurance, whichever is applicable, for brand products with no restrictions on the use of Lantus or Toujeo by Participants; and (ii) all Lantus and Toujeo NDCs must be listed on the Preferred brand Formulary tier in equal or better position with only one other manufacturer's branded product in the CPC, which as determined by Anthem, must be Levemir®; and (iii) other manufacturer's branded product(s) in the CPC on the non-Preferred Formulary access tier shall require a step edit through one Preferred Formulary tier's unrestricted brand, which as determined by [redacted] will be Tresiba® and Basaglar®; and (iv) as determined by [redacted] effective April 1, 2017, all other manufacturers in the CPC shall be NDC blocked and not covered on all of [redacted] designated exclusion formularies (optimized formularies); and (v) at no time may any of the NDCs listed above be disadvantaged versus the other product in the same Formulary tier; and (vi) the NDCs list above must meet the conditions set forth herein at the time the Products are added to Formulary through the remainder of the then-current month and for the entire month for each subsequent month; and (vii) it is understood that Lantus Rebates are contingent on Toujeo NDC being on Formulary as set forth herein and Toujeo Rebates are contingent on all Lantus NDCs being on Formulary as set forth herein.

3) Toujeo criteria based enhancement: Notwithstanding Section II(H) in the Agreement, in order for a Plan to be eligible for Rebates for Toujeo under this Rate Type beginning January 1, 2017, the Plan must hav[redacted] on the Plan's Formulary in the preferred or lowest branded copay tier with unrestricted access, consistent with the Product's package insert/product information and in accordance with Section II(E) of the Agreement and this Attachment A-1.

4) [redacted]

5) [redacted]

Attachment A-1 to Exhibit A of the Agreement

Product*	Rate Type	Footnotes	CPC**	Rebates - Stated as % of WAC: Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Rebates - Stated as % of WAC [redacted]	Footnotes	Effective Date

a) all NDCs must be available on the Non-Preferred, Preferred or specialty brand copay/coinsurance tier; and

b) all strengths and formulations of [redacted] must adjudicate on the same tier and with equal or better position as any other brand product in the CPC; and

c) all NDCs must be available with no more greater restrictions, except for the following prior authorization and step edits. Patients must meet 1, 2, 3, AND 4:

1) Patient is ≥ 18 years.

2) Praluent was prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

3) Patient meets one of A or B:

A. Patients with clinical atherosclerotic cardiovascular disease including, but not limited to, history of myocardial infarction, stroke, stable/unstable angina who in adjunct to diet and maximally tolerated statin therapy cannot achieve an LDL-C of <70 mg/dL, OR

B. LDL-C level suggestive of a diagnosis of Heterozygous familial hypercholesterolemia

4) Patient meets one of A or B:

A. Patient has tried one high-intensity statin (i.e., atorvastatin ≥ 40 mg daily; Crestor ≥ 20 mg daily [as a single-entity or as a combination product]) and [redacted] concomitantly, for a minimum of 8 w continuously (history of, time of look back not specified) and LDL-C remains ≥ 70mg/dL; OR

B. Patient is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried both Crestor and atorvastatin and has experienced skeletal-muscle related symptoms on both agents.

6) [redacted] Utilization is eligible for Rebates when the following conditions are met: i) all NDCs of [redacted] must not be restricted by any of the following: quantity limits, prior authorization, and/or step edits; (ii) [redacted] adjudicates as Preferred in the CPC; (iii) no other branded product in the CPC may be placed on a lower copay/coinsurance tier than [redacted]; (iv) Plan must implement a step edit that requires the use of [redacted] prior to prescribing any other branded product in the CPC.

7) [redacted] Utilization is eligible for Rebates when [redacted] is non-Preferred and when a step edit requires the use of [redacted] prior to the use of [redacted]. A therapeutic class prior authorization is acceptable. The [redacted] prior authorization criteria requires a six (6) month trial of [redacted]

EXPRESS SCRIPTS, INC.
AMENDMENT TO THE
PREFERRED SAVINGS GRID REBATE PROGRAM AGREEMENT

2014/2015 Rebate Cycle Bid Enhancement Opportunity

THIS AMENDMENT ("Amendment"), effective January 1, 2014, is made to the Preferred Savings Grid Rebate Program Agreement dated effective January 1, 2010, by and between Express Scripts, Inc. ("ESI") and Sanofi-Aventis U.S. LLC on behalf of itself and its affiliate Genzyme Corporation ("Company") (the "Agreement").

Recitals

WHEREAS, Company acquired Genzyme Corporation ("Genzyme") and Genzyme is a wholly owned subsidiary of Company; and

WHEREAS, ESI and Genzyme entered into a Pharmaceutical Rebate Agreement and a Participating Manufacturer Agreement, both effective June 1, 2005, for rebates and administrative fees for Genzyme's products ("Genzyme Commercial Agreement"); and

WHEREAS, the parties agree that, effective with this Amendment, the Genzyme products shall no longer be eligible for rebates and administrative fees under the Genzyme Commercial Agreement; and

WHEREAS, the parties agree to move all Genzyme Commercial Agreement rebates and administrative fees under the Agreement effective with this Amendment; and

WHEREAS, ESI has offered Company an opportunity to participate in the 2014/2015 Preferred Savings Grid Bid Enhancement Opportunity (the "2014/2015 Commercial Bid"); and

WHEREAS, Company has reviewed the conditions under which the bid enhancements offers will be considered and desires to participate in 2014/2015 Commercial Bid, for purposes of providing competitive pricing terms, on the utilization of certain Products by Participants under a Plan, in accordance with this Amendment.

NOW, THEREFORE, the parties agree as follows:

Terms of Agreement

1. Exhibit A. With respect to the 2014/2015 Rebate Cycle and all subsequent Rebate Cycles, any pre-existing Exhibit A to the Agreement is hereby deleted in its entirety and replaced with a new Exhibit A, as set forth on Attachment 1 to this Amendment.

2. Rebate Bid Offers. Exhibit A of the Agreement is amended to restate Attachment A-1 of Exhibit A in the form attached to this Amendment as Attachment 2. Company shall provide Rebate bid offers for (i) retail utilization, and (ii) home delivery/specialty

pharmacy utilization. Any Rebate bid offer not providing Rebates for both (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization shall be considered non-compliant and the applicable Products rejected from consideration for Formulary placement.

The Rebate bids, as offered on the Attachment 2 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of certain Products by Participant. Attachment 2 attached hereto shall supersede and replace Attachment A-1 to Exhibit A of the Agreement. Company acknowledges that Rebate bids offered by Company and accepted by ESI under this Amendment shall be effective as of January 1, 2014, and shall remain in effect through the term of the Agreement except to the extent replaced by an enhanced rebate bid mutually agreed to in writing by Company and ESI at a later date.

3. Rebate Enhancement Options. The Rebate Enhancement Options offered on Attachment 2 to this Amendment, when accepted in writing by ESI, shall constitute a binding agreement for Rebates on utilization of certain Products by Participant. For purposes of this Amendment and the Agreement, the term "Rebate Enhancement Options" shall mean those opportunities designated as such in Table 1 of Exhibit A attached hereto and additional Rebate opportunities outside of the intersecting Benefit Control/Formulary Positions cells (as defined in Exhibit A of Attachment 1 attached hereto) including, but not limited to, Select Client Options as defined below. Company acknowledges that Rebate Enhancement Options offered by Company and accepted by ESI under this Amendment shall be effective as of January 1, 2014 and shall remain in effect through the term of the Agreement. Rebate Enhancement Options accepted by ESI shall replace only the corresponding and existing Rebate Enhancement Options, if any. Except as amended herein, any previously contracted Rebate Enhancement Options currently in place shall remain in effect through the term of the Agreement, except to the extent modified in writing by mutual agreement of the parties at a later date. Enhanced Rebates for utilization of Products by Participants of specific Plans ("Select Client Options") currently in place shall continue in effect.

4. Affiliate Rebates and Administrative Fees. For calendar year 2014 and thereafter, ESI shall submit to Company Eligible Utilization from all its affiliates, including, but not limited to, Medco Health Solutions, Inc. ("Medco"), for payments of Rebates and Administrative Fees and Company is obligated to pay ESI such Rebates and Administrative Fees for Eligible Utilization, in accordance with the Agreement.

5. Other Agreements. Company acknowledges and agrees, for calendar year 2014 and thereafter, that this Agreement and the Rebates and Administrative Fees contained in the Agreement, and amended herein, shall supersede all agreements and related Formulary Rebates and associated Administrative Fees that have been agreed upon by Company and Medco ("Original Medco Formulary Rebate Agreements") in other agreements; provided, however, that any and all Covered Plan-specific rebate and administrative fee agreements between Company and Medco currently in effect as of the execution date of the Amendment (as noted below) shall remain in effect until Covered Plan-specific rates are

added to this Agreement through a mutual written amendment. For purposes of clarity, the Agreement shall not apply to rebates Medco receives from Company during calendar year 2013 or any prior calendar year. In such instance, the Original Medco Formulary Rebate Agreement shall apply.

6. Price Protection. In accordance with the terms set forth on Attachment 3 to this Amendment and the applicable terms of the Agreement, including Attachment A-1 to Exhibit A, Company elects to pay Price Protection Rebate, with respect to all Eligible Utilization for Company Products, as indicated on the Rebate matrix.

7. Term. Company acknowledges and agrees that effective upon the execution of this Amendment by Company, the term of the Agreement shall be extended through December 31, 2015, subject to earlier termination as provided in the Agreement.

8. Except as amended herein, all terms and conditions of the Agreement shall remain in effect.

Company represents that the following signature is that of an authorized representative of Company.

Sanofi-Aventis U.S. LLC

By: _____
Signature

Name: _____
(please print)

Title: _____
(please print)

Date: _____

Except to the extent ESI has specifically indicated otherwise on the attached matrices, ESI accepts the Rebates offered by Company on the attached matrix.

Express Scripts, Inc.

By: _____
Signature

Edward J. Adamcik
Expess Scripts, Inc.
Vice President, Pharmaceutical Strategies & Solutons

Date: 12-27-13

APPROVED AS TO LEGAL
06/02/13
LEGAL

Attachment 1

EXHIBIT A

Preferred Savings Grid Rebate Program
Rebates – January 1, 2014 and Thereafter

Bidding Process:

For purposes of evaluating applicable Formulary determinations, ESI will solicit new Rebate offers and/or enhancements to existing Rebates for Company's Products in connection with each Rebate Cycle. At any time during the term of this Agreement, ESI may solicit new or enhanced Rebate offers with respect to any CPC based on changes in the marketplace.

In connection with a re-bidding process, Company may submit Rebate offers equal to or greater than the Rebates in place for an applicable Product at the time of ESI's solicitation. If Company does not respond by submitting an enhanced Rebate offer with respect to a Product, then the previously accepted Rebate, including any previously accepted enhancements, shall be deemed to be Company's Rebate offer for purposes of the bidding process. Company shall provide Rebates for both (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization. Any Rebate bid offer not providing Rebates for both (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization shall be considered non-compliant and the applicable Products rejected from consideration for Formulary placement. Rebate eligibility shall be determined and Rebates shall be calculated on a channel specific basis (e.g. retail, home delivery/specialty pharmacy).

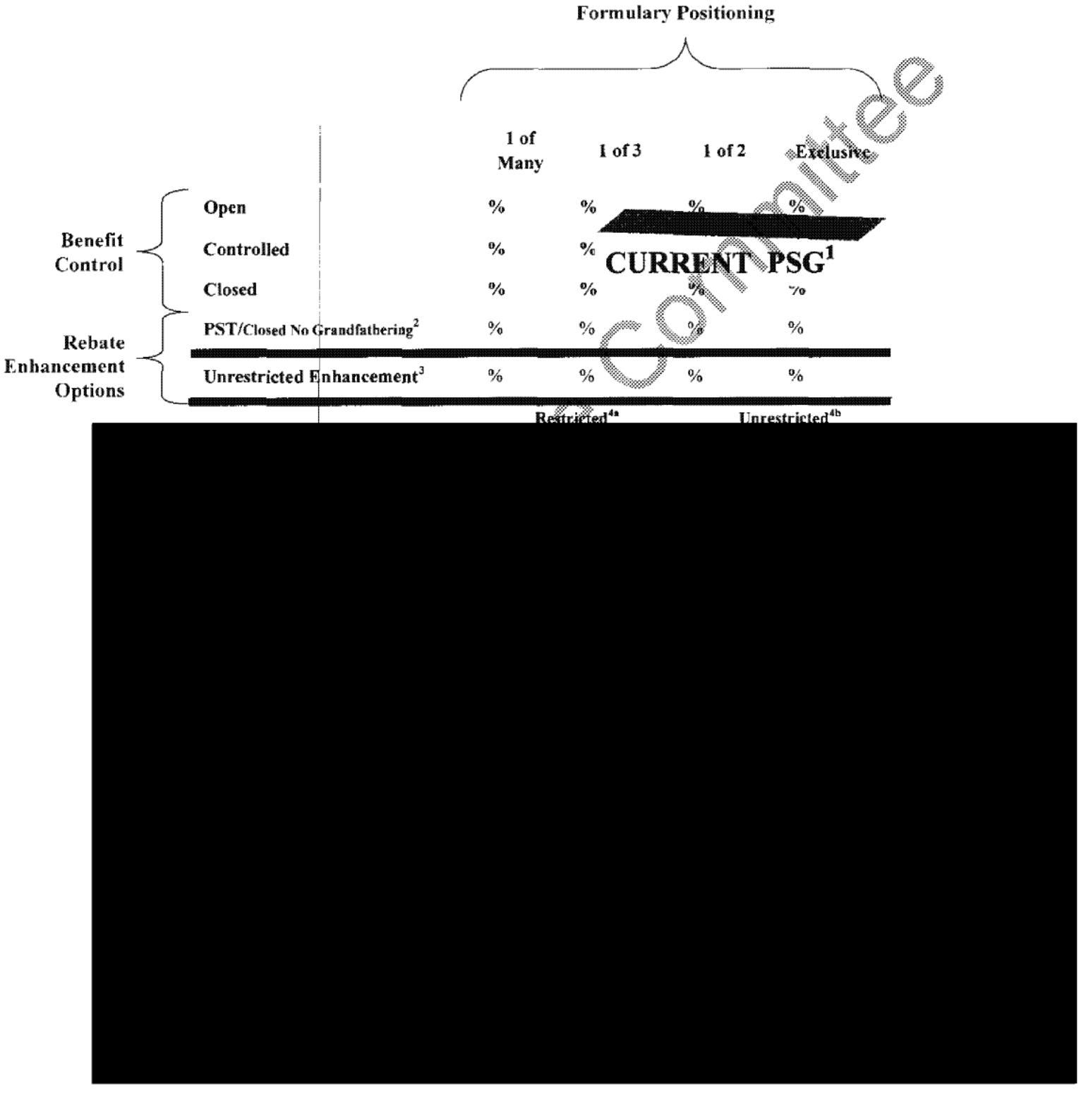
Products are grouped by ESI based on Competitive Product Categories ("CPCs"). Manufacturer products in the same CPC compete against each other for participation in the PSG Rebate Program and for formulary status with respect to each Formulary. For purposes of this Agreement, classification of a product as a "brand" or "branded" product shall be as reasonably determined by ESI.

The number of manufacturers' products within a CPC designated as Preferred for each Plan differentiates one Formulary from another in terms of the "Formulary Positioning" (described more specifically below). For purposes of this Bid Amendment, the term "Preferred" refers to a Product that adjudicates at the lowest co-pay or coinsurance tier for branded products within its designated CPC.

ESI also categorizes each Plan in the PSG Rebate Program according to the Plan's benefit design attributes. The "Benefit Control" (defined more specifically below) determines the relative level of formulary compliance control affecting product utilization by Participant under the applicable Plan.

As shown on the following diagram, a matrix (or "Grid") is used to plot the Rebates for each Product based on the intersecting points on the Grid (each such intersection is often referred to as a "cell") reflecting the foregoing elements, as applicable to each Participant's utilization:

Table 1



[redacted]

Formulary Positioning:

With respect to each Formulary, ESI or the applicable Plan, in conjunction with the oversight and approval of the applicable Pharmacy and Therapeutics ("P&T") Committee, will determine the appropriate product (or products) to be designated as Preferred. In this way, the Plan will ultimately determine the applicable "Formulary Positioning" for each designated CPC, either based on a Formulary developed by ESI or the Plan's customized Formulary design. The Formulary Positioning used within the PSG Rebate Program will be defined as follows:

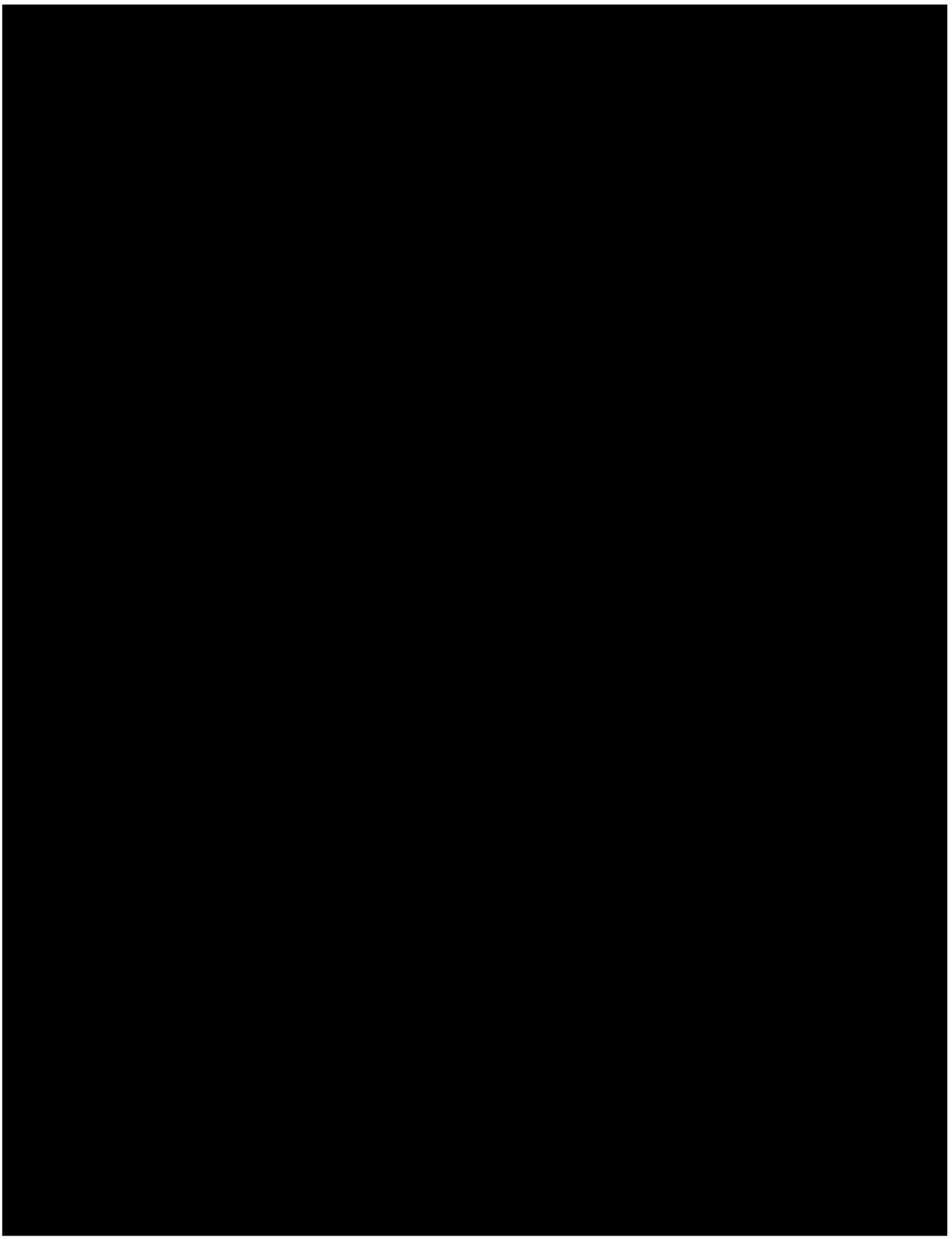
1 of Many	Designates those CPCs within a Formulary for which four (4) or more branded manufacturers whose products are competing in the CPC as Preferred.
1 of 3	Designates those CPCs within a Formulary for which three (3) branded manufacturers whose products are competing in the CPC as Preferred.
1 of 2	Designates those CPCs within a Formulary for which two (2) branded manufacturers whose products are competing in the CPC as Preferred.
Exclusive	Designates a CPC within a Formulary for which only one (1) branded manufacturer whose products is Preferred.

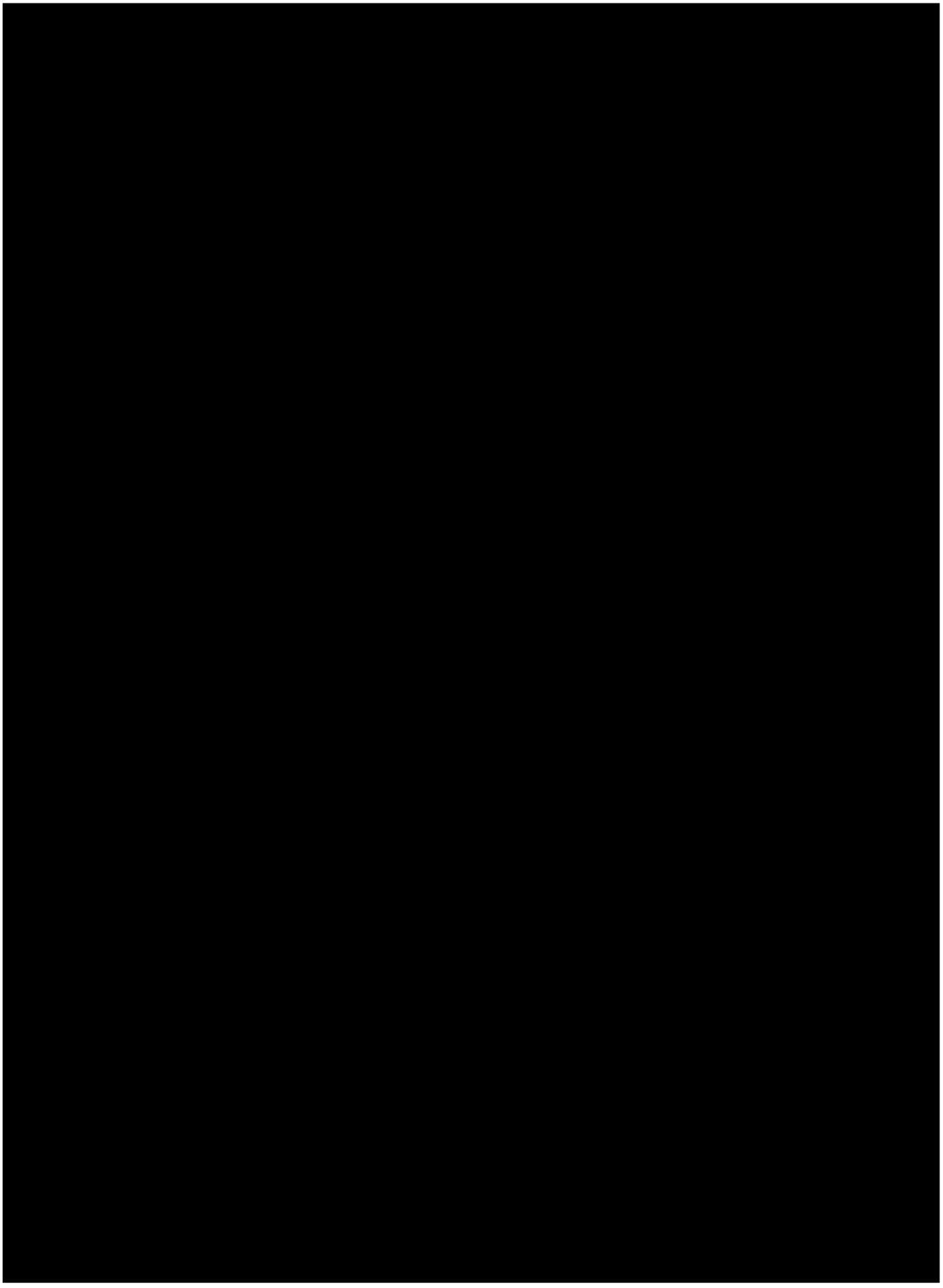
Benefit Control:

As referenced above, "Benefit Control" shall mean a certain set of Formulary compliance control mechanisms that are imposed with respect to each Plan. The Benefit Control that will differentiate the level of Rebates due are defined as follows:

Open	Refers to a benefit design under which the Product is Preferred.
Controlled	Refers to a benefit design under which the Product is Preferred and under which a higher co-payment or coinsurance percentage for non-Preferred products applies when the Plan provides reimbursement.
Closed	Refers to a benefit design under which the Product is Preferred; however, with respect to any non-Preferred products, the Plan also (i) requires use of Preferred over non-Preferred brand, through step therapy or a similar intervention process; or (ii) requires the Participant to pay 100% of the applicable price of such products regardless of whether any applicable deductible has been satisfied; or (iii) imposes an NDC block against coverage benefits for such products. Provided, however, in each case Participant may obtain the non-Preferred or non-covered product when medically necessary. Existing users of non-Preferred product shall be allowed to continue to receive the non-Preferred product.

When a Product is dispensed or administered to a Participant, the "cell" that corresponds to both the applicable Formulary Positioning and the Plan's Benefit Control will determine the Rebate amount due.





Rebate Calculations:

Rebates will be calculated on a per unit basis of a single tablet, capsule, milliliter or gram dosage, as applicable. Rebates for each Product will be billed to Company on a monthly basis as described in the Section of this Agreement titled "Billing and Payment." Rebates will be based upon Product utilization and the corresponding Formulary Positioning and the Benefit Control, or Client Classification, (each as defined above) applicable to each Plan and in place on the date the applicable Product is dispensed or administered. Rebates for a Product shall be calculated using the Rebate percentages set forth in the Rebate matrices attached to and incorporated in this Agreement as Attachment(s) to this Exhibit A, and the Product's WAC as of the date a Product is dispensed or administered to a Participant by a Participating Pharmacy. All Rebate percentages shall be stated as a percentage of WAC. Company agrees to pay the Rebate amounts determined in accordance with this Exhibit A regardless of the number of Plans that include Company's Product(s) on Formulary.

Company shall pay Rebates to ESI for all newly introduced package sizes of any Product. No Rebates shall be due from Company for any Product dispensed or administered to a Participant enrolled in or covered by a Plan which subjects such Product to maximum allowable cost reimbursement limitations.

Attachment 2 to the Amendment

Product Bid Rebate Matrix

(Individual matrices will be incorporated as Attachment A-1 to Exhibit A of the Agreement)

(See Attached)

Attachment A-1 to Exhibit A of the Agreement

Express Scripts, Inc.

Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right hand column below for each Product.

Manufacturer:	Sanofi-Aventis
Channel:	Retail/Mail/Specialty

		Rebates - Stated as % of WAC												Contract Options			
Product	CPC	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	[redacted]	[redacted]	Effective Date
[redacted]																	
LANTUS SoloStar	Insulin - Basal	No Bid	No Bid	0.625%	0.625%	No Bid	No Bid	4.625%	6.625%	No Bid	No Bid	4.625%	6.625%				01/01/2014
LANTUS Vial	Insulin - Basal	No Bid	No Bid	0.625%	0.625%	No Bid	No Bid	1.625%	2.625%	No Bid	No Bid	1.625%	2.625%				01/01/2014
Apidra Solostar/Vial	Insulin - Rapid Acting	No Bid	35.625%	45.625%	55.625%	No Bid	35.625%	45.625%	55.625%	No Bid	35.625%	45.625%	55.625%				01/01/2014
[redacted]																	

* Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable.

1) This % will establish the annual Price Protection maximum allowable price
2) [redacted]
3) [redacted]
4) Utilization on Tier 1 or Tier 2 is rebate eligible. Third tier is considered non-formulary/Access.
5) [redacted]s on formulary; Copay/coinsurance is consistent for all formulary products.
6) [redacted]s one (1) of no more than four (4) Products in the Multiple Sclerosis Therapeutic Category (MSTC). Copay/co-insurance is consistent for all formulary Products.
7) [redacted]s one (1) of no more than three (3) Products in the Multiple Sclerosis Therapeutic Category (MSTC).
8) [redacted]s covered as the preferred oral multiple sclerosis agent with a step through Aubagio before other oral multiple sclerosis agents.
9) Class PA is acceptable. [redacted] preferred. Failure of [redacted] prior to approval for [redacted] [redacted]nal 6 months per Package Insert.

[redacted]

Attachment A-1 to Exhibit A of the Agreement

Express Scripts, Inc.

Rebate Matrix Issued For Year 1 of the 2014-2015 Commercial Rebate Cycle

Company hereby offers, for acceptance by ESI, pursuant to the terms of the Agreement, the Rebate amounts specified in this matrix for utilization of Company's Products. If accepted by ESI, Company will pay the Rebate levels specified for each Benefit Control and Formulary Positioning, effective for a Product as of the effective date provided in the far right-hand column below for each Product.

Manufacturer:	Sanofi-Aventis - Managed Medicaid
Channel:	Retail/Mail/Specialty

		Rebates - Stated as % of WAC												Contract Options			
Product	CPC	Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	[redacted]		Effective Date
[redacted]																	
LANTUS/Solostar	Insulin - Basal	No Bid	No Bid	0.625%	0.625%	No Bid	No Bid	0.625%	0.625%	No Bid	No Bid	0.625%	0.625%	No Bid	No Bid	No Bid	01/01/2014
Apidra/Solostar	Insulin - Rapid Acting	No Bid	5.625%	7.625%	9.625%	No Bid	5.625%	7.625%	9.625%	No Bid	5.625%	7.625%	9.625%	No Bid	No Bid	No Bid	01/01/2014
Apidra/Solostar - WellPoint [4]	Insulin - Rapid Acting	No Bid	7.625%	7.625%	9.625%	No Bid	7.625%	7.625%	9.625%	No Bid	7.625%	7.625%	9.625%	No Bid	No Bid	No Bid	01/01/2014
[redacted]																	

- Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable.

1) This % will establish the annual Price Protection maximum allowable price.
2) [redacted]
3) [redacted]
4) [redacted] qualifies for the Closed 1 of 2 grid rate.

Attachment 3
Price Protection

1. Definitions

"Allowed Net WAC" with respect to any Price Protection Product, for (a) the calendar year beginning January 1, 2014 is calculated by multiplying Net WAC as of December 31 of the prior calendar year by one (1) plus the Price Protection Factor, and (b) each calendar year thereafter, is calculated by multiplying the Allowed Net WAC for the prior calendar year by 1 plus the Price Protection Factor.

"Net WAC" shall mean, with respect to each Price Protection Product, the WAC net of Rebate and calculated as the WAC of such Product multiplied by one (1) minus the applicable Rebate percentage set forth on Exhibit A.

"Price Protection Percentage" shall mean the amount stated in Exhibit A-1, expressed as a percentage of WAC, that each contract year's Allowed Net WAC is permitted to increase prior to the effectuation of a Price Protection Rebate.

"Price Protection Rebate" shall mean the amount, expressed in dollars, by which the Net WAC for the applicable Price Protection Product exceeds the applicable Allowed Net WAC for the applicable Price Protection Period.

"Price Protection Period" shall mean each twelve (12) month calendar year period for which Rebates are being calculated.

"Price Protection Product" shall mean each Product for which Price Protection is offered as indicated on the matrix.

2. Eligibility for and Calculation of Price Protection Rebate

A. During a Price Protection Period, if Company increases the WAC of the applicable Price Protection Product above the applicable Allowed Net WAC, Company shall pay ESI the Price Protection Rebate and Rebate ("Total Rebate") on all utilization of the Price Protection Product, including rebate enhancements and select client enhancements, occurring on and after the effective date of the Price Protection Rebate. Each subsequent WAC adjustment occurring during a Price Protection Period shall result in a new calculation of the applicable Price Protection Rebate Percentage. In no event shall the Rebates be adjusted downward below the amounts specified in Exhibit A of the Agreement.

B. The Total Rebate shall be effective on the later of (i) the day ESI updates its systems, or (ii) the first day following the applicable price increase.

C. Payment of the Total Rebate, shall be calculated, invoiced and paid pursuant the Billing and Payment Section of the Agreement.

D. For illustrative purposes only, below are hypothetical examples of a Price Adjustment Percentage calculation.

ALLOWED NET WAC									
DRUG	WAC as of 12/31/13	Rebate %	Starting Net WAC	Price Protection Percentage	Year 1 Allowed Net WAC	Price Protection Percentage	Year 2 Allowed Net WAC	Price Protection Percentage	Year 3 Allowed Net WAC
A	$100.00	5%	$95.00	8%	$102.60	8%	$110.81	8%	$119.67
B	$110.00	10%	$99.00	8%	$106.92	8%	$115.47	8%	$124.71
C	$150.00	15%	$127.50	8%	$137.70	8%	$148.72	8%	$160.61
D	$50.00	20%	$40.00	8%	$43.20	8%	$46.66	8%	$50.39
E	$225.00	25%	$168.75	8%	$182.25	8%	$196.83	8%	$212.58

A.
B.
C.

PRICE PROTECTION CALCULATION								
DRUG	Applicable WAC for the QTR	Rebate %	Rebate $	Net WAC	Allowed Net WAC	Price Protection Rebate	Total Rebate	Total Rebate %
A	$110.00	5%	$5.50	$104.50	$102.60	$1.90	$7.40	6.73%
B	$112.00	10%	$11.20	$100.80	$106.92	$0.00	$11.20	10.00%
C	$155.00	15%	$23.25	$131.75	$137.70	$0.00	$23.25	15.00%
D	$60.00	20%	$12.00	$48.00	$43.20	$4.80	$16.80	28.00%
E	$225.00	25%	$56.25	$168.75	$182.25	$0.00	$56.25	25.00%

EXPRESS SCRIPTS SENIOR CARE HOLDINGS, INC.
AMENDMENT TO THE
MEDICARE PART D REBATE PROGRAM AGREEMENT

2013-2014 Rebate Cycle Bid Enhancement Opportunity
Year 2

THIS AMENDMENT ("Amendment"), effective January 1, 2014, is made to the Medicare Part D Rebate Program Agreement dated effective January 1, 2006, by and between Express Scripts Senior Care Holdings, Inc. ("ESSC") and sanofi-aventis U.S. LLC on behalf of itself and its affilate Genzyme Corporation ("Company") (the "Agreement").

Recitals

WHEREAS, sanofi-aventis U.S. LLC acquired Genzyme Corporation ("Genzyme") and Genzyme is an affiliate of sanofi-aventis U.S. LLC; and

WHEREAS, Company has the authority to offer discounts on, and enter rebate agreements for, certain products of its Affiliate Genzyme Corporation.

WHEREAS, ESSC and Genzyme entered into a Medicare Part D Rebate Agreement, effective April 22, 2005, for rebates on the utilization of Genzyme's products ("Genzyme Medicare Part D Agreement"); and

WHEREAS, the parties agree that, effective with this Amendment, the Genzyme products shall no longer be eligible for rebates under the Genzyme Medicare Part D Agreement; and

WHEREAS, the parties agree to move all Genzyme Medicare Part D Agreement rebates under the Agreement effective with this Amendment; and

WHEREAS, ESSC has offered Company an opportunity to participate in year 2 of the 2013-2014 Medicare Part D Bid Enhancement Opportunity (the "2014 Medicare Part D Bid"); and

WHEREAS, Company has reviewed the conditions under which the bid enhancements offers will be considered and desires to participate in 2014 Medicare Part D Bid, for purposes of providing competitive pricing terms, on the utilization of certain Products by Part D Eligible Individuals under a Covered Plan, in accordance with this Amendment.

NOW, THEREFORE, the parties agree as follows:

Terms of Agreement

1. Exhibit A. With respect to year 2 of the 2013-2014 Rebate Cycle and all subsequent Rebate Cycles, any pre-existing Exhibit A to the Agreement is hereby deleted in its entirety and replaced with a new Exhibit A, as set forth on Attachment 1 to this Amendment.

2. Rebate Bid Offers. Exhibit A of the Agreement is amended to restate Attachment A-1 of Exhibit A in the form attached hereto as Attachment 2. Company shall provide rebates bids for (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization. The rebate bids, as offered on the Attachment 2 to the Amendment, when accepted in writing by ESSC, shall constitute a binding agreement for Rebates on utilization of certain Products by Part D Eligible Individuals. Company acknowledges that Rebate bids offered by Company and accepted by ESSC under this Amendment shall be effective as of January 1, 2014, and shall remain in effect through the term of the Agreement except to the extent replaced by an enhanced rebate bid mutually agreed to in writing by Company and ESSC at a later date.

3. Rebate Enhancement Options. The Rebate Enhancement Options offered on Attachment A-1 to Exhibit A, when accepted in writing by ESSC, shall constitute a binding agreement for Rebates on utilization of certain Products by Part D Eligible Individuals. Company acknowledges that Rebate Enhancement Options offered by Company and accepted by ESSC under this Amendment shall be effective as of January 1, 2014, and shall remain in effect through the term of the Agreement. Rebate Enhancement Options accepted by ESSC shall replace only the corresponding and existing Rebate Enhancement Options, if any. Except as amended herein, any previously contracted Rebate Enhancement Options currently in place shall remain in effect through the term of the Agreement except to the extent modified in writing by mutual agreement of the parties at a later date. Enhanced Rebates for utilization of Products by Part D Eligible Individuals of specific Covered Plan Sponsors ("Select Client Options") currently in place shall continue in effect.

4. Affiliate Rebates and Administrative Fees. Company acknowledges and agrees that, for calendar year 2014 and thereafter, all affiliated Part D Plan Sponsors and Part D Plan Sponsors serviced by affiliates of ESSC shall also be considered "Covered Plan Sponsors" for purposes of the Agreement. As such, for calendar year 2014 and thereafter, ESSC shall submit to Company Rebate Eligible Part D Utilization from all its affiliates, including, but not limited to, Medco Health Solutions, Inc. ("Medco"), for payments of Rebates and Administrative Fees and Company is obligated to pay ESSC such Rebates and Administrative Fees for Rebate Eligible Part D Utilization, in accordance with the Agreement.

5. Other Agreements. Company acknowledges and agrees, for calendar year 2014 and thereafter, that this Agreement and the Rebates and Administrative Fees contained in the Agreement, and amended herein, shall supersede all agreements and related formulary Part D Rebates and associated Administrative Fees that have been agreed upon by Company and Medco ("Original Medco Formulary Rebate Agreements") in other agreements; provided, however, that any and all Covered Plan Sponsor-specific rebate and administrative fee agreements between Company and Medco currently in effect as of the execution date of the Amendment (as noted below) shall remain in effect until Covered Plan Sponsor-specific rates are added to this Agreement through a mutual written amendment. For issues pertaining to calendar year 2013 or any prior calendar year, the Original Medco Formulary Rebate Agreement shall apply.

6. Price Protection. In accordance with the terms set forth on Attachment 3 to this Amendment and the applicable terms of the Agreement, including Attachment A-1 to Exhibit A, Company elects to pay Price Protection Rebates, with respect to all Rebate Eligible Part D Utilization for Company Products, as indicated on the Rebate matrix.

7 Except as amended herein, all terms and conditions of the Agreement shall remain in effect.

Signature Page Immediately Follows

Company represents that the following signature is that of an authorized representative of Company.

Sanofi-Aventis U.S. LLC

By: _____
Signature

Name: Claire Brunker
(please print)

Title: Vice President Strategic Pricing Contracts
(please print)

Date: 11/25/13

Except to the extent ESSC has specifically indicated otherwise on the attached matrices, ESSC accepts (i) the Rebates offered by Company on the attached matrix and (ii) the offered rebate enhancements elected by Company above.

Express Scripts Senior Care Holdings, Inc.

By: _____
Signature

Name: F. Everett Neville

Title: Vice President

Date: 11-26-2013

APPROVED AS TO LEGAL FORM
09/02/13
LEGAL DEPT.

Attachment 1

EXHIBIT A

Medicare Part D Rebate Program
Rebates – 2014 and Thereafter

Bidding Process:

For purposes of evaluating applicable Formulary determinations, ESSC will solicit new Rebate offers and/or enhancements to existing Rebates for Company's Products in connection with each Part D Program Rebate Cycle. At any time during the term of this Agreement, ESSC may solicit new or enhanced Rebate offers with respect to any CPC based on changes in the marketplace.

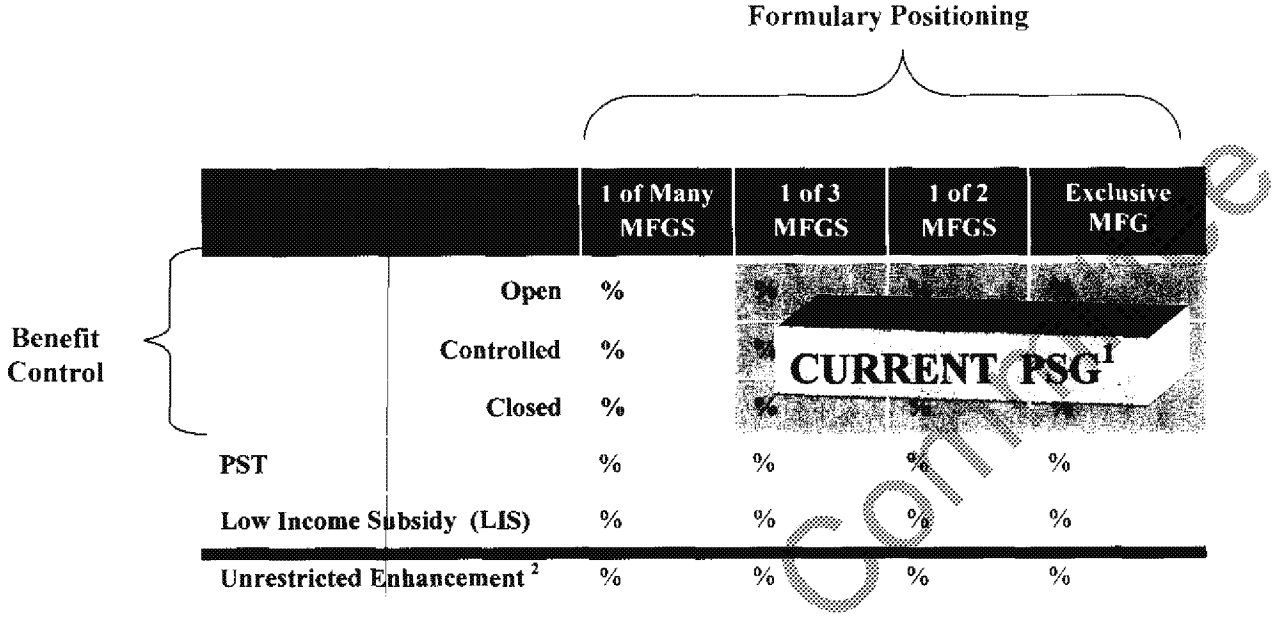
In connection with a re-bidding process, Company may submit Rebate offers equal to or greater than the Rebates in place for an applicable Product at the time of ESSC's solicitation. If Company does not respond by submitting an enhanced Rebate offer with respect to a Product, then the previously accepted Rebate, including any previously accepted enhancements, shall be deemed to be Company's Rebate offer for purposes of the bidding process. Company shall provide Rebates for (i) retail utilization, and (ii) home delivery/specialty pharmacy utilization. Rebate eligibility shall be determined and Rebates shall be calculated on a channel specific basis (e.g. retail, home delivery/specialty pharmacy).

Products are grouped by ESSC based on Competitive Product Categories ("CPCs"). Manufacturer products in the same CPC compete against each other for participation in the Part D Rebate Program and for formulary status with respect to each Formulary. For purposes of this Agreement, classification of a product as a "brand" or "branded" product shall be as reasonably determined by ESSC.

The number of manufacturers' products within a CPC designated as "on-Formulary" for each Covered Plan differentiates one Formulary from another in terms of the "Formulary Positioning" (described more specifically below).

ESSC also categorizes each Covered Plan in the Part D Rebate Program according to the Covered Plan's benefit design attributes. The "Benefit Control" (defined more specifically below) determines the relative level of formulary compliance control affecting product utilization by Part D Eligible Individuals under the applicable Covered Plan.

As shown on the following diagram, a matrix (or "Grid") is used to plot the Rebates for each Product based on the intersecting points on the Grid (each such intersection is often referred to as a "cell") reflecting the foregoing elements, as applicable to each Part D Eligible Individual's utilization:

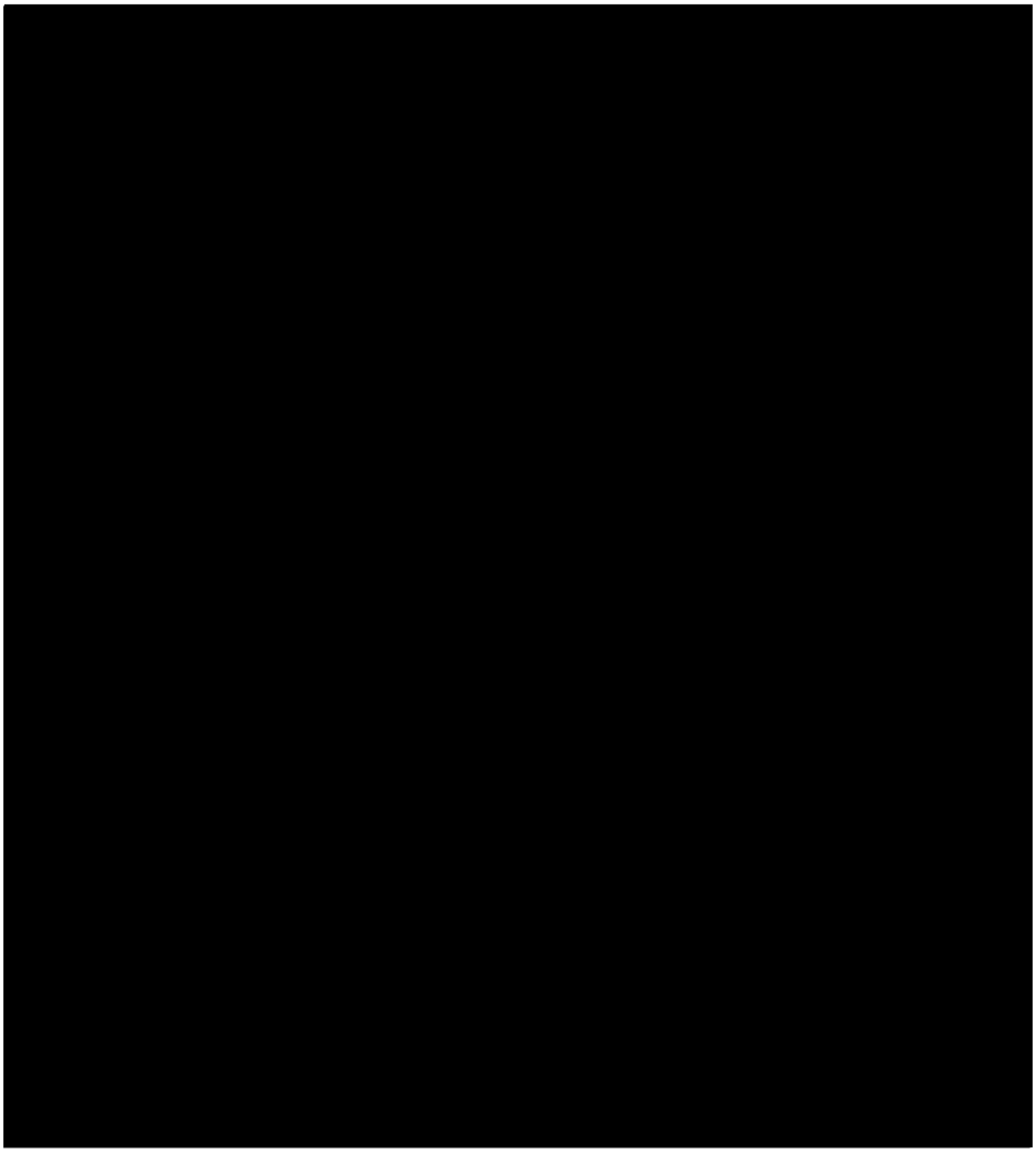


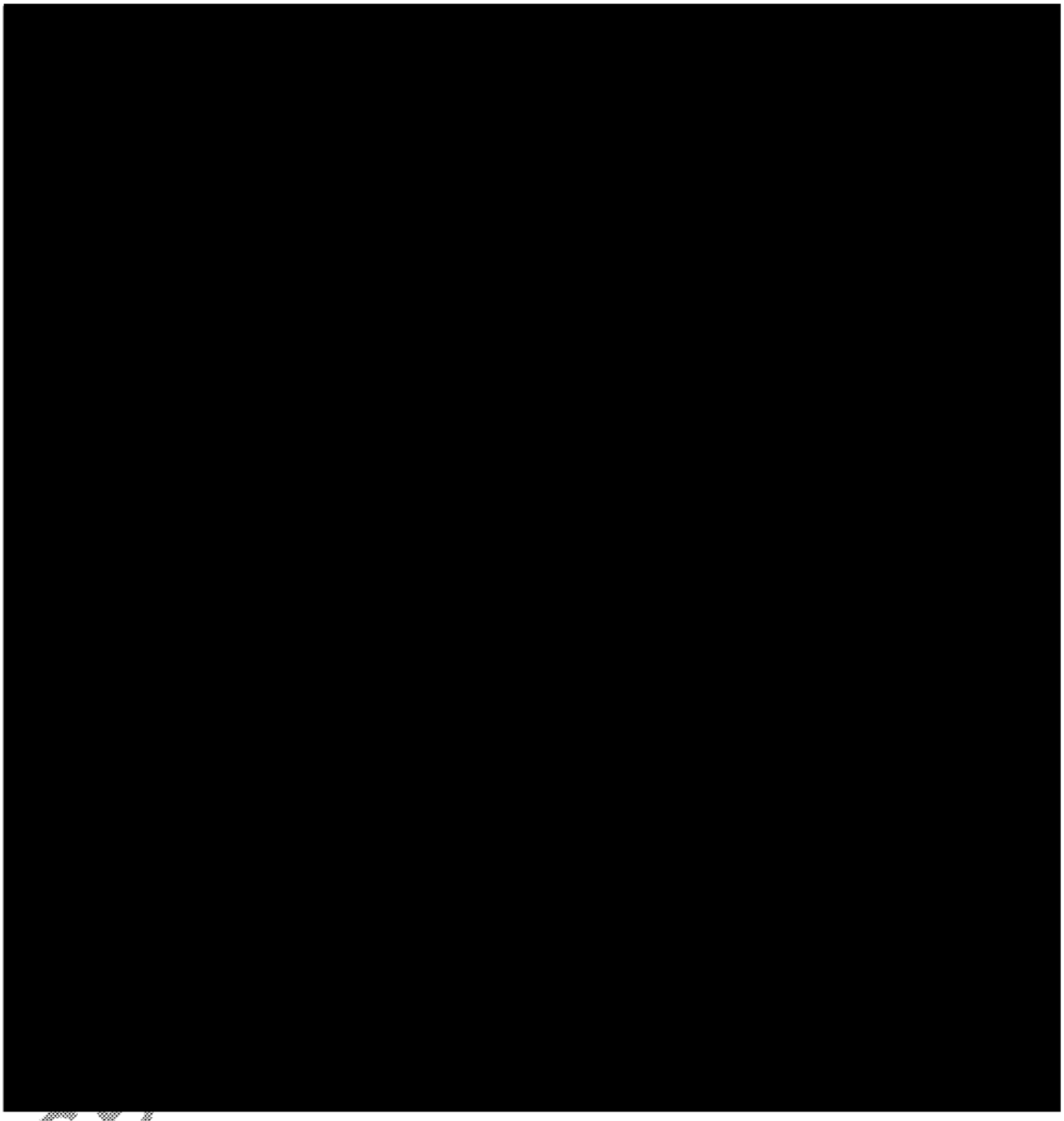
Note 1 – Current PSG shall mean those Rebates that have been offered and accepted for 2013. Unless enhanced Rebates are offered, 2013 Rebates will remain in place for 2014.
Note 2 – Rebate percentages offered in each cell shall be in addition to the Current PSG Rebates. (e.g., If the Closed 1of 2 rebate is 15% and 2% is offered for "Unrestricted Enhancement", the effective rebate shall be 17% for those Product claims in the Closed 1 of 2 cell, and for which the Product is not subject to a restriction.)

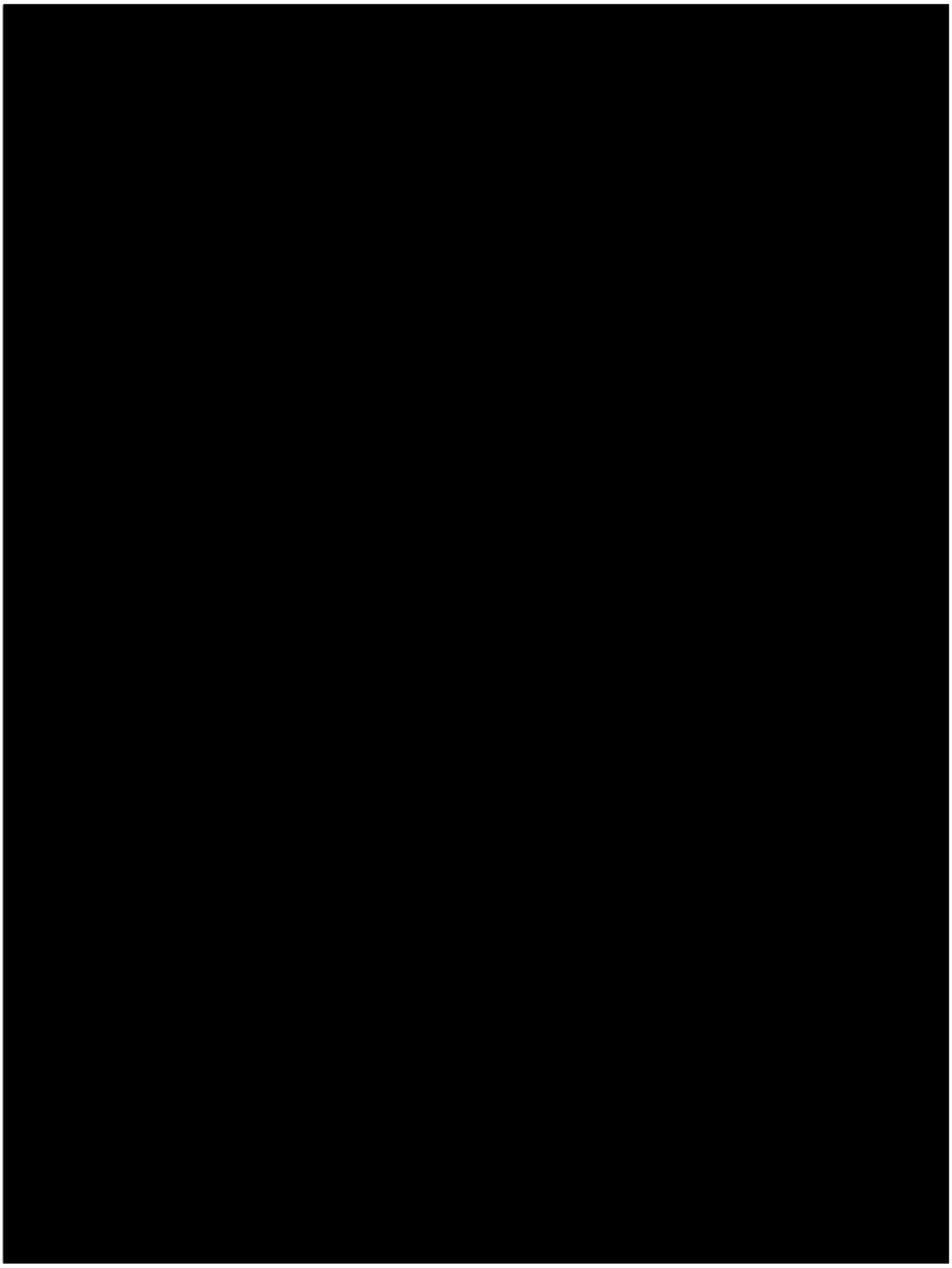
Formulary Positioning:

With respect to each Formulary, ESSC or the applicable Covered Plan, in conjunction with the oversight and approval of the applicable Pharmacy and Therapeutics ("P&T") Committee, will determine the appropriate product (or products) to be designated on-Formulary in accordance with the Part D Rules. In this way, the Covered Plan will ultimately determine the applicable "Formulary Positioning" for each designated CPC, either based on a Formulary developed by ESSC or the Covered Plan's customized Formulary design. The Formulary Positioning used within the Part D Rebate Program will be defined as follows:

1 of Many	Designates those CPCs within a Formulary for which four (4) or more branded manufacturers whose products are competing in the CPC designated as "on-Formulary."
[redacted]	Designates those CPCs within a Formulary for which three (3) branded manufacturers whose products are competing in the CPC designated as "on-Formulary."
	Designates those CPCs within a Formulary for which two (2) branded manufacturers whose products are competing in the CPC designated as "on-Formulary."
	Designates a CPC within a Formulary for which only one (1) branded manufacturer whose products is designated as "on-Formulary."







Rebate Calculations:

Rebates will be calculated on a per unit basis of a single tablet, capsule, milliliter or gram dosage, as applicable. Rebates for each Product will be billed to Company on a monthly basis as described in the Section of this Agreement titled "Billing and Payment." Rebates will be based upon Product utilization and the corresponding Formulary Positioning and the Benefit Control, or Client Designation, (each as defined above) applicable to each Covered Plan and in place on the date the applicable Product is dispensed or administered. Rebates for a Product shall be calculated using the Rebate percentages set forth in the Rebate matrices attached to and incorporated in this Agreement as Attachment(s) to this Exhibit A, and the Product's WAC as of the date a Product is dispensed or administered to a Part D Eligible Individual by a Participating Pharmacy. All Rebate percentages shall be stated as a percentage of WAC. Company agrees to pay the Rebate amounts determined in accordance with this Exhibit A regardless of the number of Covered Plans that include Company's Product(s) on Formulary.

Company shall pay Rebates to ESSC for all newly introduced package sizes of any Product. No Rebates shall be due from Company for any Product dispensed or administered to a Part D Eligible Individual enrolled in or covered by a Covered Plan which subjects such Product to maximum allowable cost reimbursement limitations.

Attachment 2 to the Amendment

Product Bid Rebate Matrix

(Individual matrices will be incorporated as Attachment A-1 to Exhibit A of the Agreement)

(See Attached)

Express Scripts Senior Care Holdings, Inc. ("ESSC")

Rebate Matrix Issued For Year 2 of the 2013-2014 Medicare Part D Rebate Program Bid Process

Manufacturer:	Sanofi-Aventis
Channel:	Retail/Mail/Specialty

Product	CPC	Rebates - Stated as % of WAC												Contract Options		Effective Date
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	Non-Form Access Rate [2]	
[redacted]																
LANTUS	Insulin - Basal	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	10.000%	No Bid	01/01/2014
LANTUS Solostar	Insulin - Basal	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	10.000%	No Bid	01/01/2014
LANTUS Solostar [redacted] [3]	Insulin - Basal	No Bid	No Bid	4.625%	4.625%	No Bid	No Bid	4.625%	4.625%	No Bid	No Bid	4.625%	4.625%	10.000%	4.625%	01/01/2014
Apidra Solostar	Insulin - Rapid Acting	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	No Bid	01/01/2014
Apidra Vial	Insulin - Rapid Acting	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	No Bid	01/01/2014
[redacted]																

Low Income Subsidy:

Product	CPC	Rebates - Stated as % of WAC												Contract Options		Effective Date
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	Non-Form Access Rate [2]	
Apidra Solostar	Insulin - Rapid Acting	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	No Bid	01/01/2014
Apidra Vial	Insulin - Rapid Acting	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	No Bid	01/01/2014

- Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable.

1) This % will establish the annual Price Protection maximum allowable price.

2) [redacted]

3) Lantus Solostar- [redacted] rebate eligible when onTier 2, Non-formulary/Access rate allowed on [redacted] book of business.

Attachment 3
Price Protection

1. Definitions

"Allowed Net WAC" with respect to any Price Protection Product, for each calendar year beginning January 1, 2014, is calculated by multiplying Net WAC as of December 31 of the prior calendar year by one (1) plus the Price Protection Percentage.

"Net WAC" shall mean, with respect to each Price Protection Product, the WAC net of Rebate and calculated as the WAC of such Product multiplied by one (1) minus the applicable Rebate percentage set forth on Exhibit A.

"Price Protection Percentage" shall mean the amount stated in Attachment A-1 to Exhibit A, expressed as a percentage of WAC, that each contract year's Allowed Net WAC is permitted to increase prior to the effectuation of a Price Protection Rebate.

"Price Protection Rebate" shall mean the amount, expressed in dollars, by which the Net WAC for the applicable Price Protection Product exceeds the applicable Allowed Net WAC for the applicable Price Protection Period.

"Price Protection Period" shall mean each twelve (12) month calendar year period for which Rebates are being calculated.

"Price Protection Product" shall mean each Product for which Price Protection is offered as indicated on the matrix.

2. Eligibility for and Calculation of Price Protection Rebates

A. During a Price Protection Period, if Company increases the WAC of the applicable Price Protection Product above the applicable Allowed Net WAC, Company shall pay ESI the Price Protection Rebate and Rebate ("Total Rebate") on all utilization of the Price Protection Product, including rebate enhancements and select client enhancements, occurring on and after the effective date of the Price Protection Rebate. Each subsequent WAC adjustment occurring during a Price Protection Period shall result in a new calculation of the applicable Price Protection Rebate Percentage. In no event shall the Rebates be adjusted downward below the amounts specified in Exhibit A of the Agreement.

B. The Total Rebate shall be effective on the later of (i) the day ESI updates its systems, or (ii) the first day following the applicable price increase.

C. Payment of the Total Rebate, shall be calculated, invoiced and paid pursuant the Billing and Payment Section of the Agreement.

D. For illustrative purposes only, below are hypothetical examples of a Price Adjustment Percentage calculation.

DRUG	WAC as of 12/31/13	Rebate %	Starting Net WAC	Price Protection Percentage	Year 1 Allowed Net WAC
A	$100.00	5%	$95.00	8%	$102.60
B	$110.00	10%	$99.00	8%	$106.92
C	$150.00	15%	$127.50	8%	$137.70
D	$50.00	20%	$40.00	8%	$43.20
E	$225.00	25%	$168.75	8%	$182.25

PRICE PROTECTION CALCULATION								
DRUG	Applicable WAC for the QTR	Rebate %	Rebate $	Net WAC	Allowed Net WAC	Price Protection Rebate	Total Rebate	Total Rebate %
A	$110.00	5%	$5.50	$104.50	$102.60	$1.90	$7.40	6.73%
B	$112.00	10%	$11.20	$100.80	$106.92	$0.00	$11.20	10.00%
C	$155.00	15%	$23.25	$131.75	$137.70	$0.00	$23.25	15.00%
D	$60.00	20%	$12.00	$48.00	$43.20	$4.80	$16.80	28.00%
E	$225.00	25%	$56.25	$168.75	$182.25	$0.00	$56.25	25.00%

TWENTY FIRST AMENDMENT TO THE
MEDICARE PART D PRESCRIPTION DRUG PLAN
REBATE AGREEMENT

THIS TWENTY FIRST AMENDMENT (the "Amendment"), entered into and made to be effective as of October 1, 2014 (the "Effective Date"), is made to the Medicare Part D Prescription Drug Plan Rebate Agreement (the "Agreement") dated effective January 1, 2006, by and between Express Scripts Senior Care Holdings, Inc. ("ESSC") and Sanofi-Aventis U.S. LLC ("Company").

RECITALS

WHEREAS, Company currently provides Rebates for Lantus and Lantus Solostar; and

WHEREAS, the parties have agreed to revise the Lantus and Lantus Solostar Rebates, effective with this Amendment.

NOW, THEREFORE, the parties agree as follows:

TERMS OF AMENDMENT

1. **Attachment A-1 to Exhibit A**. Attachment A-1 to Exhibit A of the Agreement is hereby deleted in its entirety and replaced with a new Attachment A-1 to Exhibit A of the Agreement, as attached hereto.
2. Except as provided herein, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives effective as of the Amendment Effective Date.

EXPRESS SCRIPTS SENIOR CARE HOLDINGS, INC.

By: _____

David Norton
Senior Vice President, Supply Chain Management

Date: 12/24/2014

APPROVED AS TO LEGAL FORM
12/23/14
LEGAL DEPT.

Sanofi-Aventis U.S. LLC

By: _____

Print Name: James Borneman

Title: Vice President
Strategic Pricing & Contracting

Date: 1/5/15

Sanofi-Aventis U.S. LLC

By: _____

Print Name: M. McClellan

Title: CFO

Date: 1-6-15

Express Scripts Senior Care Holdings, Inc. ("ESSC")

Rebate Matrix Issued For Year 2 of the 2013-2014 Medicare Part D Rebate Program Bid Process

Manufacturer:	Sanofi-Aventis
Channel:	Retail/Mail/Specialty

Product	CPC	Rebates - Stated as % of WAC												Contract Options		
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	Non-Form Access Rate [2]	Effective Date
[redacted]																
LANTUS	Insulin - Basal	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	10.000%	No Bid	01/01/2014 - 09/30/2014
LANTUS Solostar	Insulin - Basal	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	No Bid	0.625%	10.625%	10.625%	10.000%	No Bid	01/01/2014 - 09/30/2014
LANTUS	Insulin - Basal	No Bid	0.625%	14.625%	14.625%	No Bid	0.625%	14.625%	14.625%	No Bid	0.625%	14.625%	14.625%	10.000%	No Bid	10/01/2014 - 12/31/2014
LANTUS Solostar	Insulin - Basal	No Bid	0.625%	14.625%	14.625%	No Bid	0.625%	14.625%	14.625%	No Bid	0.625%	14.625%	14.625%	10.000%	No Bid	10/01/2014 - 12/31/2014
LANTUS Solostar - [redacted]	Insulin - Basal	No Bid	No Bid	4.625%	4.625%	No Bid	No Bid	4.625%	4.625%	No Bid	No Bid	4.625%	4.625%	10.000%	4.625%	1/1/2014
Apidra Solostar	Insulin - Rapid Acting	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	No Bid	1/1/2014
Apidra Vial	Insulin - Rapid Acting	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	45.625%	45.625%	55.625%	No Bid	No Bid	1/1/2014
[redacted]																

Low Income Subsidy:

Product	CPC	Rebates - Stated as % of WAC												Contract Options		
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	Non-Form Access Rate [2]	Effective Date
Apidra Solostar	Insulin - Rapid Acting	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	No Bid	1/1/2014
Apidra Vial	Insulin - Rapid Acting	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	10.625%	10.625%	10.625%	No Bid	No Bid	1/1/2014

• Unspecified CPC = Contracted Products currently not in a CPC; formulary positioning not applicable.

12/23/2014

Attachment A-1 to Exhibit A of the Agreement

Product	CPC	Rebates - Stated as % of WAC												Contract Options		
		Open 1 of Many	Open 1 of 3	Open 1 of 2	Open Exclusive	Controlled 1 of Many	Controlled 1 of 3	Controlled 1 of 2	Controlled Exclusive	Closed 1 of Many	Closed 1 of 3	Closed 1 of 2	Closed Exclusive	Price Protection % [1]	Non-Form Access Rate [2]	Effective Date

1) This % will establish the Allowed Net WAC.

2) [redacted]

3) Lantus Solostar-[redacted] Rebate eligible when on tier 2; Non-Formulary Access rate available to [redacted] plans only.

4) [redacted] cannot be disadvantaged to any competitive products in the therapeutic category. Therapeutic Category includes: [redacted] Third tier is considered non-formulary.

5) Prior authorization for the therapeutic class is acceptable [redacted] shall be preferred. An Enrollee must try and fail [redacted] for a period of six (6) months prior to receiving approval for [redacted]

12/23/2014

Committee Charter

Committee Name:
Express Scripts National Pharmacy and Therapeutics (P & T) Committee

Guidelines/ Groundrules:
The Committee shall meet on a regular basis, and not less frequently than once per quarter, by teleconference, in person, or e-mail exchange. Additionally, written votes may be distributed between meetings to expedite the resolution of ad hoc clinical issues in a timely fashion.

In the case of a written vote, comments from members on the issue at hand will be solicited by the Committee staff, then collated and returned to members along with a voting ballot. Results of the vote shall be appended to the minutes of the next regularly scheduled meeting.

Individual disclosures shall be reviewed by the Membership Subcommittee of the National P&T Committee prior to each meeting. The Membership Subcommittee shall determine if a disclosure translates into an actual conflict of interest. Conflicts of interest shall be disclosed at the beginning of each meeting and require that the disclosing member refrain from final discussions and voting on the relevant issue. Annual records of conflict of interest forms shall be kept on file.

A quorum shall consist of 50% attendance of members. Proxy votes will not be accepted although written ballots from members will be accepted. Decisions will be made by two-thirds majority vote of those in attendance or with written ballots.

If the P&T Chair is unable to attend, another member will be appointed by Committee vote to serve as Acting Chair and will conduct the meeting.

Minutes will be recorded by Committee staff and approved by Committee members via e-mail balloting as soon after meetings as practical. Attendance shall be recorded. A summary of the Committee discussion and recommendations shall be documented for each agenda item, as well as any follow up action necessary (along with responsible party for the action item). Minutes will be distributed to all members prior to the next meeting, and will also be archived at Express Scripts.

Membership on the Express Scripts P&T Committee shall remain confidential. Express Scripts shall not disclose membership to outside parties except to the extent required for regulatory purposes. In addition, members shall use discretion in disclosing their own membership. Members may have a legitimate need to disclose affiliations to outside groups such as academic and governmental institutions; however, there is a need for confidentiality to minimize pressure on members from outside influences.

The P&T Committee Chair and Membership Subcommittee shall be elected to a three-year term, via the highest number of votes, by members of the P&T Committee. The P&T Chair and members of the Membership Subcommittee may fulfill their three year term on the condition that they continue to meet "P&T Committee Membership Requirements".

	New members shall be selected by a nomination process whereby current members, the Express Scripts Medical Director, Express Scripts Chief Medical Officer, and the Chairperson of the Express Scripts' Clinical Integrity Council may submit names to the Membership Subcommittee for consideration. The Membership Subcommittee will present recommendations to the members of the P&T Committee for a vote. New members will begin serving a one-year probationary term, after having signed disclosure and confidentiality agreements. The Membership Subcommittee will evaluate current members against established criteria for membership. Reappointments will be determined by a unanimous vote of the Subcommittee. If the Membership Subcommittee is unable to reach a unanimous vote, the Subcommittee will request a vote of the full P&T Committee. Members of the Pharmacy & Therapeutics Committee are paid a stipend for their participation. The stipend amount is based on a reasonable estimate for all participants for the lost revenue for not seeing patients while out of the office for meeting attendance and preparation and review of clinical program content outside committee meeting time. On an annual basis, members are required to attend 5 of the 6 scheduled meetings in order to be eligible for the full stipend. Members are allowed to miss one meeting per calendar year without affecting their quarterly stipend. Members who miss more than one meeting will receive a 50% reduction in their quarterly stipend during the quarter in which they were absent. Members unable to attend at least two meetings each calendar year will have their ongoing membership re-reviewed by the Membership Subcommittee. On occasion, when performed outside the normal duties of committee membership, members are paid additional consulting fees for significant participation in the design and development of clinical programs. Product sponsor representatives are excluded from P&T committee membership. In addition, they are neither allowed to attend nor participate in P&T committee meetings.
Mission: Establish and review lists of drugs known as Express Scripts Formularies in order to promote clinically sound drug therapy for the plan participants covered by the formularies. The Pharmacy and Therapeutics Committee (P & T) is designed to ensure an unbiased clinical perspective for the formulary evaluation process from practicing physicians and pharmacists reflecting a variety of practice specialties	**Committee Chair:** Three-Year Term **Chair Responsibilities**: 1. Approve Minutes 2. Lead Meetings 3. Assures compliance with policies and procedures **Committee Staff:** ❖ Chief Medical Officer

	❖ Medical Director ❖ Chair of the Therapeutic Assessment Committee ❖ VP of the Office of Clinical Evaluation & Policy
Committee Responsibilities: 1. Review VAC formulary recommendations absent any financial information. 2. Identify TAC/VAC recommendations that require additional analysis. 3. Assign drugs reviewed to one of four possible categories: 1) Include 2) Access 3) Optional 4) Exclude 4. Approve or disapprove formulary recommendations submitted to the committee. 5. Annually review the Value Assessment Committee (VAC) Guidelines, which outline the formulary status assigned to products as they enter the Express Scripts Drug File 6. Annually review and update (as needed) the clinical parameters that govern the National Formularies Review Competitive Product Category parameters at the request of the chairperson of TAC and/or VAC. 7. Review the content of proposed clinical programs and services at the request of Committee staff. 8. Review for clinical appropriateness, the practices and policies for formulary management activities (PA, step therapy, QLL, generic substitution, and formulary exception). 9. Review/approve new non-Medicare utilization management criteria (PA, step therapy, QLL) or changes to existing criteria that further limits drug access. This task may be delegated by the Committee Chairperson to a subgroup of one or more P&T Committee member(s) with clinical expertise in the area of interest. 10. For Medicare, review and approve all new/revised standard clinical PA criteria, step therapy protocols, and quantity limit restrictions. 11. Review for clinical appropriateness, the protocols and procedures for the timely use of and access to both formulary and non-formulary drug products.	**Staff Responsibilities:** 1. Develop and distribute Agenda 2. Send out Ballots and hold On-site Meetings 3. Record Vote 4. Write and retain minutes 5. Recruit new members 6. Maintain signed agreements on all members 7. Notify CMS if there are changes in Committee membership

12. Approve the inclusion or exclusion of the therapeutic classes in the formulary on an annual basis. 13. On an annual basis, the committee will review all policies and procedures mandated by CMS in the Code of Federal Regulations, 14. On an annual basis, the committee will undergo training on Medicare Part D requirements. 15. Ensures that any Express Scripts P&T governed formulary: (i) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees (ii) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.	

Areas of Overlap:

Responsibility	Overlaps with whom

P&T Committee Membership Requirements:

- All members are practicing physicians and/or pharmacists who are not employed by or otherwise contracted by Express Scripts.
- Current, unrestricted clinical license(s) (or if the license is restricted, the organization has a process to ensure job functions do not violate the restrictions imposed by the State Board)
- Board certification (if an M.D. or D.O.)
- The majority of practicing physicians and at least one pharmacist must be independent and free from conflict of interest with respect to pharmaceutical manufacturers and part D plan sponsors.
- The committee must include at least one practicing physician and one practicing pharmacist who are experts in the care of elderly or disabled individuals. The committee must also include one practicing physician who is an expert in mental health conditions. Membership consists of a minimum of 15 practicing physicians and one pharmacist representing multiple areas of clinical expertise which may include, but is not limited to, the following:
  - Asthma/Allergy
  - Cardiology
  - Dermatology
  - Endocrinology
  - Gastroenterology
  - Geriatrics (required)
  - Geriatric Pharmacy Practice (required)
  - Infectious Disease
  - Internal Medicine
  - Neurology
  - Obstetrics and Gynecology
  - Oncology
  - Pediatrics
  - Psychiatry (required)
  - Pulmonology
  - Rheumatology

Membership is based upon the following considerations:

- Contributions to the medical literature
- National recognition in his/her specialty
- Involvement in clinical (patient care) practice (membership prerequisite)
- Previous P&T committee experience

Accountability:

Staff to the Committee is composed of:

- Medical Director
- Chair of the Therapeutic Assessment Committee
- VP, Office of Clinical Evaluation and Policy
- Chief Medical Officer, Medical Affairs

Member Responsibilities:

Members are appointed to staggered three-year terms. First-time members are appointed to a one-year probationary period, and will serve the remainder of a three-year term on approval of the Membership Subcommittee.

1. Member will submit a Curriculum Vitae and executed confidentiality agreement prior to serving on the Committee.
2. Member will submit a signed disclosure/conflict of interest statement, identifying relationships with pharmaceutical manufacturers, part D plan sponsors, or health plan issuers on an annual basis.
3. On an annual basis, member will attend at least five meetings per year (if no cancellations) and participate in written ballot votes as requested.
4. Member will be available for consultations at other times throughout the term of this agreement to provide clinical recommendations.
5. At all times the member will exercise his or her own independent professional judgment.
6. Member acknowledges that all matters discussed by the committee are confidential.
7. Member will read distributed materials in order to be prepared to respond to recommendations.
8. In addition, P & T Committee members may be called upon to;
   - Review articles intended for provider newsletters
   - Review proposed treatment guidelines
   - Provide clinical perspective relevant to current medically accepted treatment
   - Review formulary/utilization management program criteria
   - Review CPC documents
9. Inform the Committee staff of any change in job status. This may require the member to submit his/her resignation if requirements for active clinical practice are no longer met.
10. Submit a completed reappointment self-assessment form, copy of Curriculum Vitae, and confidentiality agreement at the time of reconsideration for continued Committee membership.

Subcommittee(s):

Membership Subcommittee:
Voting Members (3): P&T Chair, two ad-hoc P&T Committee members
Quorum: 50% or greater
Decisions: Unanimous of those in attendance or with written ballots
Responsibilities:

1. Identify and review new members
2. Present potential new members to full P&T Committee for formal vote
3. On an ongoing basis, evaluate current members against established criteria for membership
4. On an annual basis, review a defined P&T Committee for reappointment status
5. Prior to each meeting, review member disclosures and determine if any conflicts of interest exist.

Medicare Part D Utilization Management (UM) Rules Committee:
Voting Members (3): P&T Chair, Geriatrician (MD), Geriatric Pharmacy Practice (PharmD)
Quorum: 50% or greater
Decisions: Two-thirds majority vote of those in attendance or with written ballots
Responsibilities:

1. On behalf of the full P&T Committee, shall approve, recommend modifications to, or not approve all new, revised, and re-submitted client custom UM criteria prior to CMS submission
2. Report the results of the UM review and recommendations to the full committee. The full Committee shall review the work of the subcommittee and may make further recommendations/modifications with regard to these UM rules in whole or in part, and record decisions in the meeting minutes.
3. Should a Part D plan use the Express Scripts' P&T as their P&T of record for Medicare Part D, and seek to create a client custom formulary for the subsequent plan year that require formulary status review, the utilization management rules subcommittee can act on behalf of the full committee with regard to keeping custom formulary content consistent with P&T Committee decisions.

Charter Originator: **Name:** Raulo S. Frear, Pharm.D.	**Title:** Vice President, Clinical Evaluation & Policy	**Approval:** **Name:** Andy Behm, **PharmD, BCGP**	**Title: Vice President, Office of Clinical Evaluation & Policy**
Modified: **Name: Andrew Behm, PharmD, BCGP**	**Title: VP, Office of Clinical Evaluation & Policy**	**Signature:** 	**Date: 2/20/2020**
Clinical Integrity Council **Review Date:** 2/18/99, 7/19/02, 1/17/03, 3/14/03, 2/20/04, 2/18/05, 10/13/05, 10/13/06, 5/11/07, 9/21/07, 12/21/07, 9/26/08, 4/16/09, , 4/15/10, 1/20/11, 1/19/12, 2/21/13, 8/15/13, 8/21/14, 8/20/15, 8/18/16, 9/23/16, 4/17/17, 8/28/17, 8/16/18, 8/15/19, 11/13/19, 2/20/2020		**CIC Chairperson Signature:** 	**Date: 2/20/2020**
Revision Date: 1/5/01, 7/19/02, 1/17/03, 3/14/03, 2/20/04, 2/18/05, 10/13/05, 10/13/06, 5/11/07, 9/21/07, 12/21/07, 9/26/08, 4/16/09, 4/15/10, 7/15/10, 1/20/11, 1/19/12, 2/21/13, 8/15/13, 8/21/14, 8/20/15, 8/18/16, 9/23/16, 4/17/17, 8/28/17, 8/16/18, 8/15/19, 11/13/19, 2/20/2020			
P&T Committee Review Date: 7/22/07, 7/12/08, 7/10/10, 9/24/11, 7/14/12, 7/13/13, 7/12/14, 7/11/15, 7/9/16, 7/15/17, 7/21/18, 7/13/19			

Message

From: Pehl, Nancy (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=NANCY A PEHL2FDPS]
Sent: 7/25/2013 2:44:51 PM
To: Dohm, Jason G. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p001144]
CC: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=BehmA]; Kautzner, Adam W. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p039691]; Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JEichholz]; Grillo, Tony L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=AGrillo]
Subject: RE: Pebble - Clinical Support Talking Points
Attachments: Clinical Talking Points - 2014 Formulary Updates.docx

Jason,
Here is the next draft based on the collection of feedback. Please let me know if you want further changes before this gets posted. I will not post until after Tony's presentation to your group next week. This document will be posted here:

http://esidepartments/sites/Dep043/Formulary/default.aspx

Nancy

Clinical Talking Points - 2014 For...

From: Dohm, Jason G. (BLM)
Sent: Thursday, July 25, 2013 9:27 AM
To: Pehl, Nancy (BLM)
Subject: RE: Pebble - Clinical Support Talking Points

Thx. Can I see the next draft

From: Pehl, Nancy (BLM)
Sent: Thursday, July 25, 2013 9:26 AM
To: Dohm, Jason G. (BLM)
Cc: Behm, Andrew (BLM); Eichholz, Jeff R. (EHQ); Grillo, Tony L. (EHQ); Kautzner, Adam W. (EHQ)
Subject: RE: Pebble - Clinical Support Talking Points

Hi Jason,
Thanks for the feedback. We will take a look at your suggestions and make changes.
Nancy

From: Dohm, Jason G. (BLM)
Sent: Thursday, July 25, 2013 7:59 AM
To: Pehl, Nancy (BLM)
Cc: Behm, Andrew (BLM); Eichholz, Jeff R. (EHQ); Grillo, Tony L. (EHQ); Kautzner, Adam W. (EHQ)
Subject: RE: Pebble - Clinical Support Talking Points

Nancy:

This is amazing work. Thank you very much for pulling together this document; it will be a significant support tool for my team.

Here are my suggestions:

- Remove the term "Pebble" from the title and from the name of the file.
- Change the title to "Clinical Talking Points for 2014 National Preferred Formulary Changes"
- Can you break the biologic section up into the indications. I think it will help the reader navigate through this one better.
- For the Ophthalmic category, can you expand on why Zioptin is preferred for folks with issues with preservatives. Is this the only preservative free product?
- For the Pulmonary Anti-Inflammatory/Bet Agonist Combinations can you expand on the second bullet point to note how the FDA approved indications compare to Advair

- One final note. I absolutely love how the document identifies the "covered drug" and the "not covered drug". Can this be applied consistently throughout the entire document for each of the CPCs. Having this language included will be a huge help.

Thx again.

J

From: Pehl, Nancy (BLM)
Sent: Wednesday, July 24, 2013 1:25 PM
To: Dohm, Jason G. (BLM)
Cc: Behm, Andrew (BLM); Eichholz, Jeff R. (EHQ); Grillo, Tony L. (EHQ); Kautzner, Adam W. (EHQ)
Subject: Pebble - Clinical Support Talking Points

Jason,

I want to provide you with these clinical support talking points for the drugs that will be in the Pebble Program. The DEU has provided brief bullet points by therapy classes which focus on the specific drugs that will move to not covered. Please review, especially in the cases where you see the issues to be "sticky". [We added a little more detail than other classes to support not coverage products like the Biologics (Xeljanz/Stelara), and the Inhalers (Advair HFA/Diskus).]

In addition, my plan is to posted this document on the OCEP Sharepoint site on this page after the program is rolled out. The DEU can keep the document current and address more rationale as issues arise as needed all in one concise spot.

http://esidepartments/sites/Dep043/Formulary/default.aspx

So if you have comment/questions/change/additional changes, please let me know.
Nancy

<< File: Clinical Talking Points - Pebble 2014.docx >>

Nancy Pehl, Pharm D, BCPS
Senior Director, Drug Evaluation Unit
Office of Clinical Evaluation and Policy
[redacted]

Message

From: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=BEHMA]
Sent: 9/21/2016 9:30:13 AM
To: Komor, Dave (EHQ) [/o=Express-Scripts/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=p058794]
Subject: RE: Can you tell me.....

We certainly view Basaglar as a reasonable clinical alternative to Lantus. That said, biosimilars are typically not priced in the same way as oral solid generics. On average, it has been our estimate that biosimilars will be available at anywhere from a 20-40% discount to the originator brand. When rebates are considered, the innovator brand may be end up being the lowest net cost option. With respect to Basaglar, it is my understanding that the financials led us to offer either Basaglar or Lantus.

From: Komor, Dave (EHQ)
Sent: Wednesday, September 21, 2016 6:15 AM
To: Behm, Andrew (BLM)
Subject: RE: Can you tell me.....

Andy,

I'm prepping for a meeting this morning at 9 AM. I received a list of questions from WTW last night to discuss and have included one below I don't have an answer for and am looking for help.

Does ESI have a strategy for the biosimilar to Lantus?

I see Lilly received FDA approval for Basaglar (insulin glargine) on Dec. 16, 2015 and it appears the drug will launch in US market in Dec. 2016. I missed a lot of internal meetings due to travel, so I'm not sure if I missed internal discussions on this topic?

Why don't you address the Lantus biosimilar strategy if you know of any update. Candidly, all the more so since CVS is making such a big deal out of using it and pointing out that ESI isn't using it. I'm not sure that would have percolated up to HR as I don't foresee the CVS sales reps calling on them…just sayin'

a. Might be good to just give a biosimilar update…especially in light of your other e-mail about specialty remaining such a concern.

Thanks for your thoughts/input on this,

Dave Komor RPh I Senior Clinical Account Executive I Express Scripts

[redacted]

From: Komor, Dave (EHQ)
Sent: Tuesday, September 20, 2016 9:08 PM
To: Behm, Andrew (BLM)
Subject: RE: Can you tell me.....

Hi Andy,

For ESI employees, we use the NPF. For 2016, there are no exclusions in this category.

The preferred drugs are: Breo Ellipta, Dulera, Symbicort
The non-preferred/non-formulary drugs are: Advair

Dave Komor RPh I Senior Clinical Account Executive I Express Scripts
[redacted]

From: Behm, Andrew (BLM)
Sent: Tuesday, September 20, 2016 1:04 PM
To: Komor, Dave (EHQ)
Subject: Can you tell me.....

Which inhaled corticosteroid/LABA inhalers are on the ESI formulary for employees?

Andrew Behm, PharmD, CGP | Vice President | Office of Clinical Evaluation & Policy | [redacted]

Message

From: Brown, Raymond [redacted]
Sent: 3/2/2016 11:29:20 AM
To: Dohm, Jason G. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p001144]; Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=BehmA]
Subject: RE: Insulin

Thanks guys. This is helpful as always.

From: Dohm, Jason G. (BLM) [redacted]
Sent: Wednesday, March 02, 2016 9:22 AM
To: Brown, Raymond; Behm, Andrew (BLM)
Subject: RE: Insulin

For clients on NPF the rebates for regular and short acting Insulins are very large (I am on a plane on going from memory - they are at least 50% off). We continue to negotiate deeper rebates with each annual contracting cycle.

We also have a very aggressive rebates on basal Insulins (they are not as large as those for regular and short acting but pretty close).

I was recently on a call with Ed Adamcik. A biosimilar for Lantus is anticipated in the near future (Andy can confirm). A few more competitors are also entering the basal insulin space which will help with competition.

Expect us to take some bold moves in diabetes this year. To you point below, diabetes is a high cost driver for the vast majority of our book.

I am in LA today and tomorrow. Let me know if you want to catch up on Friday if you need more detail.

Sent with Good (www.good.com)

-----Original Message-----
From: Brown, Raymond [redacted]
Sent: Tuesday, March 01, 2016 10:36 AM Central Standard Time
To: Dohm, Jason G. (BLM); Behm, Andrew (BLM)
Subject: Insulin

You guys getting questions on all these buzz on insulin and when will a biosimilar be available?

[redacted] raised the question to us of how much is being spent on insulin and the fact that how come there is no generic insulin. There was an article on this in the Times recently.
http://www.nytimes.com/2016/02/21/opinion/sunday/break-up-the-insulin-racket.html

Do you guys have a perspective on this? Are any employers doing anything beyond the NFP to curb the cost of this drug?

We had one of our partners google generic insulin (always scares me when they start googling) and found that Walmart offers some repackaged products. Do we have a perspective on mandating the use of these relative to more expensive branded products?
http://www.diabetesed.net/page/_files/Diabetes-Meds-on-a-Budget.pdf

My comment back to her was I don't think you'll see generic manufacturers in this space as it will have to technically be a biosimilar and I'm not sure when these lose their patent. I'm not sure how much it will help as the guidelines keep changing and more of the long acting products are more heavily leveraged. Last count I think I saw was there we something like 6 bolus insulins inclusive of one that inhaled, and something like 5 basal ones. Most of the major pbms and carrier are pushing to one of the two major insulin manufacturers (Lilly or Novartis) and excluding the others player from their formulary. We would expect this would be a heavily rebated class but unfortunately do not have insight into the exact net price.

Anything else you guys are seeing? Suggestions?

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Message

From: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=BEHMA]
Sent: 1/26/2016 10:51:40 PM
To: Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JEichholz]
CC: Davis, Shawn (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p043522]
Subject: RE: Lantus formulary status

Grandfathering was only required if we went exclusive with Levemir or Tresiba. We'll revisit the Tresiba decision in approximately 6 months and should be able to gain more flexibility.

-----Original Message-----
From: Eichholz, Jeff R. (EHQ)
Sent: Tuesday, January 26, 2016 05:04 PM Central Standard Time
To: Behm, Andrew (BLM)
Cc: Davis, Shawn (EHQ)
Subject: Lantus formulary status

Andy,
Can you outline where we are with clinical guidance on Lantus? I know from a parameter standpoint, we need a basal and the exclusive can be any agent. Where did we land with grandfathering current utilizers?

Jeff

Message

From: Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=JEICHHOLZ]
Sent: 12/3/2015 6:08:23 PM
To: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=BehmA]; Grillo, Tony L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=AGrillo]
Subject: RE: Humulin u-500

So we have zero flexibility and can do nothing at this point with u-500?

From: Behm, Andrew (BLM)
Sent: Thursday, December 03, 2015 4:52 PM
To: Grillo, Tony L. (EHQ)
Cc: Eichholz, Jeff R. (EHQ)
Subject: RE: Humulin u-500

I don't think we'll get any additional flexibility at this time. My next move is to revisit the Tresiba exceptions in ~6 months and get it fully "on par" with the other basal insulins. I spoke with the P&T endocrinologist about basaglar and the biosimilars to Lantus. He is very supportive of those products and views those as products that could be exclusive from day one.

From: Grillo, Tony L. (EHQ)
Sent: Wednesday, December 02, 2015 5:05 PM
To: Behm, Andrew (BLM)
Cc: Eichholz, Jeff R. (EHQ)
Subject: Humulin u-500

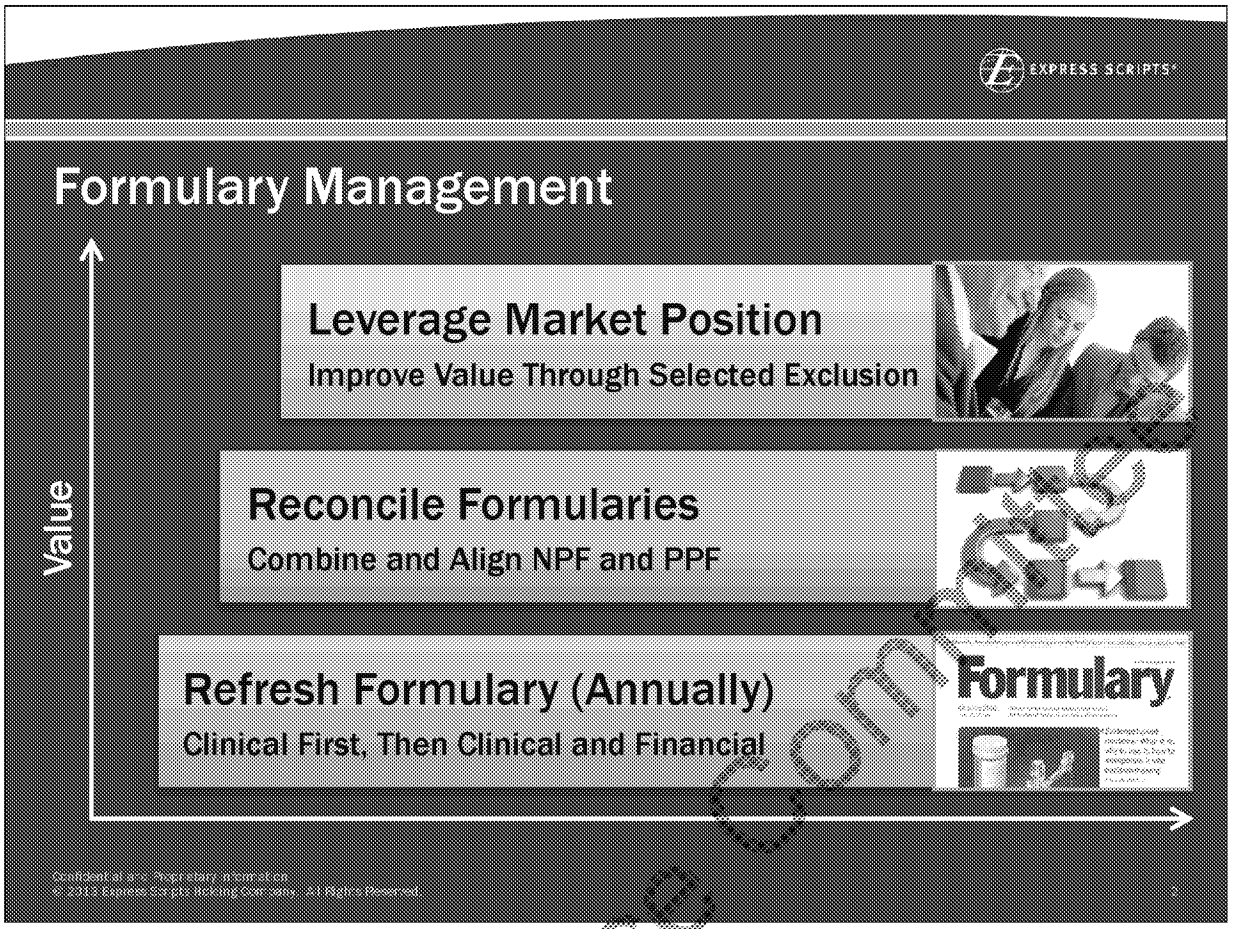
Andy,
I know the include parameter for Humulin u-500 was just officially established in July but with the approval and launch of Tresiba I wanted to follow up to see if you see any additional flexibility from a parameter or even management perspective for Humulin u-500. As the diabetes and insulin space becomes more robust from a product standpoint this is something that we would like to be able to manage if possible. If the parameter stands at this point, I am wondering if there is a certain dosing cutoff that we could target for claims on Humulin u-500 such that a move to a different insulin could be supported. I know that this is a very high risk product and many physicians try to stay away from it but if there are "lower" doses that we could reasonably move to other products even that level of flexibility may be valuable.
Thanks,
Tony

Tony Grillo, Pharm.D.
Clinical Director
Formulary Solutions
Express Scripts, Inc.
[redacted]

EXPRESS SCRIPTS®

Update on Express Scripts 2014 Formulary

Jeff Eichholz, Pharm. D., Senior Director, Formulary Development and Appeals



That creates an opportunity for us. In light of all these changes, our best response, and that of our clients, is more aggressive formulary management.

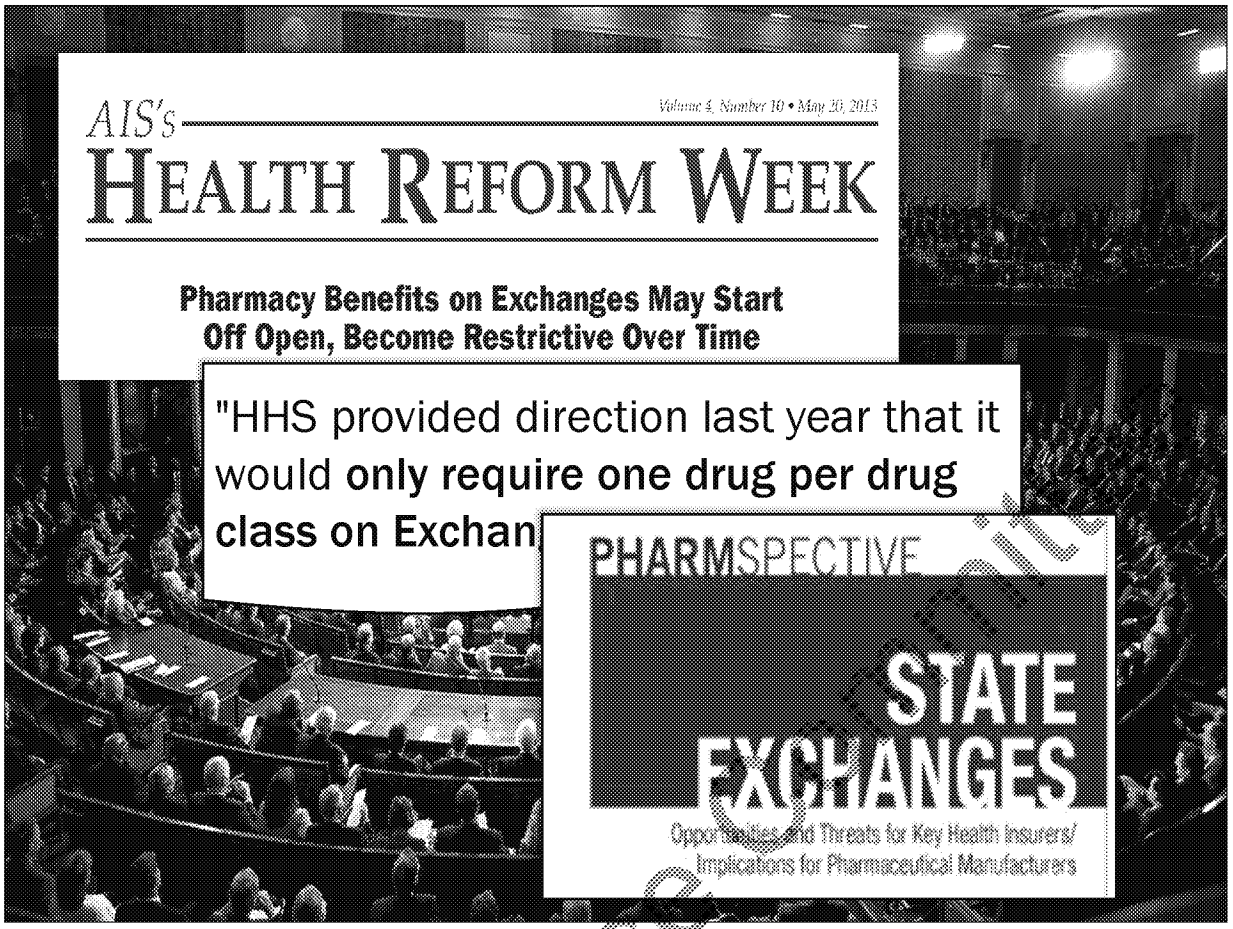
It's the natural evolution of what we've been doing.

It also moves us to a One Company formulary. It's proof that we truly are Better Together.

Key Topics

- Marketplace Dynamics Are Changing
- Formulary Management Is Our Next Lever
- Our 2014 National Formulary Update
- Member/Provider Communication Plan

Changes in the Pharma manufacturing industry is another key driver making now the right time for us to act. We must adapt to successfully lead our clients and patients into the future.
Carefully dissecting the market allowed us to define our 2014 strategy:
Steve talked about the patent cliff, which is putting pressure on Pharma to hang on to market share – and that makes them more willing to increase rebates to get preferred positions on formulary, even as they're pushing higher prices to the market as a whole.
Raising prices multiple times per year
11%+ brand inflation
And, in the absence of real innovations hitting the market (though, as Steve said, several are in the mid- to long-term pipeline), Pharma is pushing "me too" medications to combat increasing use of generics.
Direct-to-consumer advertising also is an issue. The industry is using more aggressive tactics as patients influence physician prescribing.
They're also using Copayment Discount Cards to attract members who otherwise might be diverted by high copays…

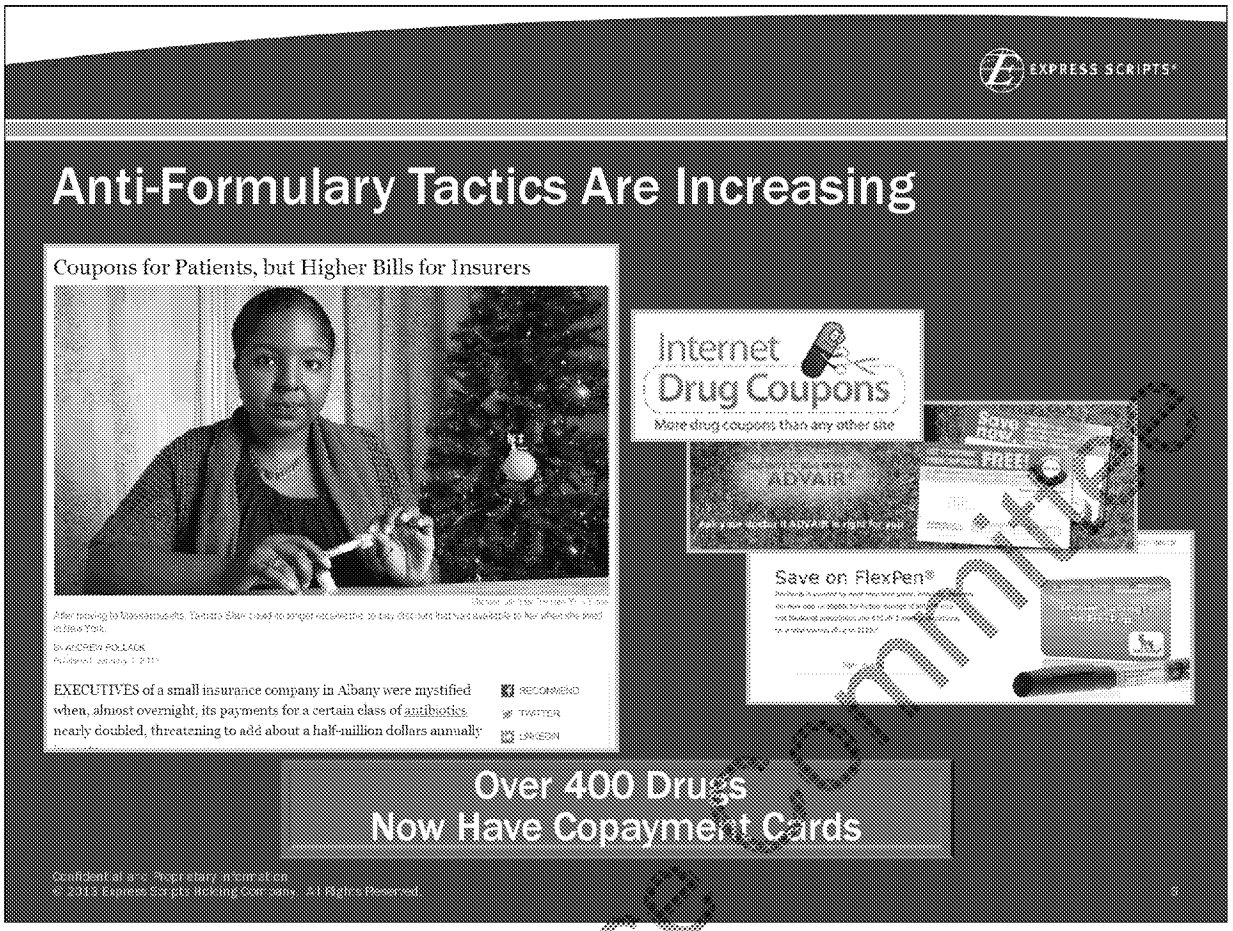


As Dr. Miller said, this is a unique time for us.

We all know our industry is changing, and one of the biggest drivers is Healthcare Reform. As we get closer to key provisions of the Affordable Care Act being enacted, we're getting greater clarity on how it will affect the pharmacy benefit.

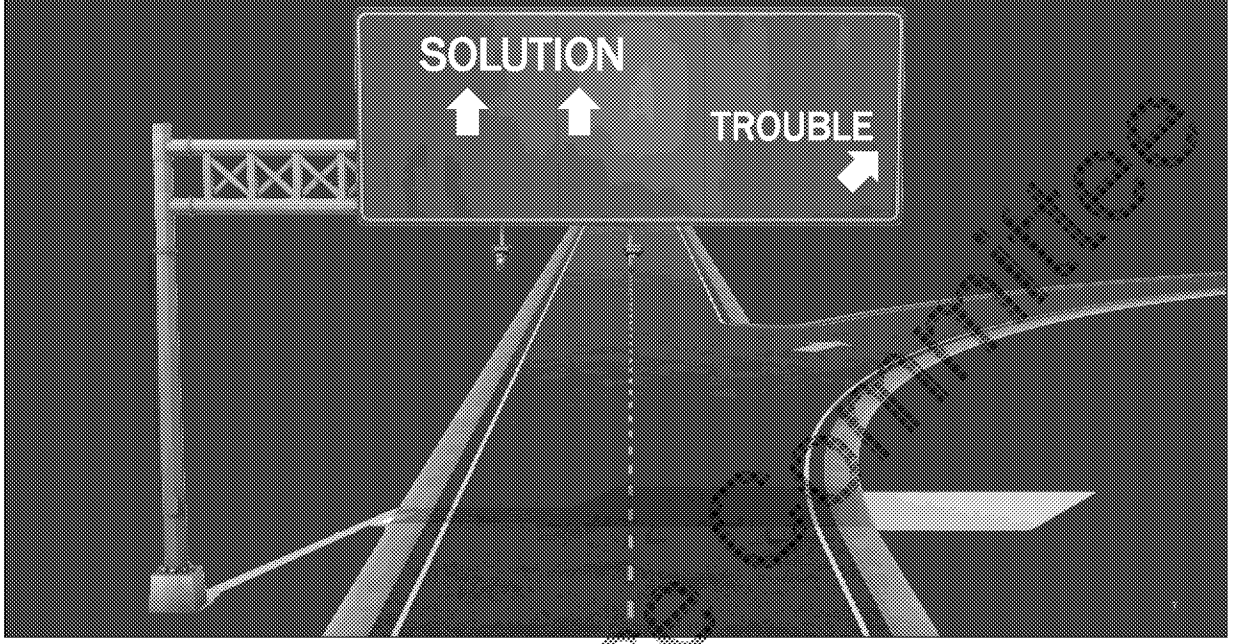
One significant piece is growing acknowledgement that formulary management is an important tool for controlling pharmacy spend. As you can see in these headlines, it is gaining favor across industry and government. Aggressive management will be the new norm to mitigate risk.

Healthcare Reform hinges on cost savings… on making care affordable and accessible to millions of people who've never had it before, as well as on controlling costs for people who already are insured. And on doing so in the face of some really big trends that will drive up spending:
Baby Boom generation is ageing
Obesity and poor lifestyle choices are driving the number of people with chronic conditions such as diabetes, high cholesterol and cardiovascular disease – which already have the highest trend among Traditional disease classes
And, of course, HCR will dramatically add to the number of people who are insured and able to seek preventive/regular care (such as maintenance drugs) rather than relying on the emergency room.



The biggest issue with copay cards is that they circumvent formulary tiers. Here's how they work…
(give brief explanation)
And while they might be a better deal for members, they increase the cost to insurers.
A report commissioned by the Pharmaceutical Care Management Association (PCMA) in 2011 estimated that copay cards could raise the cost of prescription drugs by $32 billion over a decade. It is big business. Consider some other statistics in the 2011 report:
The number of copay coupon programs marketed to the American public has increased by more than 260% in the past two years.
The number of programs listed on the consumer website www.internetdrugcoupons.com is now over 340.
Brand drug makers now spend $4 billion annually on copay coupon programs and vendors that administer such programs report that manufacturers earn a 4:1 to 6:1 ROI

Smart formulary management is rewarded financially



2014 Formulary Updates

Product Summary	
Non-Preferred to Excluded	29
Preferred to Excluded	19
Total Products*	48

*These changes impact the National Preferred/Preferred Prescriptions Formulary Only. Medicare Part D is excluded.

Notable Therapy Classes and Products Not Covered

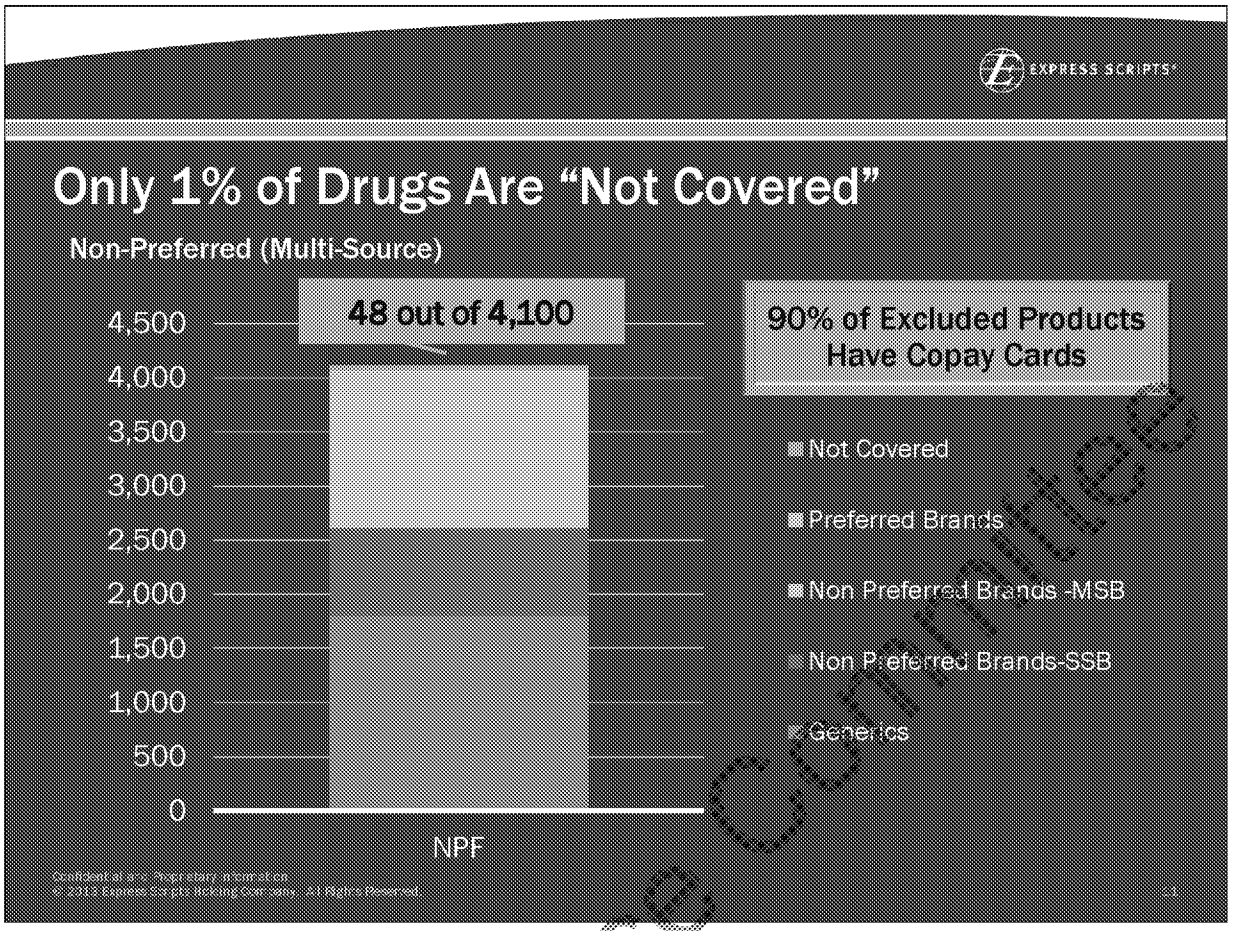
Therapy Class	Products Removed
Pulmonary Anti-Inflammatory	Advair, Alevsco, Flovent
Insulin	Novolog, Novolin, Apidra
Diabetic Test Strips	Roche, Bayer, Abbott
Topical Testosterone	Fortesta, Testim
Growth Hormones*	Tevtropin, Nutropin, Omnitrope, Saizen
Multiple Sclerosis*	Betaseron

*Specialty Classes

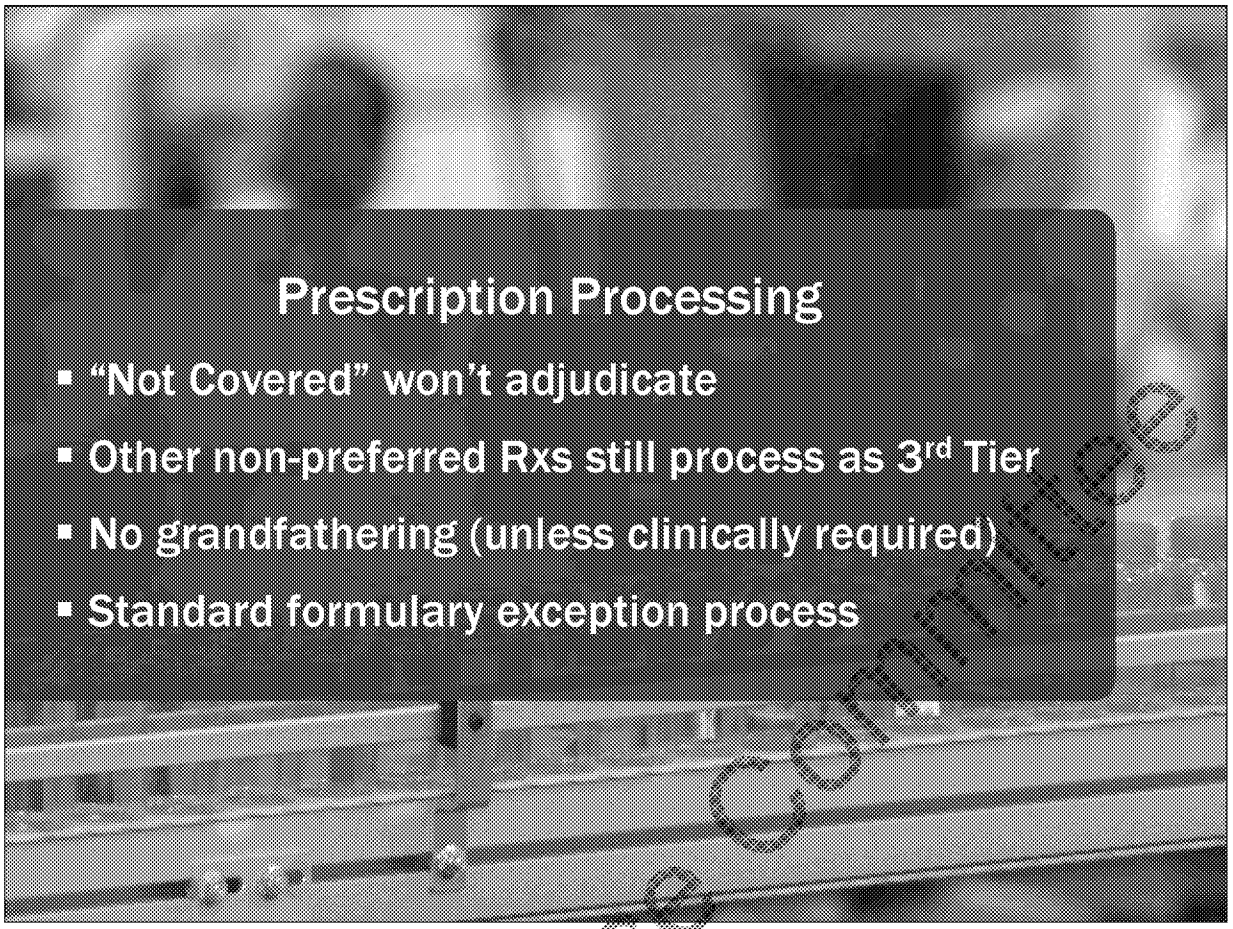
Why is this Necessary? Advair is Perfect Example

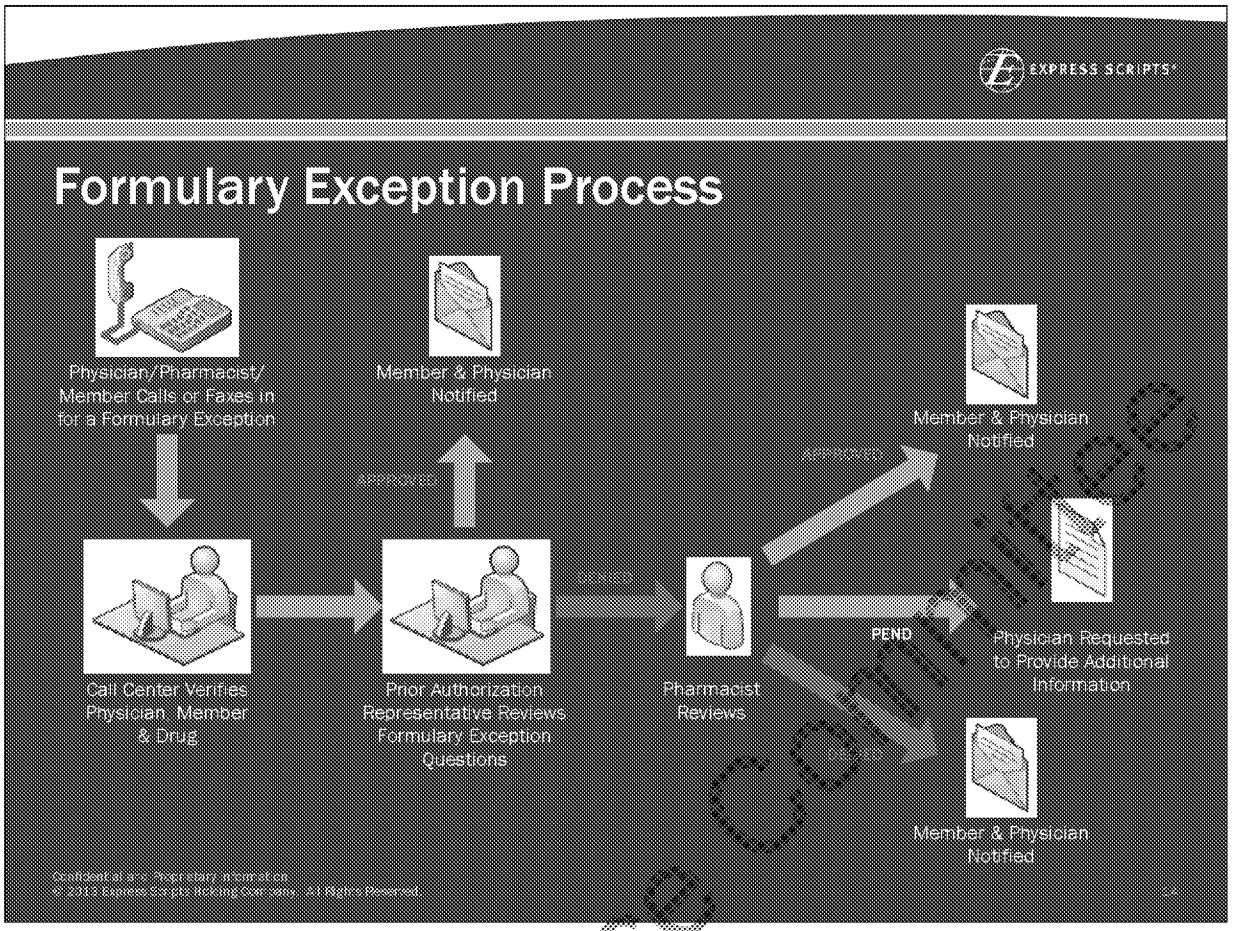
- No added value versus clinically appropriate alternatives
  - Dulera, Symbicort
- High potential for inappropriate use
  - Drug-induced cough
- 25%* higher wholesale cost
- 50%* higher net cost to clients

*2014 projections



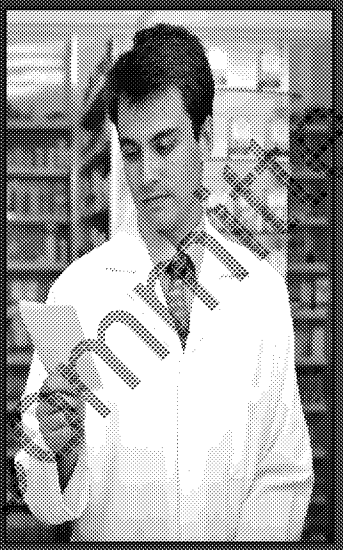
While this is a significant change, at the end of the day we're impacting about 48 medications out of about 4,100. We'll dive deeper into which drugs/classes in a minute, but first I want to put this number into perspective…





Combining and Aligning 2014 Formularies: What's Out

- Custom Formularies
- Medicare Part D
- Medicaid
- High-Performance Formularies
- Federal Clients
- Workers' Compensation



Comprehensive Communication Plan is Tailored and Timely

- **Members:** Communications to targeted plan members
- **Providers:** Communications to physicians and pharmacists.

We understand the importance of communicating our National Preferred Formulary changes in a timely and effective manner for affected members, physicians and pharmacists.
Beginning in October 2013, we will launch a comprehensive communication plan tailored to members and providers (pharmacists and physicians). We have designed this plan to minimize patient disruption.
USE THIS TIME TO share the interactive PDF that includes links to these communications as well as the distribution schedule.

EXPRESS SCRIPTS®

The Right Formulary for Right Now

- Starts with unbiased clinical evaluation
- Effectively addresses market dynamics, including controls on inflation
- Sustains the pharmacy benefit
- Assures a smooth transition through timely and targeted communications

Assures sufficient therapeutic representation in each class

Message

From: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=BEHMA]
Sent: 9/26/2013 7:52:18 PM
To: Dohm, Jason G. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p001144]; Miller, Steven B. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=SMiller]; Kautzner, Adam W. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p039691]
CC: Koch, Rhonda S. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p047132]; Ito Hollander, Susan M. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P453SI]; Flemming, Jay P. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p040393]; Noehren, Jill (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=noehrenj]
Subject: RE: Contract / Formulary Discussion

Steve,

Nancy and I are getting ready to hop a flight back to BLM. Here are a couple thoughts.

1) Diabetes supplies, meters, insulins --- the blood glucose meters are all very easy to use these days (small amount of blood, fast results, and convenient size). While the features may differ slightly, members will be able to easily navigate and adapt (even if they are loyal to their current device). For the insulins, I believe that the Novolog and Humalog agents are essentially interchangeable on a unit by unit basis. Also, as we all know, these agents are dosed to effect and will be quickly fine-tuned. Our P+T experts claimed that switching from one form/manufacturer to another is common and relatively painless.

2) While it's true that Advair is available as a dry powder and HFA, both Dulera and Symbicort are HFA only. The HFA devices are pretty easy to use, but can be combined with a spacer when needed. We have a formulary exception for the dry powder if patients cannot coordinate the HFA. I think this is rare but it helps us here. While Advair is a great drug, both Dulera and Symbicort are great too. Our experts deem them clinically equivalent.

3) Epipen --- the products do have different shapes/sizes, but the points made below are really related to convenience; not true differences in therapeutic outcomes or performance. Since Auvi-Q has voice commands, we do grant an exception for visually impaired and day care providers.

Thanks,
Andy

-----Original Message-----
From: Dohm, Jason G. (BLM)
Sent: Thursday, September 26, 2013 04:52 PM Central Standard Time
To: Miller, Steven B. (EHQ); Behm, Andrew (BLM); Kautzner, Adam W. (EHQ)
Cc: Koch, Rhonda S. (BLM); Ito Hollander, Susan M. (BLM); Flemming, Jay P. (BLM); Noehren, Jill (BLM)
Subject: RE: Contract / Formulary Discussion

I am boarding a plane. Adding my sr directors to get back to you with the talking points document and any other points that they have found beneficial

-----Original Message-----
From: Miller, Steven B. (EHQ)
Sent: Thursday, September 26, 2013 04:02 PM Central Standard Time
To: Behm, Andrew (BLM); Kautzner, Adam W. (EHQ); Dohm, Jason G. (BLM)
Subject: FW: Contract / Formulary Discussion

Gentleman,
Any standard talking points for the below issues? Appreciate any assistance.
Steve

Sent with Good (www.good.com)

-----Original Message-----
From: Horstmann, Laura [redacted]
Sent: Thursday, September 26, 2013 03:57 PM Central Standard Time
To: Miller, Steven B. (EHQ); Potz, Victoria G. (EHQ); Nowatzky, Janine (NJ2)
Cc: Ruzicka, Jesse (NJ2); Edwards, Andy M. (EHQ); Kenny, Peter (NJ2); Scaturro, Theresa A. (NJ2); Brodsky, David L. (EHQ); Horstmann, Laura M. (EHQ)
Subject: FW: Contract / Formulary Discussion

Hi- I just sent a meeting request for tomorrow morning at 7:30 central for a discussion with some of the members of the [redacted], which is the [redacted]. As of now, [redacted] are confirmed, along with [redacted] from [redacted] The other members of [redacted] will be invited as well and may dial in. Calendars are such that I couldn't get a prep call for today, so I thought I'd email the concerns I'm aware of. The group doesn't want our "sales pitch" according to their consultant, and several of them have all ready seen the client facing deck. This call will really just be a discussion and an opportunity for the schools to ask questions.

[redacted] is the main driver behind the call. Linda is down to 3 areas of concern surrounding NPF. These are her concerns/comments that she would like to discuss:

*diabetic supplies, meters and insulin: she is concerned that members will struggle with how to use their new meter and won't use correct insulin dosages. Also, members are stable on their current insulin and Linda doesn't want to disrupt that.

*Advair: concerned that the method of inhalation is different with Dulera. Linda has received emails from members indicating "Advair has saved my life, and I haven't had to go to the hospital since I started using it"

*Epipen: men won't carry an Epipen because of the size, and the alternative is smaller. Also, Auvi-Q is easier for a daycare provided to use on a child, and simpler for a child to use.

Linda knows our preferred products are fine clinically, and fine if used properly, but she's concerned about compliance and ease of use if members don't use the products properly. Linda isn't happy with our timing, but thinks she could be comfortable putting in all categories but these for 4/1, and then rolling these in 7/1. The war room didn't want to go down that path with a custom formulary if we had to split implementation dates, so if she can't get comfortable with all for 4/1 then we would recommend a delay until 7/1.

[redacted] has indicated their issues are focused on communications and timing. The communication materials have been provided to them, but they still have concerns. Victoria and Janine, I've asked you to attend to respond to those questions.

[redacted] haven't raised specific concerns.

If you would like to talk through any of these items or have questions, please don't hesitate to call me at [redacted].Thanks to you all for agreeing to participate on the call tomorrow.

Laura

-----Original Message-----
From: Miller, Steven B. (EHQ) [redacted]

Sent: Monday, September 23, 2013 3:44 PM
To: Horstmann, Laura
Cc: Ruzicka, Jesse; Horstmann, Laura; Miller, Barb R. (EHQ)
Subject: RE: Contract / Formulary Discussion

Laura,
Happy to participate in a call. Please work with Barb to schedule. Thanks.
Steve

-----Original Message-----
From: Horstmann, Laura [redacted]
Sent: Monday, September 23, 2013 12:24 PM
To: Miller, Steven B. (EHQ)
Cc: Ruzicka, Jesse (NJ2); Horstmann, Laura M. (EHQ)
Subject: FW: Contract / Formulary Discussion

Hello Dr Miller- I'm hoping you'd be able to help us on a client and NPF. [redacted], as you can see below, is not happy with our plan to exclude prescriptions from coverage. They are very paternalistic and don't like change. They have requested a call with our medical officer to discuss how the decisions were made. Is this call one that you would be willing to participate in?

Thank you
Laura

-----Original Message-----
From: [redacted]
Sent: Friday, September 20, 2013 1:27 PM
To: [redacted]
Cc: [redacted]
Subject: Contract / Formulary Discussion

Laura,
I received Jesse's note which was far from helpful regarding this matter.
I understand other clients have been offered extensions to make their decision regarding opt-out, some are offered grandfathering of existing patients on the excluded products, some are offered extended start dates for the formulary into next year. All of these would be helpful options.

I've reviewed our signed contract and I do not agree with the legal departments interpretation of rights in this instance.

Here are excerpts from our contract below that clearly state ESI may change their formulary, of course, but it will be done so "consistent with good pharmacy practice" and no product will be removed from the formulary without a "substantive reason to do so".

The contract states that we will disuss and review formulary changes together. We will certainly consider each product and the merits of the substitution. Provided they meet "good pharmacy practices" and should be removed for 'substantive reasons" there will be no problem. Based on two products we have reviewed with Jesse already, this is not the case.

Section 6.1 of contract –

"ESI reserves the right to modify or replace the Preferred Prescriptions Formulary…consistent with good pharmacy practice" "ESI agrees to notify [redacted] at least 90 days in advance, if possible, when a formulary drug is targeted to be removed from the formulary. ESI will provide a detailed disruption and financial impact analysis by school at the same time. With the exception of FDA recalls or other safety issues, The PBM agrees it will not remove prescription drugs from its formulary unless there is a substantive reason which will be discussed with [redacted] prior to its removal."

Laura, as you know, we selected ESI instead of Caremark because we were looking for a true partnership in the delivery of prescription products to our members.

The recent announcement to unilateral changes to the formulary, of this magnitude and with this timing so close to open enrollment, is not consistent with the partnership we formed.

[redacted] wishes to have an open, transparent and informative dialogue regarding how these decisions were reached by the P&T committee.

We consider this an urgent matter so I look forward to discussing this with you today. Please call my cell phone so I may be reached at any time. [redacted]

[redacted]

Message

From: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=BEHMA]
Sent: 9/4/2013 4:00:46 PM
To: Pehl, Nancy (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=Nancy A PEHL2fDPS]
Subject: FW: 2014 National Formulary

Nancy,

See below. If you get any Pebble-related inquiries, please copy Ed and Everett and redirect to them.

Thanks,
Andy

From: Neville, Everett (EHQ)
Sent: Wednesday, September 04, 2013 2:35 PM
To: Behm, Andrew (BLM); Adamcik, Edward John (FKN)
Subject: RE: 2014 National Formulary

Redirect and cc us

-----Original Message-----
From: Behm, Andrew (BLM)
Sent: Wednesday, September 04, 2013 12:53 PM Central Standard Time
To: Adamcik, Edward John (FKN); Neville, Everett (EHQ)
Subject: FW: 2014 National Formulary

When manufacturers approach us about Pebble, do you want to be copied, or should I just redirect? I don't want to clog up your inbox.

From: Behm, Andrew (BLM)
Sent: Wednesday, September 04, 2013 12:33 PM
To: 'LOBT (Leonard Bennett)'; Boomhower, Dana L. (BLM)
Cc: Adamcik, Edward John (FKN); Neville, Everett (EHQ)
Subject: RE: 2014 National Formulary

Leonard,

I can't directly answer your question, but I can say that you've always provided all of the necessary clinical information and product support.

If you have additional questions, I would highly recommend that you connect with Everett Neville or Ed Adamcik.

Andy

From: LOBT (Leonard Bennett) [redacted]
Sent: Wednesday, September 04, 2013 12:09 PM
To: Behm, Andrew (BLM); Boomhower, Dana L. (BLM)
Subject: 2014 National Formulary

Hey Andy and Dana,

I hope that you are having a good day. I am just returning from vacation and was informed of the recent announcement that Novolog, Novolog Mix, and Victoza are being removed from the 2014 Express Scripts National Formulary. I wanted to touch base with both of you to see if the decision was made solely on a financial basis or was there anything clinical that we did not provide during this formulary decision process. I know that Todd and I have shared with you on several visits updates on Victoza clinical data and health economic outcome data when comparing to exenatide and sitagliptin. Can you please share with me your thoughts if this decision was financial, clinical or a combination of both factors.

I look forward to seeing you in a future meeting.

Kind Regards,
Leonard

Leonard Bennett, PharmD
Senior Medical Liaison, Managed Markets
Clinical Development, Medical, and Regulatory Affairs

Novo Nordisk Inc.
100 College Road West
Princeton, New Jersey 08540
USA
[redacted]

Message

From: Henry, Brian (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P062959]
Sent: 11/26/2013 11:26:40 AM
To: Behm, Andrew (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=BehmA]
Subject: RE: [redacted]

Thanks...to your point, would this work better?

We appreciate that there may be times when a covered alternative may not be an option. In these rare instances, we have a exception process that physicians may pursue beginning January 1, 2014.

From: Behm, Andrew (BLM)
Sent: Tuesday, November 26, 2013 10:23 AM
To: Henry, Brian (EHQ)
Subject: RE: [redacted]

Brian,

In general, this looks good. The FE paragraph needs some work. A couple points. ESI offers standard formulary exception criteria. The exceptions are developed, with our P+T experts, during the formulary assessment process. If a client takes one of our nationals, we strongly recommend that they take our FEs. Historically (even 2-3 years ago), we let clients create their own custom FE PR just handle on a case-by-case basis. While many clients follow our FE process which is similar to a PA, we recommend that patients simply call the number on their prescription card.

I'm happy to serve as the signatory if needed.

Andy

-----Original Message-----
From: Henry, Brian (EHQ)
Sent: Tuesday, November 26, 2013 09:01 AM Central Standard Time
To: Behm, Andrew (BLM)
Subject: RE: Rick Miller/former Lucent CEO

Wanted to follow up on this request. Please advise.

From: Henry, Brian (EHQ)
Sent: Monday, November 25, 2013 11:57 AM
To: Miller, Steven B. (EHQ); Behm, Andrew (BLM)
Subject: Rick Miller/former Lucent CEO

Today, we received a tweet from [redacted], a c-suite consultant and [redacted], regarding the diabetes changes to the NPF. He has 59,000+ followers and his tweet was retweeted twice. We clearly don't come to you with every tweet we get, but this is more prominent than most. We reached out to him via

Twitter and offered to provide some more context (he responded favorably and we wanted to send a note to him via e-mail).

Here is his original tweet:

BEINGCHIEF

"Not happy with @ExpressScripts raising prices on Novolog to push Humalog. Those w diabetes like me rely on this insulin."

Here is our proposed e-mail response, based on language we've been using for other queries re: NPF (also, would like to know if there is someone we should connect him with in re: exception process). And would like to know if one of you would want to be the signatory on the e-mail:

Mr. [redacted]

Thank you for responding with your contact information, and for sharing your perspective about the changes to the 2014 Express Scripts National Preferred Formulary. I appreciate the opportunity to share some additional information about these changes for your consideration.

At Express Scripts, it is our job to continually look for ways to reduce waste, lower healthcare costs and improve patient outcomes. As such, smart formulary management is becoming increasingly important in helping our clients – plan sponsors that include health plans, employers, and government agencies – sustain the pharmacy benefit they offer to their members.

Drug choices in some classes are larger than ever with many products that cost more but do not offer notable, additional health benefits. Also, the industry is moving to more aggressively managed formularies help counter manufacturer tactics that increase a plan sponsor's share of healthcare costs. Nearly all of the drugs being given "not covered" status on our National Preferred Formulary have copayment cards that unnecessarily drive up the cost of care.

Our formulary is developed with guidance from an independent group of physicians and pharmacists who reevaluate it annually. The formulary is first evaluated from a clinical perspective to ensure it provides access to safe and effective medications in all therapy classes. Secondly, and only after the clinical requirements have been achieved, do we evaluate the formulary for its cost-effectiveness. If there are more expensive products that, according to independent experts, offer no additional health benefit than products already covered on the formulary, we may choose to remove these products.

Plan sponsors make the final decision on the formulary for their members. We are offering our National Preferred Formulary to plan sponsors that, combined, represent just over one-third of our membership. Out of the 4,100 products on our formulary, 48 are being moved to "non covered" status, including the diabetes product mentioned in your Tweet. Fewer than 2 percent of our members are impacted by any of the changes.

We appreciate that there may be instances where an on-formulary alternative may not be an option for a patient. For these rare instances, we have a standard exception process that physicians may pursue to have an off-formulary, medically necessary drug covered. Plan sponsors ultimately decide what types of exceptions to allow, and we administer these criteria on their behalf. If you would like pursue the exception process, [IS THERE A NUMBER HIS PHYSICIAN CAN CALL TO GET THE EXCEPTION FORM?]

If you have any additional questions about these changes, please let me know. Thanks, in advance, for your time.

Message

From: Marzulli, Robert [redacted]
Sent: 10/8/2013 2:13:14 PM
To: Whitrap, David M. (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P053599]; Nowatzky, Janine (NJ2) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P312JN]; Potz, Victoria G. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=VPotts]; Knebel, Glenda (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=RECIPIENTS/cn=P000438]; Dohm, Jason G. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p001144]; Kautzner, Adam W. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p039691]; Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JEichholz]
CC: Sasse, Rebekah L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p044453]
Subject: PLEASE REVIEW: Pink Sheet Reports on 2014 National Preferred Formulary

OK to release as a SAM comm?

Thanks.

Pink Sheet Reports on 2014 National Preferred Formulary

An Oct. 7 article in the *Pink Sheet* detailed Express Script's 2014 National Preferred Formulary. The article reflects Express Scripts messaging about the NPF.

Account teams can share it with clients at their discretion.

Key points from the article include:

- Pharmacy benefit manager Express Scripts Inc. is stepping up formulary controls in its commercial plan business by introducing a list of drugs that are excluded from coverage beginning Jan. 1, 2014.
- Given the size of Express Scripts' client base, the move marks an important step toward more restrictive formularies in employer-sponsored coverage, which has been relatively generous compared to other markets.
- The excluded list covers 44 drugs across a range of classes and applies to the Express Scripts recommended national formulary, which is expected to be adopted by employers and health plans that represent between 30 million and 40 million members, the PBM said.
- The use of co-pay assistance cards has been a sore point with payers, who say they bear the burden of reimbursing the higher-cost drug when a patient chooses the brand over a generic.
- "The 'not covered' status is a new status for our recommended formulary, but it is in no way unique to the industry," the spokesman said.
- "If you look across our industry, there is broad and growing acknowledgement from organizations that not all drugs need to be covered. Drug choices in some classes are larger than ever, with many products costing more with no additional health benefit."
- Rival PBM CVS Caremark Corp. instituted an excluded drug list that went into effect in 2012.
- Express Scripts' decision is "very disappointing for patients whose health care providers had elected to treat" their patients with Advair or Breo Ellipta, a GSK spokesperson said.
- The company [GSK] expects Advair to be covered on CVS Caremark's standard formulary.
- The "not covered" designation could be a significant setback for Breo Ellipta, which began its launch only a few weeks ago.

Contact David Whitrap with any questions.

Robert Marzulli

Express Scripts Tightens Commercial Formulary Control With "Not Covered" List

By Cathy Kelly / Email the Author / *Oct. 7, 2013*

Pharmacy benefit manager **Express Scripts Inc.** is stepping up formulary controls in its commercial plan business by introducing a list of drugs that are excluded from coverage beginning Jan. 1, 2014.

The list was developed in response to increasing payer costs resulting from drug manufacturer price increases and programs including co-pay assistance coupons, according to the pharmacy benefit manager. Given the size of Express Scripts' client base, the move marks an important step toward more restrictive formularies in employer-sponsored coverage, which has been relatively generous compared to other markets.

The excluded list covers 44 drugs across a range of classes and applies to the Express Scripts recommended national formulary, which is expected to be adopted by employers and health plans that represent between 30 million and 40 million members, the PBM said *(see table below)*.

It was developed on the advice of "a group of external experts [that] has deemed that these drugs provide no added health benefit when compared to more affordable alternatives that are covered," an Express Scripts spokesman explained in an email.

He further noted, "The industry is evolving to more aggressively managed formularies as a way to counter pharmaceutical manufacturers' tactics that increase payers' share of health care costs." For example, "nearly all of the drugs being given 'not covered' status have co-payment cards that unnecessarily drive up the cost of care."

Co-pay coupons are issued by drug firms as a way to reduce or eliminate cost-sharing for private insurance members. They can help circumvent formulary pressures such as placement on tier three, which involves higher member cost-sharing designed to encourage members to accept lower-cost alternatives.

The use of co-pay assistance cards has been a sore point with payers, who say they bear the burden of reimbursing the higher-cost drug when a patient chooses the brand over a generic. Another major payer that recently took action against co-pay coupons is **UnitedHealth Group Co.**, which started a program in early 2013 requiring that pharmacies participating in its Designated Specialty Pharmacy network stop redeeming manufacturer-sponsored coupons for six branded specialty drugs ("UnitedHealthcare Program Will Bar Copay Coupons For Six Specialty Drugs" — *"The Pink Sheet" DAILY*, Oct. 26, 2012).

Express Scripts pointed out that its decision to establish an excluded list for its commercial clients is in line with a growing trend among payers toward more narrow formularies.

"The industry is evolving to more aggressively managed formularies as a way to counter pharmaceutical manufacturers' tactics that increase payers' share of health care costs." – Express Scripts

"The 'not covered' status is a new status for our recommended formulary, but it is in no way unique to the industry," the spokesman said. "If you look across our industry, there is broad and growing acknowledgement from organizations that not all drugs need to be covered. Drug choices in some classes are larger than ever, with many products costing more with no additional health benefit."

Rival PBM **CVS Caremark Corp.** instituted an excluded drug list that went into effect in 2012. A company spokesperson explained that "in general, the majority of drugs removed from the [preferred drug list] are higher-cost, non-preferred drugs with lower utilization. For those drugs that are removed, equally effective

products with lower overall costs, including many generics, remain available on the formulary."
The spokesperson also explained CVS Caremark "positions this as our standard formulary; however, clients are allowed to opt-out of the formulary and select another formulary that does not leverage the drug exclusions."
Express Scripts' "not covered" list includes biologics for autoimmune diseases, diabetes drugs and respiratory agents. Many of the excluded drugs are older and smaller products in their class, and in important categories such as the TNF antagonists, multiple sclerosis treatments and DPP-4 drugs, the market leaders are covered.
The PBM pointed out that less than 2% of drugs on the market have been given not covered status. Nevertheless, there are notable exceptions.

Victoza, Advair and Breo Ellipta Off Formulary

Novo Nordisk Inc.'s market-leading once-daily GLP-1 agent *Victoza* (liraglutide) is on the "not covered" list ("Express Scripts Formulary Drops Novo Nordisk's Victoza Based On Lack Of "Added Health Benefit"" — *"The Pink Sheet" DAILY*, Sep. 11, 2013).The decision leaves two options on formulary in the GLP-1 class – **Bristol-Myers Squibb Co./AstraZeneca PLC**'s twice-daily *Byetta* (exenatide) and once-weekly *Bydureon* (exenatide).
GlaxoSmithKline PLC's blockbuster asthma and COPD treatment *Advair Diskus* (fluticasone/salmeterol) is another noteworthy exclusion. Express Scripts has also denied formulary status for GSK's newly launched COPD drug *Breo Ellipta* (fluticasone/vilanterol).
Express Scripts' decision is "very disappointing for patients whose health care providers had elected to treat" their patients with Advair or Breo Ellipta, a GSK spokesperson said.
Nevertheless, Advair "remains available for the majority of patients served" by Express Scripts, the spokesperson maintained. "A subset of employers is impacted by this program, and these employers have the choice to not participate."
GSK will be "working closely with [Express Scripts] to minimize any potential patient therapy disruptions as a result" of the decision not to cover Advair, "and to secure patient access to these important treatment options," the spokesperson said. The company expects Advair to be covered on CVS Caremark's standard formulary.
The "not covered" designation could be a significant setback for Breo Ellipta, which began its launch only a few weeks ago ("Breo Launch Timing Slips But No "Drama," GSK's Witty Says" — *"The Pink Sheet" DAILY*, Jul. 24, 2013). However, the spokesperson downplayed the potential negative impact and pointed out the company is taking a deliberate approach with the introduction. "Building strong coverage for a brand like Breo will take some time," she noted, and "so far we have had some encouraging responses to our presentations."
Breo is intended as a successor to Advair, which could face generic competition in a few years. Advair lost patent protection for the drug substance combination in September 2010, but the Diskus inhaler has helped GSK hold on to market dominance with its patent protection extending into 2016 ("Advair Generics Likely Lucrative Product For Few That Can Clear High Bar" — *"The Pink Sheet,"* Sep. 16, 2013).
The newer drug has a convenience advantage over Advair, in that it is dosed once-daily instead of twice-daily, but it did not demonstrate an efficacy advantage over Advair in clinical studies. However, GSK is looking to demonstrate that Breo's dosing convenience improves compliance in a way that impacts patient outcomes and reduces broader health care costs. Data from those studies are expected in 2015 or 2016.

Express Scripts 2014 "Not Covered" List

Below are drugs excluded from coverage in Express Scripts' recommended national formulary for commercial plans and recommended alternatives in 18 drug classes. Recommended alternatives do not always list all covered options.

Excluded Drugs	Recommended On-Formulary Alternatives
Diabetes: DPP-4 inhibitors	

Jentadueto (Boehringer Ingelheim/Lilly)

Tradjenta (BI/Lilly)

Kazano (Takeda)

Nesina (Takeda)

Diabetes: GLP-1 antagonists

Victoza (Novo Nordisk)

Diabetes: insulins

Novolin (Novo Nordisk)

NovoLog (Novo Nordisk)

Apidra (Sanofi)

Respiratory: beta agonist combination inhalers

Advair Diskus (GlaxoSmithKline)

Breo Ellipta (GSK)

Respiratory: short-acting inhalers

Maxair Autohaler (Medicis)

Proventil HFA (Merck)

Xopenex HFA (Sunovion)

Respiratory: pulmonary anti-inflammatory inhalers

Alvesco (Sunovion)

Flovent Diskus HFA (GSK)

Respiratory: epinephrine auto-injectors

Auvi-Q (Sanofi)

TNF antagonists for inflammatory conditions

Cimzia (UCB Group)

Simponi (J&J)

Stelara (J&J)

Xeljanz (Pfizer)

Januvia (Merck)

Janumet XR (Merck)

Onglyza (Bristol-Myers Squibb/AstraZeneca)

Kombiglyze (Bristol/AZ)

Byetta (Bristol/AZ)

Bydureon (Bristol/AZ)

Humulin (Lilly)

Humalog (Lilly)

Symbicort (AZ)

Dulera (Merck)

ProAir HFA (Teva)

Ventolin HFA (GSK)

Asmanex (Merck)

Pulmicort Flexhaler (AZ)

QVAR (Teva)

EpiPen (Mylan)

EpiPen Jr. (Mylan)

Humira (Abbvie)

Enbrel (Amgen)

Multiple Sclerosis	
	Avonex (Biogen Idec)
Betaseron (Bayer)	*Rebif* (Merck KGAA)
	Extavia (Novartis)
Interferons for hepatitis C	
PegIntron (Merck)	*Pegasys* (Roche)
Angiotensin II receptor antagonists with diuretics	
	Benicar/HCT (Daiichi Sankyo)
Edarbi/Edarbyclor (Takeda)	candesartan/HCTZ (generic)
Micardia/Micardis HCT (BI)	irbesartan/HCTZ (generic)
Teveten/Teveten HCT (Abbott)	losartan/HCTZ (generic)
	valsartan/HCTZ (generic)
Endocrine: growth hormones	
Nutropin (Roche)	
Omnitrope (Novartis)	*Humatrope* (Lilly)
Saizen (Merck)	*Genotropin* (Pfizer)
Tev-Tropin (Teva)	*Norditropin* (Novo Nordisk)
Nasal steroids	
Beconase (GSK)	*Nasonex* (Sanofi)
Veramyst (GSK)	*Qnasl* (Teva)
Omnaris (Sunovion)	flunisolide (generic)
Zetonna (Sunovion)	fluticasone propionate (generic)
Rhinocort Aqua (AstraZeneca)	triamcinolone acetonide (generic)
Erectile dysfunction agents	
Levitra (Bayer/GSK)	*Cialis* (Lilly)
Staxyn (Bayer/GSK)	*Viagra* (Pfizer)
Long-acting opioids	
Avinza (Pfizer)	*OxyContin* (Purdue Pharma)
Exalgo (Mallinckrodt)	*Nucynta ER* (J&J)
Kadian (Actavis)	morphine sulfate ER (generic)

	oxymorphone ER (generic)
Endocrine: topical testosterone agents	
Fortesta (Endo)	*Androgel* (Abbott)
Testim (Auxilium)	*Axiron* (Lilly)
Ovulatory stimulants	
Bravelle (Ferring)	*Gonal-f* (Merck KGAA)
Follistim AQ (Merck)	
Ophthalmic prostaglandins	
	Lumigran (Allergan)
	*Travatan (*Novartis/Alcon)
Zioptan (Merck)	latenoprost (generic)
	travoprost (generic)

Source: Express Scripts

From: Marzulli, Robert [redacted]
Sent: Monday, October 07, 2013 9:38 AM
To: Whitrap, David M. (EHQ)
Subject: Pink Sheet article

Can you send me a PDF of the Pink Sheet article Brian mentioned in the team meeting and any talking points? I'll put it into a SAM comm.

Thanks!

Robert Marzulli
Marketing Services/Field Communications
[redacted]

<< OLE Object: Picture (Device Independent Bitmap) >> Follow us on Twitter: @ExpressScripts

Message

From: Gentry, Emily (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P079028]

Sent: 9/23/2013 10:49:00 AM

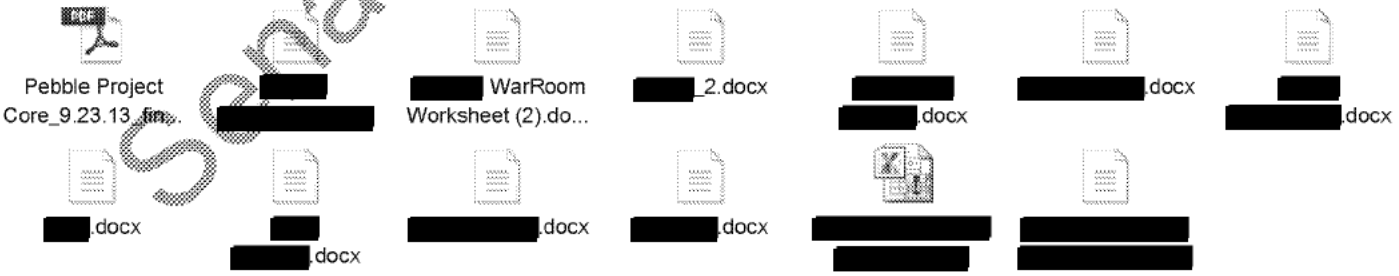
To: Achter, Leslie (NJ2) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=N433L9]; Becker, Scott A. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=Sabecker]; Blaisdell, Robert J. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=RJBlaisdell]; Dohm, Jason G. (BLM) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p001144]; Drzewucki, Danielle L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=DLDrzewucki]; Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JEichholz]; Gentry, Emily (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P079028]; Glogovac, Kelly M. (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P082216]; Heiney, Sarah J. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=SHeiney]; Kautzner, Adam W. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p039691]; Knebel, Glenda (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=RECIPIENTS/cn=P000438]; Marzulli, Robert (FKN) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P542RM]; Meyer, Julayna (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JMeyer]; Mueller, Lauren (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P056689]; Myers, Tara L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=TMeyers]; Nowatzky, Janine (NJ2) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P312JN]; Pettyes, Thomas J. (MMN) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P458TP]; Pisano, Paul (FKN) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P06199]; Potz, Victoria G. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=VPotts]; Pozzo, Amanda J. (EHQ) [/O=EXPRESS-SCRIPTS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=P060412]; Pummill, Denise M. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=DPummill]; Ruebenacker, Erik P. (NJ2) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=P310RE]; Schlett, David A. (NJ2) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=N433DXS]; Timmers, Dana L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=DLTimmers]

Subject: Core Team Meeting Materials

Attachments: [redacted].docx; [redacted] WarRoom Worksheet (2).docx; [redacted].docx; [redacted]docx; [redacted].docx; [redacted].docx; [redacted]docx; [redacted].docx; [redacted]_2.docx; [redacted].docx; ClientTemp_Final_09 23 13 (2).xlsm; Abbreviated 2014 Exclusion Rationale-[redacted].docx; Pebble Project Core_9.23.13_final.pdf

Good morning!

Attached are materials for this morning's meeting.



Questions for discussion:

09/20/2013	Cathy Casale	Kathy Korducki	[redacted]	Greater of Guarantee or 100%	[redacted] has been updated to purple in database, but we need to exclude 6000 retirees moving to EGWP for 1/1/14. Guidance needed on how to address dependents of EGWP retirees that are not eligible for EGWP (less then 65) to ensure they remain in NPF and are notified of the change. Currently these members share the same group numbers so group opt out may not be feasible.					
09/23/2013	Erica Thomas	Cindy Leisey	[redacted]	Greater of Guarantee < 100%	Client has its own 340B pharmacy that does not earn rebates from ESI. They have asked if we can allow them to use Accu-Check, their preferred product at the onsite pharmacy ONLY. They will adhere to the NPF formulary at all standard network pharmacies and at [redacted] Pharmacies but would like to grandfather/override anyone taking [redacted] Of the total strip utilization, this accounts for about 2/3 of the total. Rebates would not be impacted and we can have the overrides put in place outside of any operational undertaking. Please confirm. Thanks					

Escalations for discussion:

09/20/2013	Chris Ruegg	Gina Gruhn	[redacted]	Greater of Guarantee or 100%	3K	75,000	01/01/2014	[redacted]		Client would like the ability, on occasion, to grant adminsitrative override to a formulary exclusion. They would be open to a finite limit to the number of exclusions. This would apply their C Suite executives.
09/23/2013	Peter Breilmann	Jesse Ruzicka	[redacted]	Greater of Guarantee or 100%	14K	0	01/01/2016	[redacted]		Client is very concerned about drug exclusions on the 2014 NPF. They are considering requesting a move to the Basic but based on discussions, they would

									consider enrolling in the NPF if we would delay it until 4/1/14. [redacted] has been a strong ally and we feel confident that we can convince them to enroll with a delay but without a delay the odds are strong that the client will ask to opt out.
09/23/2013	Tracey Caldiero	David Brodsky	[redacted]	Greater of Guarantee or 100%	150K	8480000	12/31/2014	[redacted]	[redacted]% of [redacted] volume of from the Union Retiree Population. They added PDST rules effectvie 7/01/13 inclding Advair. In order for Union to approve NPF, any clinical approval for the new rules since 7/01/13 can not be end dated on 12/31/13. Also, Union has also asked for clinical approvals made since 7/01/13 for other PDST rules also not be end dates 12/31/13.

09/23/2013	Tracey Caldiero	David Brodsky	[redacted]	Greater of Guarantee or 100%	87K	2566000	12/31/2013	[redacted]	[redacted]s eliminating the U[redacted] where ESI is the PBM. Members will have a choice between 2 reamining plans. [redacted] which is carved in, and [redacted] where ESI is the PBM. [redacted]s concerned that more members will choose the [redacted]lan since the Formulary is administered on an open basis vs our Formulary with exclusions. Is [redacted] adoption of NPF important enough toward our 85% goal to risk losing lives to Cigna plan? [redacted] Pricing has confirmed there is no risk for basic

									vs current guarantees. [redacted] has asked us to consider increasing guarantees for upside rebates for NPF. We should consider this in lieu of market check if we need them in NPF.

Emily Gentry
Sales Coordinator - Commercial Division
[redacted]

2014 National Preferred Formulary Launch
Account Team Preparation Worksheet

Scheduled for XXXXXX

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Account Executives- Michele Valianatos Senior Director- John Rasulo Regional Vice President- Frank Gentilella
4.	Escalation Reason	[redacted] came to ESI from [redacted]. They were not unhappy with [redacted] and did not want to leave until the formulary changes. The sole reason that ESI won this business is because of the formulary change. At the presentation we assured them that this was not something we would ever do. The client is extremely unhappy. They have stated that if we go through with this they will term as fast as they can.
5.	Background Information	• [redacted] came to ESI because of the [redacted] formulary change. • They thought that they were protected in the contract but this language expired. • At the finalist presentation Express Scripts stated that this was never something we would do. In doing this we are not upholding the Express Way Values to our clients. • [redacted] • [redacted]- KMQA [redacted]
	Proposed Solutions	• Leave current rebates in place on the Basic formulary. • Start discussions with the plan on formulary movement in the future.
	Risks / Other Considerations	The client is look to leave ESI and we will lose the plan as well as the 2,000 life EGWP.
	Benefits	Client retention and renewal in 2015.

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Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Chip Haring Keith Urich
4.	Escalation Reason	Client very concerned in regards to 3 items: 1) Increased costs due to additional office visits and additional member hassle 2) [redacted] was once owned by [redacted] and still has a very close relationship with them. They would like all [redacted] Products being excluded to be allowed at a non-formulary copay for [redacted] members. 3) They have an issue with us excluding products because they feel that this could potentially hurt their contracting with [redacted] companies. Consultant requested call with client and Dr. Miller
5.	Financial Information	[redacted]
6.	Background Information	[redacted] has been a client since 2008 and has been a great partner. They have implemented many programs over the years such as Step, P/A, SHD, EHD, Exclusive Curascript, DQM. They were formerly owned by [redacted] and have strong ties to many of the former [redacted] employees. [redacted] utilizes [redacted] as their benefits consultant, however [redacted] took the pharmacy analysis piece of the renewal and sub contracted it out to [redacted]. [redacted] has been supportive of our NPF initiative but believes we need to overcome the [redacted] products exclusion to have a chance at leaving the NPF in place.

7.	Lives	16,000 (Currently at around 14,000 lives, however adding about 2,000 HSA Lives from [redacted] on 1-1-14)
8.	ARx	95,000 through July 2013
9.	Proposed Solutions	We should consider allowing the [redacted] Products to go through for their membership as a non-formulary brand.
	Risks / Other Considerations	A risk to consider is that we recently made a 3 year renewal offer which was almost closed out and now they coming back and saying that they feel like the NPF updates should have been disclosed to them during the renewal review process.
	Benefits	

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Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Ralonda Jasper/Tim Rackovan
4.	Escalation Reason	Client Opt Out Request
5.	Financial Information	[redacted]
6.	Background Information	Client is [redacted] We just won an RFP for a 3 year renewal with them. Due to drug exclusions client views staying on NPF as a benefit change and would need board approval. Client is not able to put before board until sometime in 2014. Additionally, client believes the changes will result in major member disruption. Client agreed to resume discussions next year about moving to the NPF. This decision was made after several discussions with the account team as well as after hearing a presentation from Dr. Miller.
7.	Lives	7200
8.	ARx	79,317
9.	Proposed Solutions	Opt Out to basic and resume discussions in 2014
	Risks / Other Considerations	
	Benefits	

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Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Tim Capstick/Johanna van Nijkerk
4.	Escalation Reason	The client is making a decision to move to the Basic Formulary
5.	Financial Information	[redacted]
6.	Background Information	This client is extremely sensitive to perceived member disruption. The client is making a decision to move to the basic formulary regardless of the financial penalty. They felt that since they are allowed another market check on 04/01/14 per their current contract, they would be able to absorb some of the cost increase with this exercise.
7.	Lives	8,840
8.	ARx	119K
9.	Proposed Solutions	Client indicated they would reconsider if ESI: 1) Allows a case by case override option post 01/01, for those members who were targeted and called their HR team to complain. 2) Lowers the current per Rx guarantee for year 2 in the agreement (Effective 04/01/14), in which case the client **would forego their right to a market check.**
	Risks / Other Considerations	The Client has a large leadership team with several parties involved who can sway the decision. The consultant feels there is a good chance the client will adopt NPF if we can provide these solutions, yet there is no guarantee the client to adopt the NPF strategy.
	Benefits	Client adopts the NPF strategy.

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Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Cathy Bustamante/Tim Capstick
4.	Escalation Reason	Basic Formulary 1/1/14
5.	Financial Information	[redacted]
6.	Background Information	[redacted] Rebates: Flat dollar: 30 Day Retail: $[redacted] per brand; $[redacted] per brand 84-90 day retail; $[redacted] per brand mail order Renewal date: 7/1/15 Account team has discussed NPF value prop with client and consultant, provided disruption and financial impact/value. Client has an insurance committee that reviews all plan decisions and they understand the rationale and reasons for the NPF strategy and are supportive of the idea. Their insurance board ruled that they cannot adopt this strategy at this time due to their union contract obligations and their diabetes education program funded by Novolog. Financials for the client aren't of issue as the budget can support the rebate reduction.
7.	Lives	10,500
8.	ARx	90,000
9.	Proposed Solutions	*Discussed rebate impact, loss of approximately* [redacted] They have money in their budget, and they feel it is more important to not disrupt their employees. *We could engage One Touch to provide diabetes education program.* This program is run by [redacted] member, they want to keep as is

	Risks / Other Considerations	Consultant discussed BID process for renewal 7/1/15. [redacted] feels this is being forced upon them, even though they realize the contract language allows for the update. They are upset about rebate impact, but willing to live with it to stay on BASIC formulary. This could negatively affect their renewal 7/1/15, but they are willing to discuss exclusions ideas, market place dynamics in 2014 plan year and will reconsider for 1/1/15 formulary updates.
	Benefits	COB understands financial impact.

2014 National Preferred Formulary Launch
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Scheduled for Monday, September 23rd

1.	Client Name and Structure (DIV/carrier)	[redacted] **(5474)**
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	Davonda Williams (AE), Robyn Cooper (SRD)
4.	Escalation Reason	Client has requested to Opt Out to Basic Formulary
5.	Financial Information	[redacted]
6.	Background Information	• [redacted]. As a first point of contact, these offices connect members to both national and regional solutions. • New client – 1/1/13 • Flat rebates • Chose ESI over Prime for service. • [redacted] understands our position, and candidly shared that they are surprised [redacted] opted out considering their line of business. • Client has a few PA programs, but many DQM rules in place. • Does not like member noise. Very paternalistic. • Doesn't believe they should limit what medications should be offered or covered. Have been operating under the impression that they didn't have a formulary at all. • Have presented opt-out 30%/60% rebate reduction proposition and they understand the implications of this choice.
7.	Lives	3,329
8.	ARx	48,570
9.	Proposed Solutions	Unless we can cover the excluded medications, they are not interested in any solutions.
	Risks / Other Considerations	Renewal is 1/1/16 – could put this at risk.

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	Benefits	

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Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted] **-2518**
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	John Steible Sr AE
4.	Escalation Reason	Client is opting out of NPF and will go with Basic
5.	Financial Information	[redacted]
6.	Background Information	Client is part of [redacted] they have made numerous Rx changes over the past 2 years and this year are focusing on their other benefits. Sr. Mtg did not want to do anything else to disrupt them. Keep in mind, they [redacted], holding down costs is not a high priority. They did promise to revisit for 2015.
7.	Lives	6,179
8.	ARx	Adjusted Rx approx 70K
9.	Proposed Solutions	Continue to discuss during 2014 and bring them on board for 2015
	Risks / Other Considerations	
	Benefits	

2014 National Preferred Formulary Launch
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To ensure that the discussion is productive and decisions can be reached, please come prepared to discuss the following information.

Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	AE- James Antonelli SRD- Dan Castellano VP – Frank Gentilella
4.	Escalation Reason	Client's renewal is 11/1/13 and they issued an RFP back in July. Express Scripts is a finalist. We have been told that [redacted] will move their PBM business from Express Scripts if we do not allow them to move to the basic formulary, with NO change to our current b&F offer.
5.	Background Information	• [redacted] client since 2004 • Satisfied client with service • Highly sensitive to all disruption. • Consultant recommended that they move to the 2014 NPF • Understands the issue. Education or awareness of value is not the issue. • Understands the communication strategy • [redacted] put NPF to a vote and it was voted down. Board's recommendation is to term with Express Scripts, unless we accept their terms • Wants to be opted out • Client is aware that moving to the basic formulary means that the 48 drugs will be moved to Non-Preferred status. • Client will NOT accept any reduction to our b&F final rebate offer. ESI was not the best price as it stands now. • ARx – Year 1: 60,664, Year 2: 61,234, Year 3: 61,929, LOD: 183,826 [redacted]

[PAGE * MERGEFORMAT]

		[redacted]
6.	Proposed Solutions	Client has agreed to renew with Express Scripts if we meet their request. They said that they will be open to further discussion on NPF for 2015 or 2016. No promises however. [redacted] is on board with NPF and will help further the discussion
	Risks / Other Considerations	Client will term
	Benefits	Retain client with an opportunity sell in NPF in the future.

2014 National Preferred Formulary Launch
Account Team Preparation Worksheet

Instructions:

This worksheet should be used by account management representatives who have escalated a client-specific topic for discussion at a 2014 NPF – Leadership Review Session.

Once your topic is scheduled for discussion with leadership, you will receive a meeting invitation (from the Strategy and Planning Mailbox or L Mueller) requesting your attendance at one of the daily 3:00 p.m. – 4:00 p.m. sessions. ***Meeting invitations will be sent out daily for the next day's review session. Please make every effort to juggle your schedule to attend the session for which you are scheduled.***

To ensure that the discussion is productive and decisions can be reached, please come prepared to discuss the following information.

Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	[redacted]
3.	Account Team/Sales Representative	JORDAN DEBEIJ
4.	Escalation Reason	[redacted]
5.	Financial Information	[redacted] Incremental Rebate savings range from $2,160,000 - $2,430,000 Ingredient Cost savings resulting from NPF for this client would range from about $1,050,000 -$1,190,000. In consideration of the Basic Formulary option, we have relayed the potential impact to rebates as 60% (2-tier plan designs). The client receives the greater of 100% of rebates, including specialty, or the guaranteed rebate amounts for open (not 3-tier) benefit designs. Client is part of the [redacted] and will be up for renewal 1/1/2015.
6.	Background Information	[redacted] has received our NPF changes positively and believes the changes we're making are necessary to address the current market dynamics. Industrial relations has spoken with the [redacted], and a vote will be required and if successful, the effective date would be 1/1/2015. Client is requesting opt out to basic, for at least their [redacted] benefits department is on-board with the initiative, but may not be willing or able to implement due to requirements that they negotiate such changes with the [redacted] first.

[PAGE * MERGEFORMAT]

		[redacted] for u[redacted] They do not believe they will be able to separate the two plans and implement NPF for the [redacted] population on 1/1/2014.
7.	Lives	56,311
8.	ARx	1,170,937
9.	Proposed Solutions	Opt out for 2014. Participation in NPF may still be possible in 2015 through a union vote. We had previously requested to delay NPF until 3/1/2014, without financial impact to the client's rebates, in order to give the client time to gain [redacted] approval. Unfortunately, [redacted] has relayed that excluding drugs from the formulary will require a vote will be required and thus this change cannot be implemented before 1/1/2015.
	Risks / Other Considerations	[redacted] [redacted] agreement with [redacted] requires one benefit plan for [redacted] They do not believe they will be able to separate the two plans and implement NPF for the [redacted] population on 1/1/2014.
	Benefits	Client is up for renewal on 1/1/2015 and it will be possible to gain the client's participation in NPF at that time through [redacted] approval.

2014 National Preferred Formulary Launch
Account Team Preparation Worksheet

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Once your topic is scheduled for discussion with leadership, you will receive a meeting invitation (from the Strategy and Planning Mailbox or L Mueller) requesting your attendance at one of the daily 3:00 p.m. – 4:00 p.m. sessions. ***Meeting invitations will be sent out daily for the next day's review session. Please make every effort to juggle your schedule to attend the session for which you are scheduled.***

To ensure that the discussion is productive and decisions can be reached, please come prepared to discuss the following information.

Scheduled for

1.	Client Name and Structure (DIV/carrier)	[redacted]
2.	Benefit Advisor	
3.	Account Team/Sales Representative	Patricia Gallagher, Sr. AE and Dave Robarge, Director/CAE
4.	Escalation Reason	1) Due to [redacted] contracts, client needs to opt out for 1/1/14, but may be able to implement at a later date in 2014. 2) Also, we may need some technical assistance with break-out reports – we created 22 reports, but it is double counting too many members. 3) Basic rebate guarantees will be needed for 1/1/14 (contract addendum).
5.	Financial Information	[redacted]
6.	Background Information	[redacted] has multiple [redacted] and it was determined that they cannot move ahead with NPF. The Director will need to meet with [redacted] to gain their approval. This may take a few months.
7.	Lives	31,000
8.	ARx	992,000
9.	Proposed Solutions	Although [redacted] will need to go with Basic on 1/1/14, may we agree to implement NPF at a later date, perhaps 4/1/14 or later? How would member communications be handled? How much notice do we need to implement NPF post 1/1? In addition, we need some technical assistance with the 22 break-out reports because too many members are double counted.
	Risks / Other Considerations	The client's renewal date is 1/1/15. They may go out to bid in early 2014. The [redacted] continues to pursue [redacted] to join them ([redacted] is the PBM).
	Benefits	We may still be able to enroll [redacted] into NPF, although it would be a later date.

Agenda

Subject: War Room Core Team
Location: STL 1N26
Dial-in: 1.877.374.3741 ID 834870
Dates/Times: Monday, September 23, 2013 10:00 a.m. - 12:00 p.m. CT
Attending: L Achter, R Blaisdell, J Dohm, D Drzewucki, J Eichholz, E Gentry, S Heiney, A Kautzner, R Marzulli, J Meyer, L Mueller, T Myers, J Nowatzky, T Pettyes, V Potz, A Pozzo, E Ruebenacker, D Timmers
Guests: Michele Valiantos, John Rasulo, Chip Haring, Jordan Debeij, Ralonda Jasper, Keith Urich, Johanna Van Nijkerk, Cathy Bustamante, Tim Capstick, Davonda Williams, Robyn Cooper, John Steible, Marianne Jacks, James Antonelli, Dan Castellano, Patricia Gallagher
Unable to attend: D Schlett

Topic	CT	Contributors
War Room Topics for 9/23	**10:00 a.m.**	**Glenda/Account teams**
1.) [redacted] - Request to opt out w/out rebate penalties		Michele Valiantos/John Rasulo
> Worksheet attached		
2.) [redacted] - Request to keep [redacted] products		Chip Haring/Keith Urich
> Worksheet attached		
3.) [redacted]- Request to opt out		Jordan Debeij/Keith Urich
> Worksheet attached		
4.) [redacted]- Request to opt out		Ralonda Jasper/Keith Urich
> Worksheet attached		
5.) [redacted]		Johanna Van Nijkerk/Tim Capstick
> Worksheet attached		
6.) [redacted] - Request to opt out		Cathy Bustamante/Tim Capstick
> Worksheet attached		
7.) [redacted] - Request to implement all changes 4/1		Cathy Bustamante/Tim Capstick
> Worksheet attached		
8.) [redacted] - Request to opt out		Davonda Williams/Robyn Cooper
> Worksheet attached		
9.) [redacted] - Request to opt out		John Steible/Marianne Jacks
> Worksheet attached		
10.) [redacted] - Request to opt out		James Antonelli/Dan Castellano
> Worksheet attached		
11.) [redacted]- Request to opt out		Patricia Gallagher
> Worksheet attached		
12.) [redacted]- additional financial analysis		Kelly Gallagher
Zoomerang	**11:00 a.m.**	**Lauren**
> Questions Attached		
Client Escalations		
> Escalations attached		
General Topics	**11:30 a.m.**	**Team**
1.) Formulary exception criteria		Dana
2.) Formulary exclusion rationale document		
3.) Client Temperature - Clients in red/yellow & opt outs		

Message

From: Sowles, Amanda M. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/CN=RECIPIENTS/CN=AMSOWLES]
Sent: 4/2/2014 5:45:04 PM
To: Kautzner, Adam W. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p039691]
CC: Davis, Shawn (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=p043522]; Grillo, Tony L. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=AGrillo]; Martin, Jason P. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JMartin4]; Eichholz, Jeff R. (EHQ) [/O=EXPRESS-SCRIPTS/OU=STLOUIS/cn=Recipients/cn=JEichholz]
Subject: RE: CFO Meeting
Attachments: Drug Choices Update_04072014.pptx

Adam,

Here is the deck for your meeting. If you want anything else added or removed, let me know. I left a few slides in the appendix in case you want them.

Drug Choices Update_0407201...

Thank you,
Amanda

From: Kautzner, Adam W. (EHQ)
Sent: Tuesday, April 01, 2014 9:21 AM
To: Sowles, Amanda M. (EHQ)
Cc: Davis, Shawn (EHQ); Grillo, Tony L. (EHQ); Martin, Jason P. (EHQ); Eichholz, Jeff R. (EHQ)
Subject: CFO Meeting
Importance: High

I have a meeting on Monday with our new CFO. She would like me to spend an hour going through our products/formularies.
I'm going to ask Amanda to coordinate putting together some slides but she will need those for each of your areas.
I don't see this as anything new we need to create and should just be pulling a few slides on each topic.
We should include a financial slide showing the ancillary revenue generated as well as overall rebate value from the formularies.

Slide Flow:
Org Chart
Overall Financials
VAC process
Formulary overall and all we offer
NPF focus on exclusions and stats thus far
Looking forward for Formulary 2015 and beyond
UM-what it is
Package creation and pricing of the building blocks
Lives, clients, stats
Immediate Future
FWA overview and stats
Slide on Medicare UM and Review & Appeals

Initiatives:
Compounds
CRD Reconciliation
Billing Optimization
Biosimilars

I'd like to see a deck by EOD Thursday.

Please stop by if you have any questions.
Thank you and sorry for the late notice.

Adam Kautzner, Pharm.D.
| Vice President, Formulary & Drug Trend Solutions | Clinical Solutions | Express Scripts, Inc. [redacted]

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Drug Choices Overview

Drug, Trend, and Formulary Update

Adam Kautzner
Vice President
Drug Trend and Formulary Team

April 7, 2014

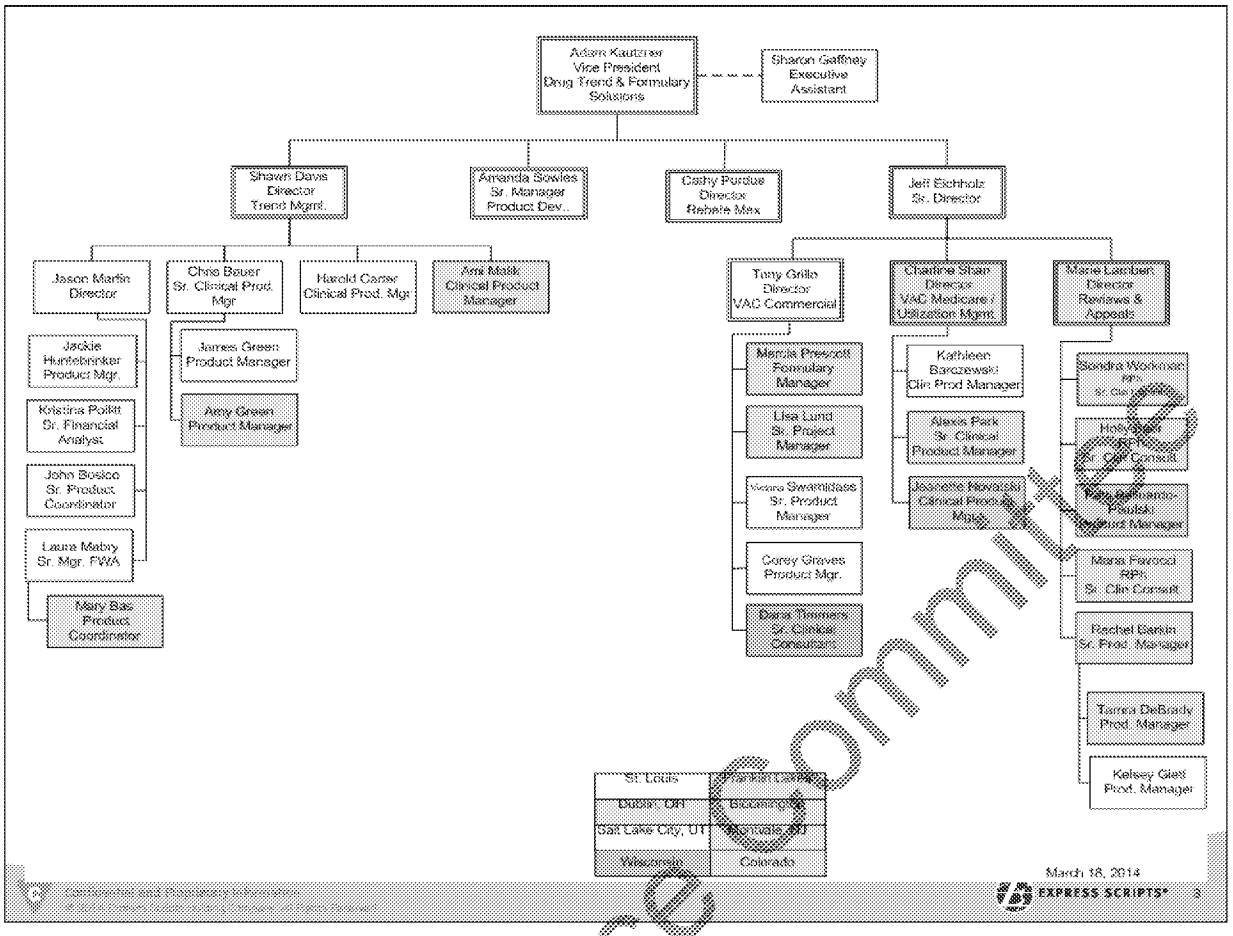
Topics

- Drug Trend and Formulary Team Structure
- Financials
- Formulary
- Utilization Management
- Other team initiatives

We realize that every program does not work across the board for every client but I want to talk to you today about what Drug, Trend and Formulary has to offer. . And hope, in turn, you feel comfortable contacting me or someone else on our team to discuss your client's individual needs.
[redacted] – Not as applicable due to custom formularies and programs
Other Federal – Applicable as a standard

There are two types of client concerns our programs address:
Are drugs being taken appropriate?
Which drugs are we allowing?

Two of our larger initiatives right now are some updates to our Utilization Management programs and results plus ongoing movement on our formulary strategy. . .specifically the National Preferred Formulary.



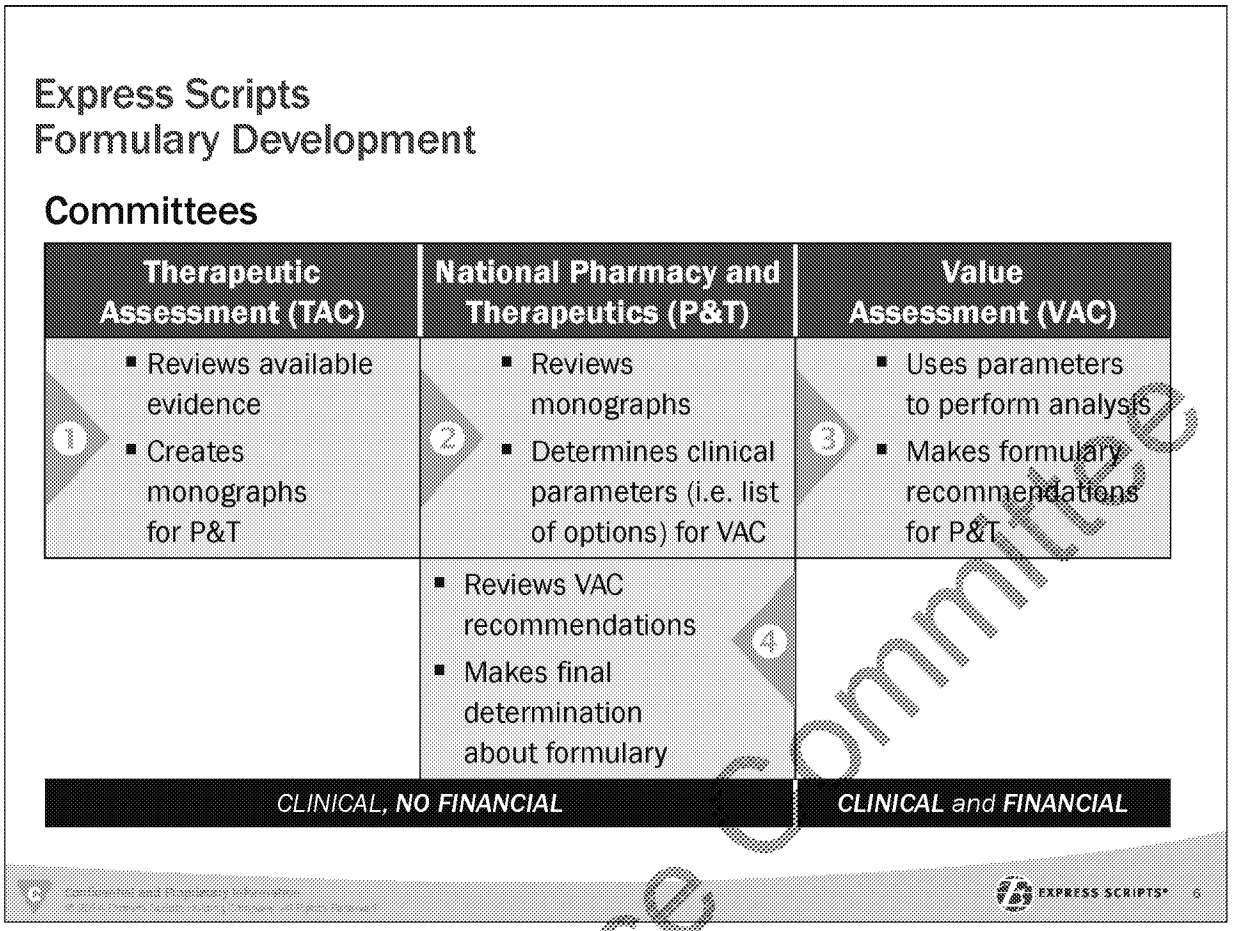
Year-to-date Financials:
Utilization Management and Fraud, Waste and Abuse

	Current Period.					
	Total Actual		**Total Budget**		**Variances**	
	Feb	**%**	**Feb**	**%**	**$**	**%**
UTILIZATION MANAGEMENT	$13,103,398	54.9%	$3,577,919	59.9%	$(474,520)	-3.7%
FRAUD WASTE AND ABUSE	$670,098	2.8%	$148,883	0.7%	$521,215	350.1%

	Year to Date.					
	Total Actual		**Total Budget**		**Variances**	
	YTDFeb	**%**	**YTDFeb**	**%**	**$**	**%**
UTILIZATION MANAGEMENT	$25,237,600	54.8%	$27,094,381	59.7%	$(1,856,781)	-6.9%
FRAUD WASTE AND ABUSE	$851,454	1.9%	$297,781	0.7%	$553,673	185.9%

	Year to Date.					
	Total Forecast		**Total Budget**		**Variances**	
	Year Total	**%**	**Year Total**	**%**	**$**	**%**
UTILIZATION MANAGEMENT	$165,616,352	58.4%	$167,270,965	58.8%	$(1,654,613)	-1.0%
FRAUD WASTE AND ABUSE	$2,330,892	0.8%	$1,785,811	0.6%	$545,081	30.5%

Formulary Strategy



A great example of our philosophy regarding clinical program management is anchored in our approach to Formulary Management. ESI acts on behalf of our clients and their members to provide affordable access to clinically sound, high-quality pharmaceutical products. Drug formularies are one method of achieving this result.

There are 4 steps included in our formulary development process. Notice that 3 of the 4 steps take into account only clinical considerations. We are able to take this approach because of our legacy of independence and unique business model. This allows us to achieve our primary goals; improving health outcomes and managing drug spend trend for plan sponsors.

The first step is review by our Therapeutic Assessment Committee. This team, composed of board certified clinical pharmacists and a medical director, perform primary drug review by reviewing the medical literature, review published data and clinical trials and review of medical practice guidelines.

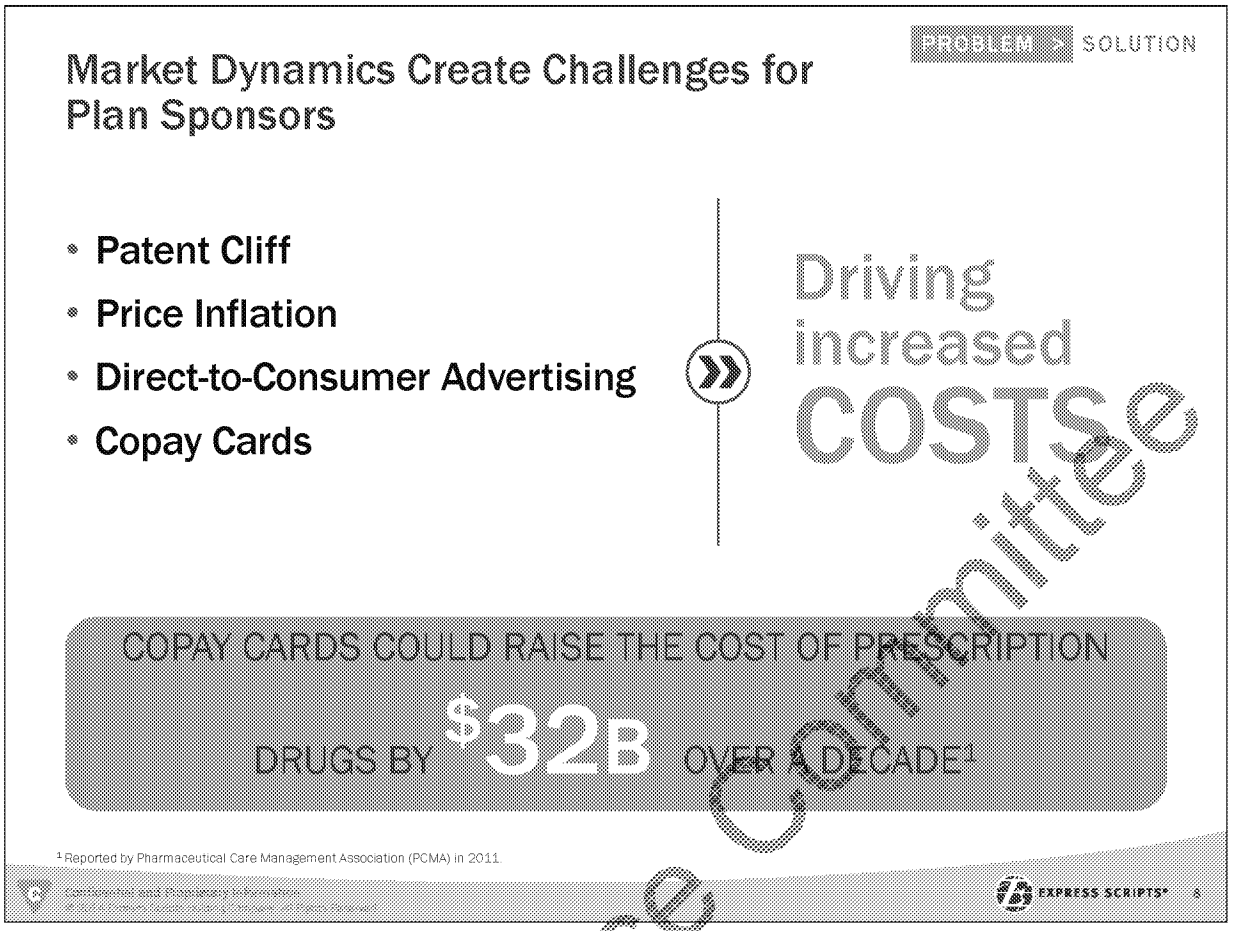
The National Pharmacy and Therapeutics Committee is the next step. The P&T Committee consists of 19 non-employee physician members and one pharmacist member from active community and academic-based practices representing a broad range of medical specialists who are leaders in their area of practice. This committee determines if the drug is an include (clinically superior and required on formulary), optional (clinically equivalent to current formulary drugs so may be on formulary, but not required) or exclude (clinically inferior and not appropriate for formulary inclusion)

- For drugs determined to be Optional, the Value Assessment Committee then considers the value of drugs by comparing the cost of clinically equivalent products and makes a recommendation for “formulary” or “non-formulary”, which is reviewed again by the P&T Committee for final approval.

Formulary development is an example of our clinical 1st benefit management philosophy. This philosophy allow us to align our interest with those of our clients and their members.

Formulary Strategy

	National Preferred	Basic	High Performance
Features	▪Three-tier or open formulary benefit design ▪Excludes 48 products ▪Broad brand and generic products selection	▪Three-tier or open formulary benefit design ▪No formulary exclusions ▪Broad brand and generic products selection	▪Closed formulary benefit design ▪Comprised of generics and the lowest-cost brand drugs
Trend Focus	▪Optional trend programs	▪Optional trend programs	▪Mandatory trend package
Ideal Plan Sponsor	▪Marginally managed ▪$20 copayment differential and less	▪Minimally managed ▪$20 copayment differential and less	▪Aggressive ▪Closed benefit design



Part of our job as a PBM is to identify and implement solutions that lead to better health outcomes and lower cost.

Over the last few years and on an ongoing basis, we are seeing a lot of drugs go off patent causing drug manufacturers to seek out ways to offset lost revenue.
The rising cost of specialty drugs
Runaway inflation on brand drugs that often outpace the savings we see from increased generic dispensing
Direct-to-consumer advertising and copay cards and coupons
and an overabundance of drugs in certain categories.

These tactics made it difficult to control drug costs.

A report commissioned by the Pharmaceutical Care Management Association (PCMA) in 2011 estimated that copay cards could raise the cost of prescription drugs by $32 billion over a decade. It is big business. Pharma is spending over $4B annually to support them and now over 400 drugs have some sort of copay subsidy associated with them.

The number of copay coupon programs marketed to the American public has increased by more than 260% in the past two years.

As a PBM, we look for ways to keep those costs in check for our clients. Thus, we made the decision to exclude 48 drugs from our National Preferred Formulary.

Consistent with trends in formulary management
Rationale of decision with exclusions

You made the right choice with implementing National Preferred Formulary. It is the path to better decisions.

Through National Preferred Formulary, Express Scripts is changing the dynamic of formulary management and combating pharma strategies. National Preferred Formulary has addressed challenging market dynamics.

You have avoided potential waste and costs increases driven by:
Patent Cliff
Price Inflation
Direct-to-Consumer Advertising
Copay Cards

Success through Partnership

~90% client adoption

Limited member & client disruption

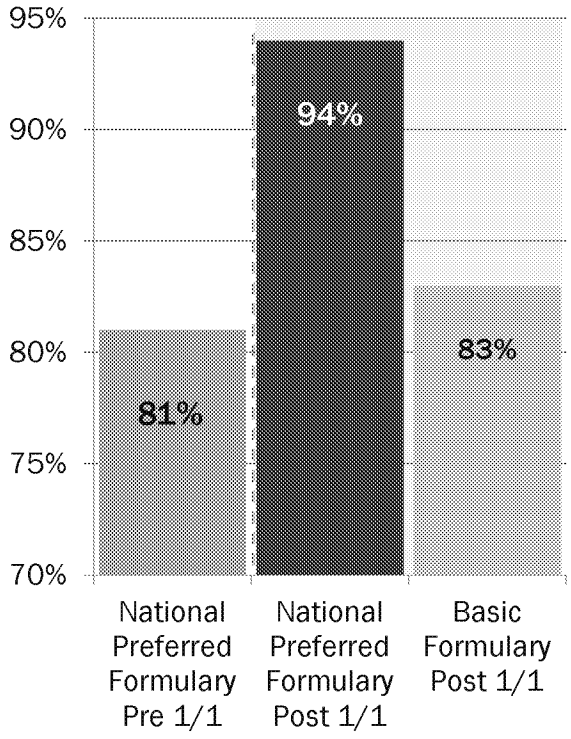
Significant market share shift

Home delivery conversions exceed retail

» FIRST YEAR CLIENT SAVINGS EXCEED $700M

Together we have achieved success

Preferred Prescription Adoption



Less than 3.7%

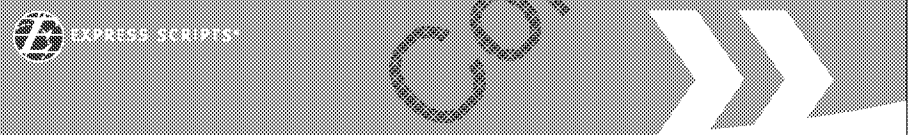
of members pursued a clinical exception

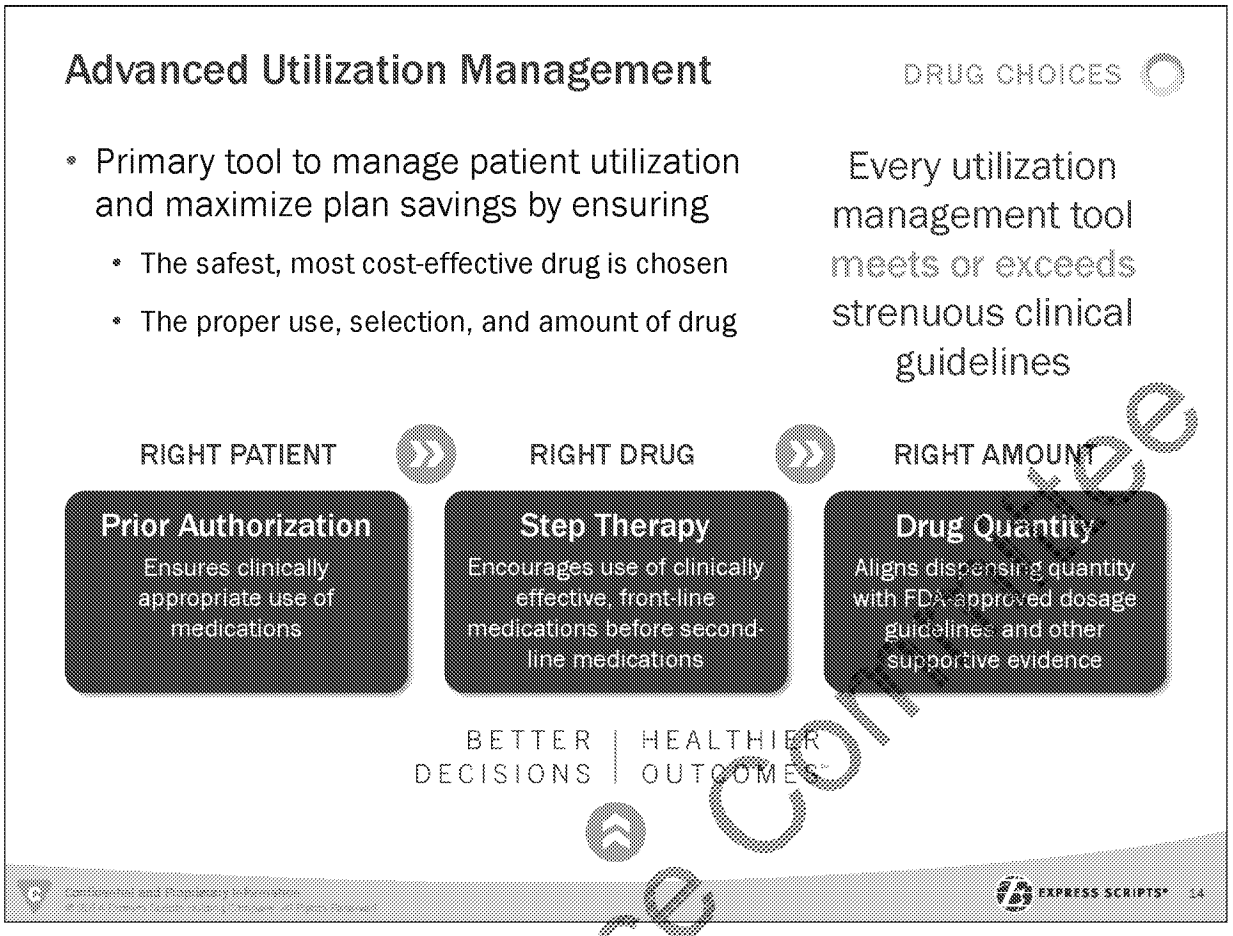
Potential Therapy Class Exclusions
2015 Classes

Diabetes	»	• Basal Insulin • SGLT-1
Asthma	»	• Long Acting Muscarnic Antagonists • Long Acting Muscarnic Antagonists/ Beta Agonist Combo
Specialty	»	• Erythroid Stimulants • GNRH Antagonists

Select medication with the same clinical effectiveness that drives to the least amount of waste

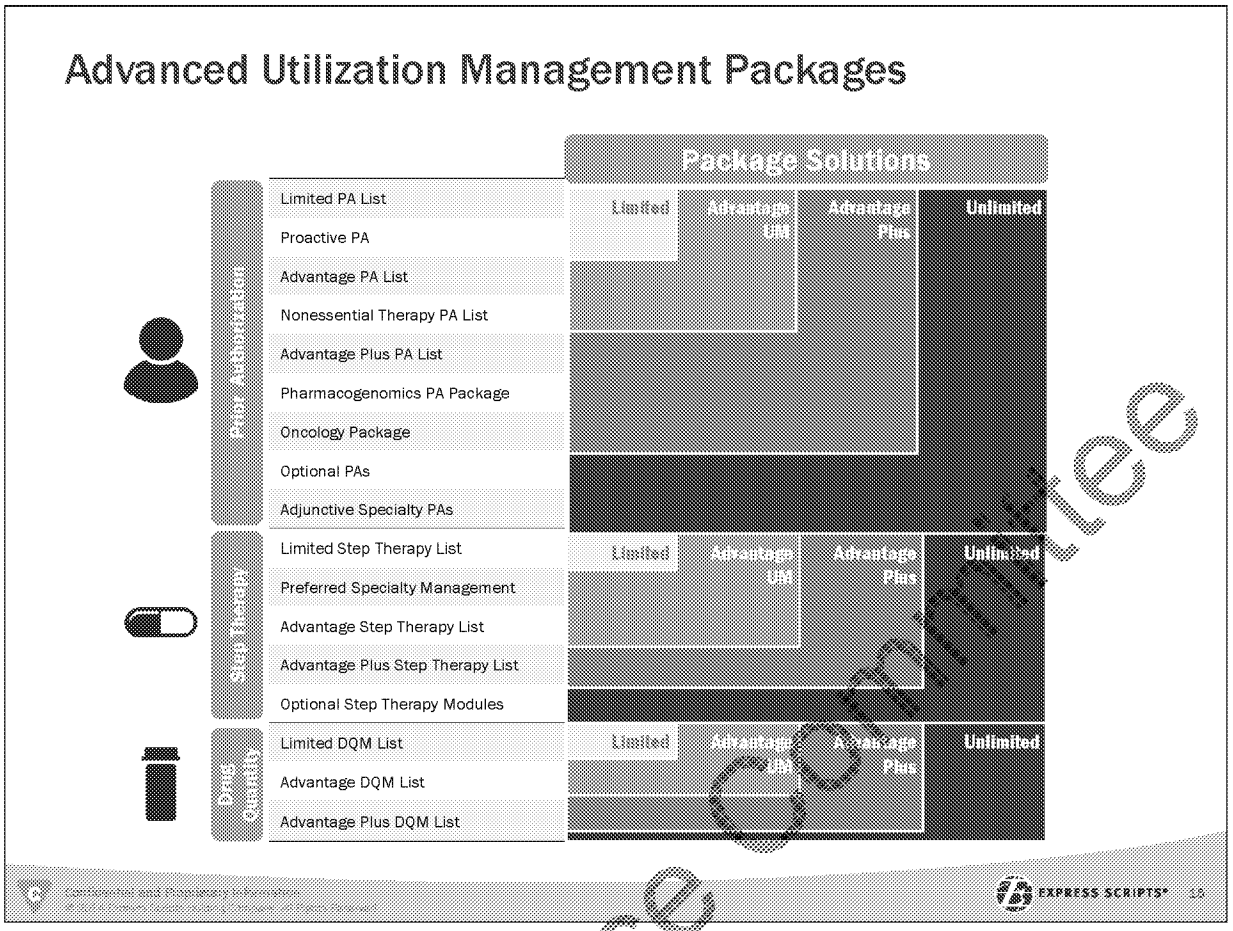
Advanced Utilization Management (AUM)





Setup
In the portfolio of clinical products offered by Express Scripts, Advanced Utilization Management programs are the primary tool to managing patient utilization using Health Decision Science principles.
To make sure the safest, most cost-effective drug is chosen, AND
To ensure the proper use, selection, and amount of drug
Utilization management boils down to managing the drug choice to the Right Patient—Right Drug—Right Amount

Overview
The three primary Advanced Utilization Management program offerings are :
Prior Authorization which is the baseline for ensuring clinically appropriate use of a medication
Step Therapy which encourages use of front-line medications before second-line medications, AND
Drug Quantity which aligns dispensing quantity with FDA-approved dosage guidelines as well as other clinical evidence



Clients have been able to target specific drugs or specific lists. However, effective 1/1 we packaged solutions allowing clients to be prepared and ready for appropriate utilization when their population changes.

New for 1/1 - Package Solutions
Limited: Delivers plan savings on lower-utilized, high-cost medications with minimal member impact
Advantage: Everything in Limited + Provides solutions for chronic disease states as well as broad specialty offering
Advantage Plus: Everything in Advantage + Includes traditionally under-managed classes that treat select chronic disease states
Unlimited: All-inclusive option for all UM programs

Clients have plenty of options to ensure their members are taking the RIGHT amount of the RIGHT drug at the RIGHT price.

Pricing Philosophy

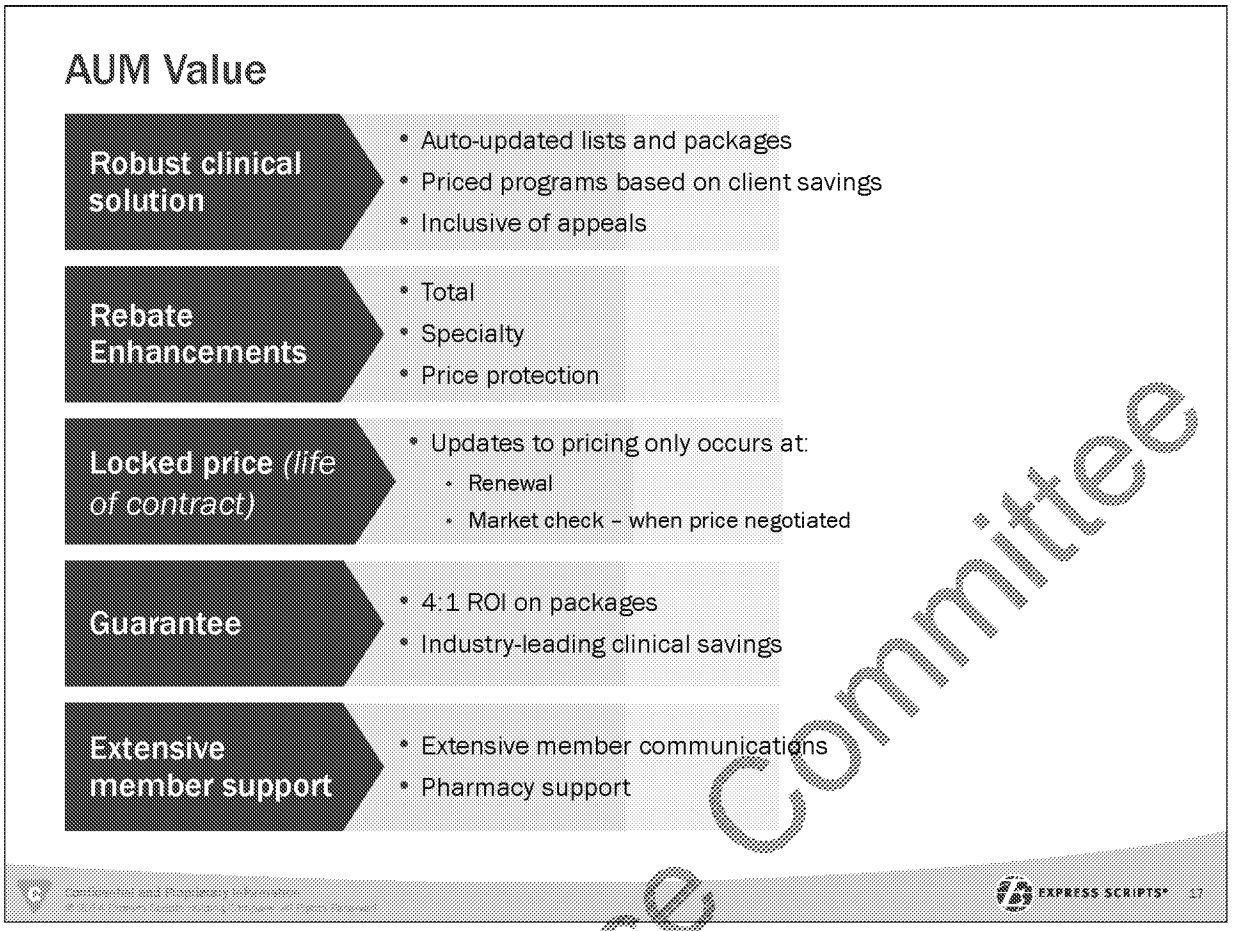
Packages combine best practices, established rules and predictive modeling to provide a comprehensive solution with superior clinical value

1. Client value
2. Proactive clinical services
3. Member experience support
4. Savings guarantee

Increased savings with packaged AUM solution

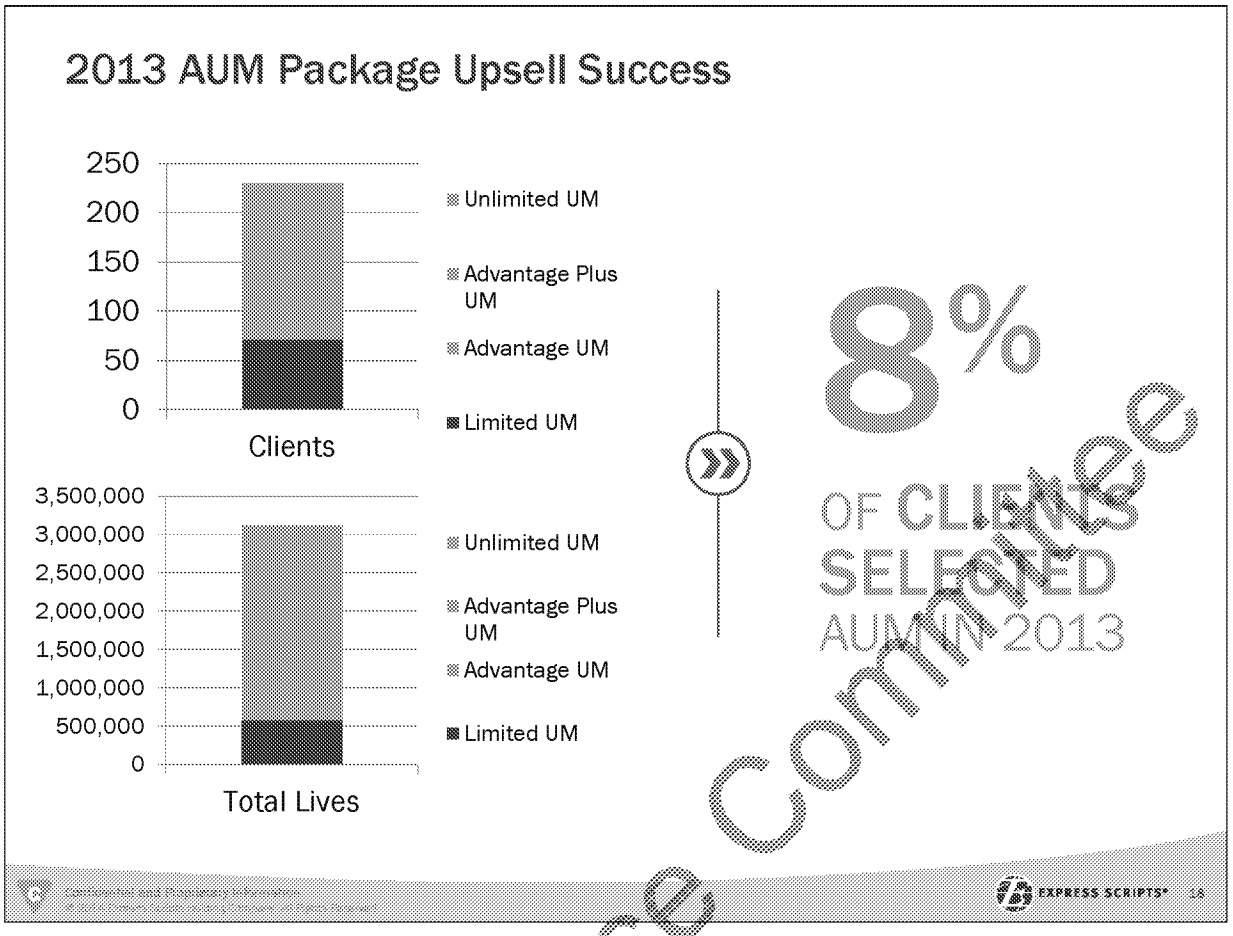
with a **4:1 ROI** client guarantee

Modeled clinical savings for each program 73% (4/15) have > 5:1 ROI
Programs that don't (Proactive, Oncology, Adjunctive Specialty, PSM) are due to low BoB utilization, but they have huge upside



Had opportunity to create best in class clinical offering
Took best practices from both organizations (evaluated >2,100 rules)

Member communications
Pre-Notification on ST, PA, DQM
Rapid Response letter to member and MD



Intended for INTERNAL audience

230/3032 = 8% clients
3.2M/34.7M = 9% Commercial Lives

2013 was the year of:
Integration and Migration
Pebble (NPF)
Sitting almost 3 weeks into 2014, and the world is not perfect
However, we've had ALMOST NO problems with members and NPF

2014
Walk into clients and tell them that they hired us to be the best PBM in the industry
We just provided significant rebate uptake
Little member noise
Wrap the NPF with clinical programs that will save clients additional money

Fraud, Waste and Abuse

Member and Physician Fraud and Abuse

- Unusual prescribing patterns
- Excessive utilization behavior
- Rising prescription drug costs

Abuse costs
$41,000
in medical claims
for every $1,000
in prescription
drug claims*

Healthcare Fraud Costs an Average of
$72 Billion Annually

* Research from WellPoint, Inc. Dec. 2007. Average 41:1 medical to pharmacy cost ratio. http://www.insurancefraud.org/downloads/drugDiversion.pdf

Fraud, Waste & Abuse – Service Comparison

Base FWA – Standard Services

- Standard network-wide pharmacy monitoring and audit
- Identification of fraudulent pharmacies
  - Express Scripts notifies clients that have exposure at a potential fraudulent pharmacy
- Fraud tips (reactive)
  - External fraud tips from retail pharmacies, prescribers, or law enforcement investigated

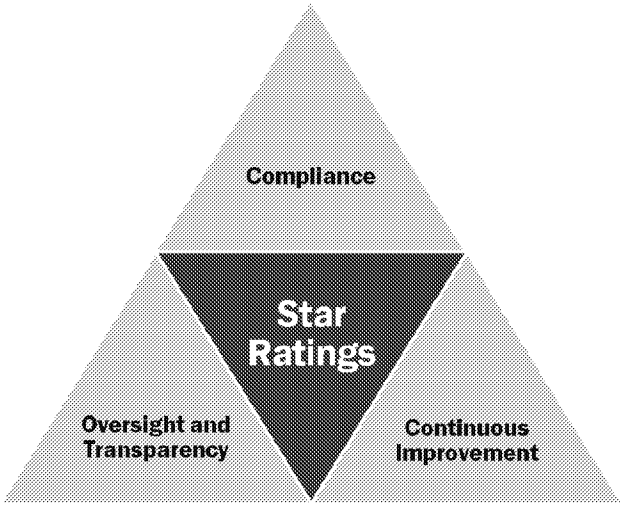
Enhanced Member-Prescriber FWA

- Proactive Advanced Analytics
  - Client-specific claims review
  - Identification of potential member & prescriber fraud
- Full Service Investigations
  - Express Scripts obtains evidence to confirm or dismiss allegations
  - Express Scripts completes detailed, written investigation reports
  - Integrate medical claims with prescription investigations (when possible)
- Client Consultation

Medicare Utilization Management

EXPRESS SCRIPTS®

Medicare UM Solution
The Right Amount of the Right Drug at the Right Value



Medicare UM includes CMS-compliant versions of the three UM solutions:

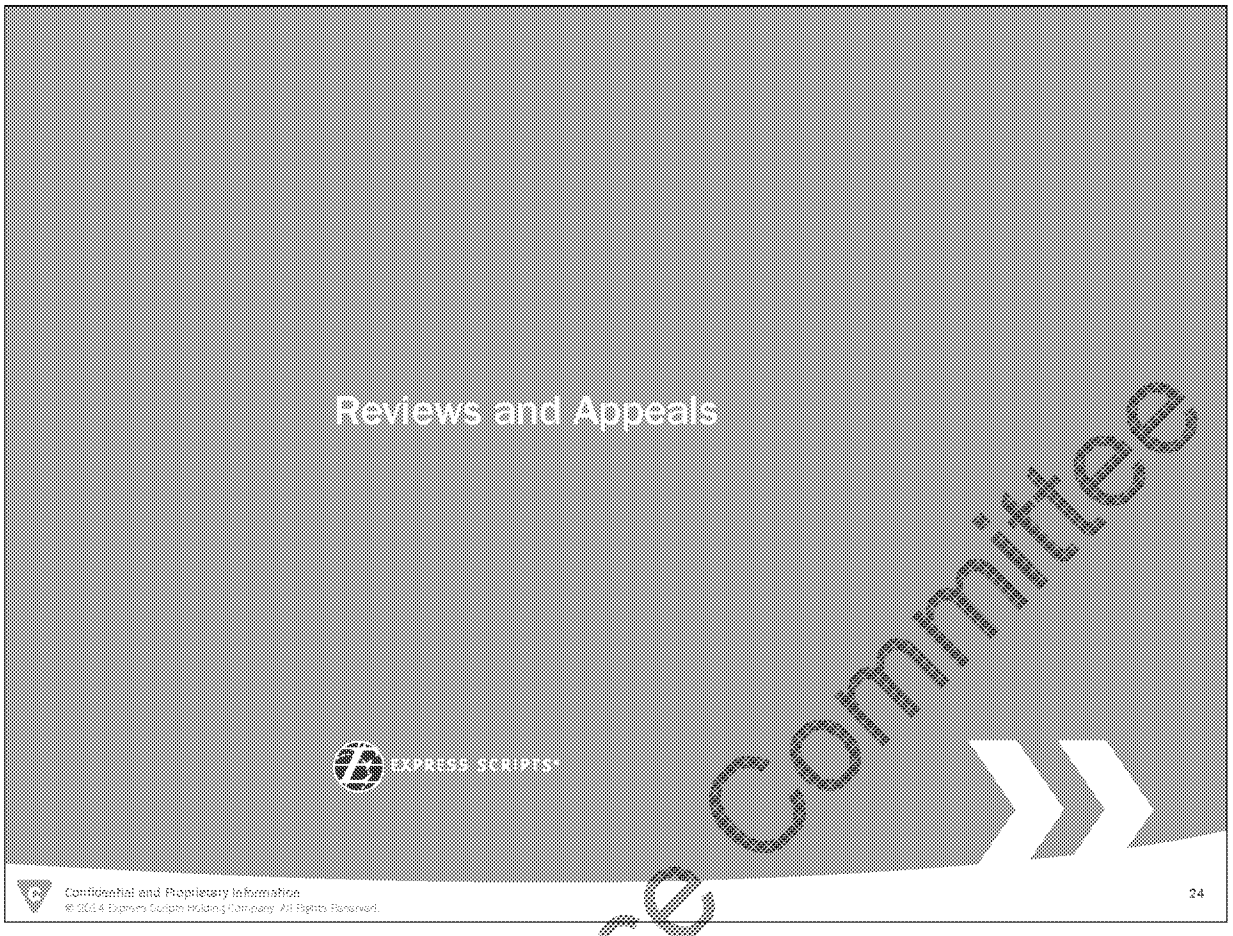
- Prior Authorization
- Step Therapy
- Drug Quantity Management

Assess Value of each rule based on:

- Approval rate
- Total plan cost savings
- Plan PMPM savings

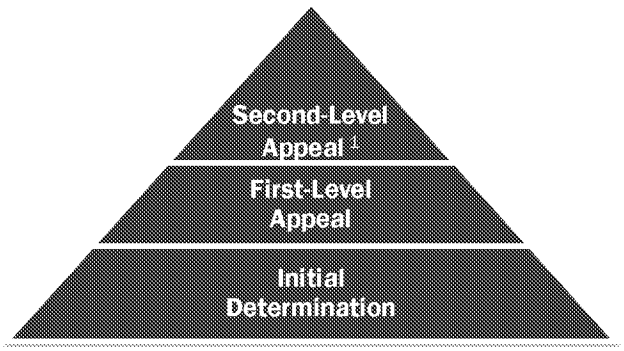
Medicare Landscape
Star Ratings are key indicator of quality
5 Star Special Election Period
CMS functional audits
Demonstration plans
Plan sponsor oversight
Timely CMS notification
Operational excellence

Reviews and Appeals



Reviews and Appeals

- Comprehensive process for managing review and appeal requests for pharmacy benefit coverage decisions
- Processes are governed by complex Federal and state regulations
- Standard Federal process consists of two levels of internal appeals



Express Scripts offers a process for **ALL levels** of clinical and administrative reviews and appeals

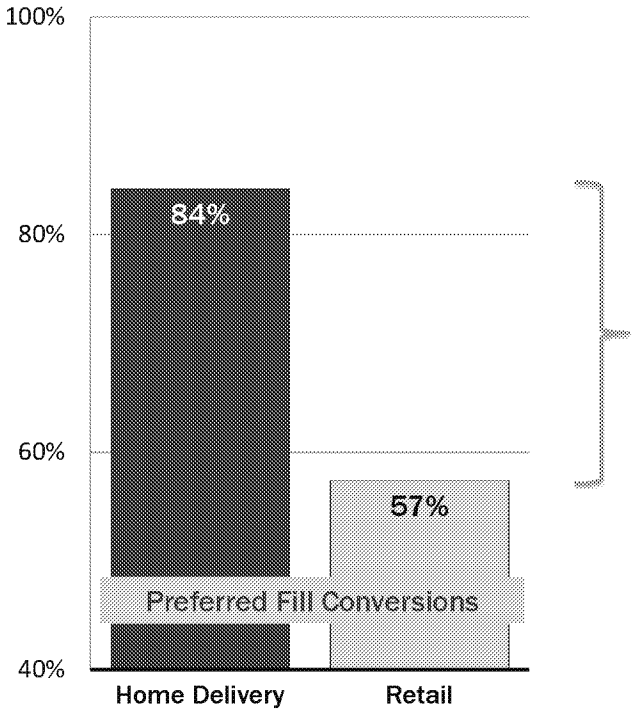
[1] Medicare process differs from standard Federal process, i.e. second-level appeals are managed by an Independent Review Entity contracted by CMS

Other Initiatives

Compound Strategy	»	Own organizational compound strategy and sell-in process to reduce compound cost to clients and minimize margin impact to ESI
CRD Reconciliation	»	Identify and drive solutions to improve operational efficiencies and enhance the provider experience. Support CRD through stronger criteria assessment and forecasting
Billing Optimization	»	Partner with Finance, Billing and IT for improved billing functionality and accuracy
Biosimilars	»	Refine a strategy and positioning to further differentiate us in the handling of biosimilar products to further demonstrate ability to control Specialty costs

Appendix

Home Delivery Conversions Exceed Retail



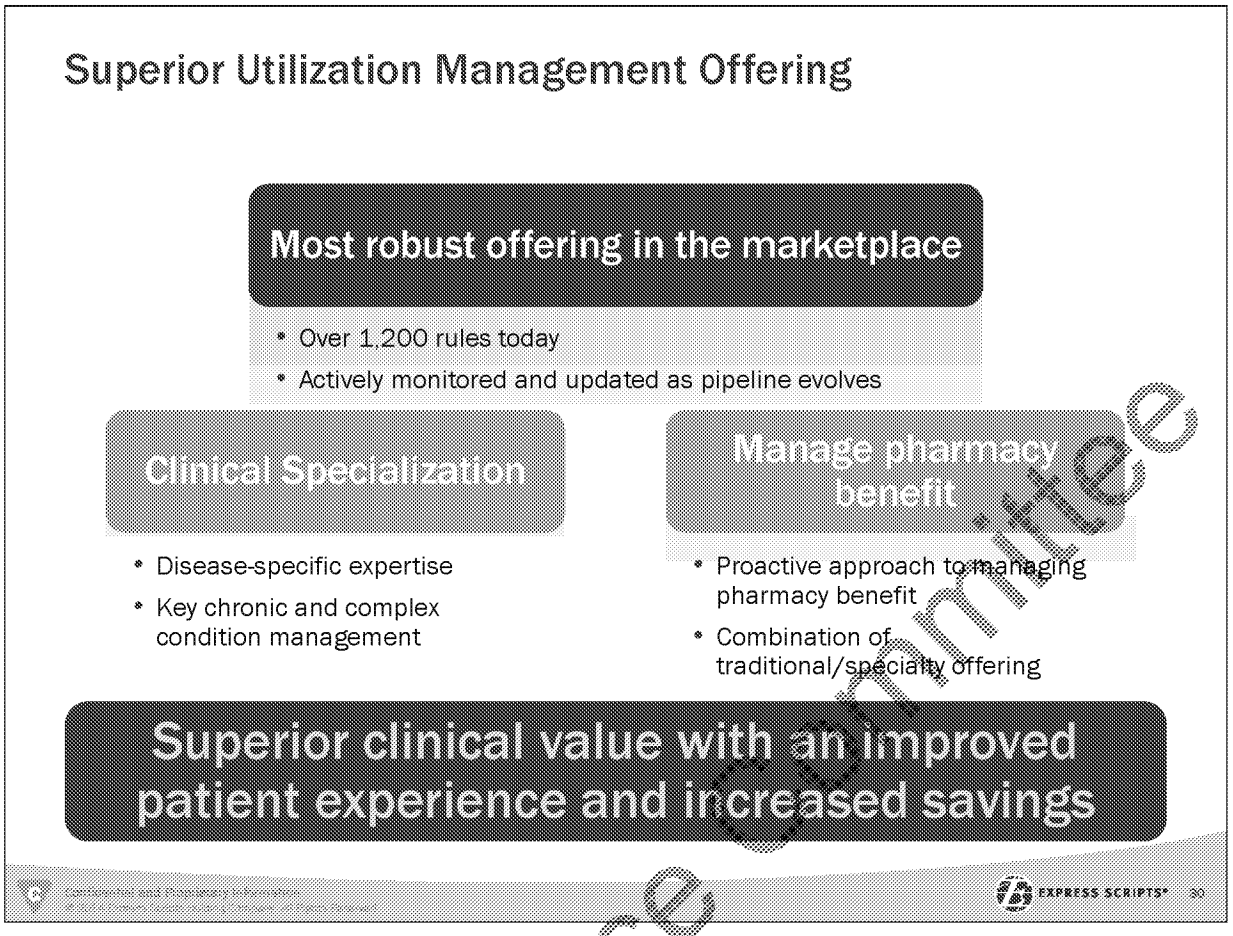
46%

Greater Share Shift at Home Delivery

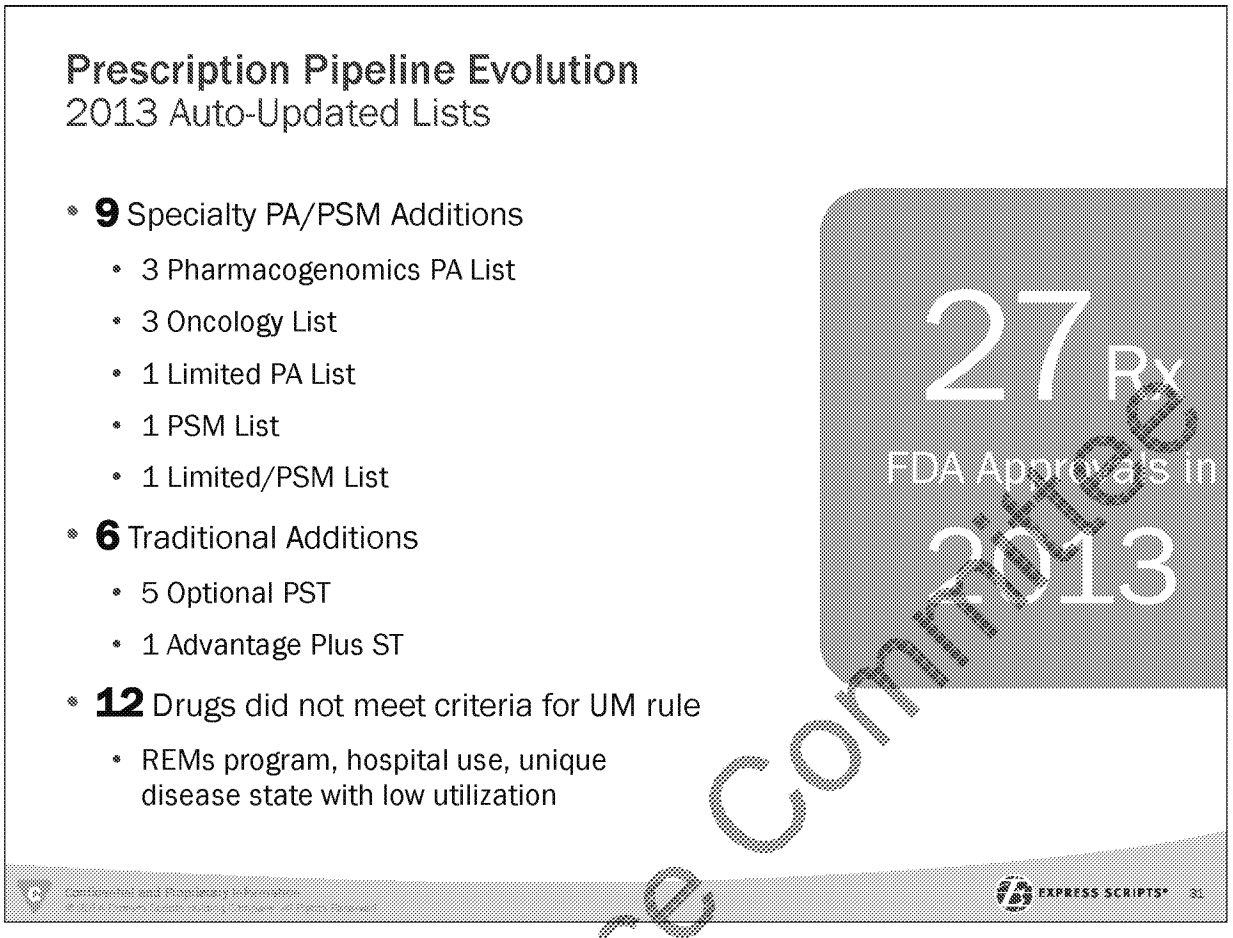
Results as of 3/14/14

Let's start with what has NOT changed with our utilization management programs. Utilization Management includes programs that address three different plan concerns.

Prior Auth: Applies evidence-based authorization criteria to ensure patients use the Rx that is clinically appropriate for their condition. 3-5% projected savings relative to client spend.
Step Therapy: Encourages patients to use clinically-effective, front line Rxs before second-line Rxs. Also uses patient and physician communications and pharmacy POS messaging to support programs. 4-6% projected savings relative to client spend.
Drug Quantity Management: Promotes appropriate dispensing by aligning quantities with FDA-approved dosage guidelines and other medical evidence. Also ensures proper claim processing and prevents medication stockpiling. 1-2 % projected savings relative to client spend.



ST Categories PSM
ESI 26 15
CVS/Caremark 18
Catamaran 15
Optum



Kadcyla- Rolled into PGx PA List
Olysio- Rolls into PGx PA List
Sovaldi- Rolls into PGx PA List
Adempas- Roll into Limited PA List
Opsumit- Rolls into Limited PA List and PSM
Tecfidera- Rolled into PSM
Gilotrif- Rolled into Oncology Package
Tafinlar- Rolled in Oncology Package
Mekinist- Rolled in Oncology Package

No UM
Kynamro – REMs program
Pomalyst, Imbruvica – Utilization extremely low and similar to Revlimid; Revlimid has very low denial (including appeal overturns) . ESI will monitor utilization to determine if future add
Xofigo – Radio-isotope – no pharmacy utilization
Rixubis/Novoeight – Hemophilia product; d/t complexity, specialty RPhs must mix and utilize
Gazyva – IV chemo product – hospital

2013 AUM Target Brand Medication Inflation Costs

	Average % Increase	Average Annual Medication Cost
• Limited PA	10%	$5,432
• Advantage PA	13%	$2,232
• Advantage Plus PA	29%	$2,135
• Non Essential Therapy PA	13%	$256
• Proactive PA	20%	$12,609
• Oncology PA	18%	$7,23[illegible]
• Adjunctive Specialty PA	18%	$4698
• Limited Step Therapy	15%	$237
• Advantage Step Therapy	11%	$110
• Advantage Plus Step Therapy	15%	$274

Pharmacy & Physician Lock-In

1. Restrict member to one pharmacy and/or physician for all controlled substances and muscle relaxers
2. Efficiently manages and reduces risk within membership
3. Completed through series of letters to member

Automatic Pharmacy Lock	Client Choice Pharmacy Lock | Physician Lock | Pharmacy & Physician Lock

• Express Scripts initiates process once abuse allegation is confirmed
• Series of letters notify member of restriction
• Member chooses pharmacy
	• Decision made by client on a case by case basis
	• Client chooses to restrict member to one pharmacy and/or physician
	  ◦ Series of letters notify member of pharmacy restriction; enable member to choose pharmacy
	  ◦ Client must choose physician to be locked
	  ▪ Member and physician notified of lock

Enhanced Fraud, Waste and Abuse Program

The industry's most comprehensive solution

Analyze	Investigate	Consult
Advanced analytics proactively identify abusers	SIU consisting of former law enforcement and clinical professionals	Communicate outcomes & implement interventions
▪ Relationships, patterns, & scenarios ▪ Identify and review outliers ▪ Flag suspicions for investigative review	▪ Gather and review evidence ▪ Leverage industry-leading investigative expertise ▪ Generate actionable investigative report	▪ Collaborate to review medical cost opportunities ▪ Ensure ongoing case collaboration ▪ Share best practices to mitigate risk

Program Benefits

Patient Focused

Helps promote patient health and safety

Savings

Average ROI of 3:1 – helps reduce costs associated with prescription drug spend

Peace of Mind

Helps ensure compliance, identify potential abuse quickly, and promote overall risk management

RFP #31786-00143 *PRO FORMA* CONTRACT

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

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,

LOCAL EDUCATION INSURANCE COMMITTEE,
AND LOCAL GOVERNMENT INSURANCE COMMITTEE
AND
CONTRACTOR NAME

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee ("State") and CONTRACTOR LEGAL ENTITY NAME ("Contractor"), is for the provision of a pharmacy benefits manager for the Public Sector Plans, as further defined in the "SCOPE." State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is A/AN INDIVIDUAL, FOR-PROFIT CORPORATION, NON-PROFIT CORPORATION, SPECIAL PURPOSE CORPORATION OR ASSOCIATION, PARTNERSHIP, JOINT VENTURE, OR LIMITED LIABILITY COMPANY.
Contractor Place of Incorporation or Organization: LOCATION
Contractor Edison Registration ID # Number

A. SCOPE:

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

The Contractor shall provide pharmacy benefit management services, which shall include custom clinical programs as required, specialty care management, Formulary management, network management, Member services, and an online POS pharmacy claims processing system. This POS system shall include a state-wide Retail Pharmacy network, prospective/concurrent DUR, Retro-DUR, utilization management, reporting capabilities, adjudication capabilities, and full pharmacy benefit Member services for retail, Mail Order Service and Specialty Pharmacy benefits for Members.

A.2. Definitions shall be as follows and as set forth in the Contract:

a. **Administrative Fee** – The fee for pharmacy benefit management services paid by the State to the Contractor. The Administrative Fee is the only compensation due the Contractor under the contract, unless the Contractor also bid a Clinical Fee. The Contractor's monthly compensation is a function of the contractor's Administrative Fee multiplied by the number of participating Members per month ("PMPM"). The State recognizes that Clinical Fees are not included in the Administrative Fee The State also recognizes that the Contractor may make a margin on mail and Specialty Drugs that it dispenses out of its own pharmacies.

b. **At-Risk Performance Payment** – Contractor's payment based on KPI performance listed on the SLA Scorecard set forth in Contract Attachment D. The payment is calculated based on the SLA Scorecard quarterly score and percentage of the administrative fees at risk.

c. **Average Seconds to Answer ("ASA"):** The mean time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a Member services representative at the call center Answers the call. For this definition, the term "Answer" shall mean begin an uninterrupted dialogue with the caller. If a Member services representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be Answered for purposes of this definition until the Member services representative returns to the caller and

begins an uninterrupted dialogue. If a caller requested a returned call using the dial-back feature the ASA shall be defined as the time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time of the returned call (regardless of whether the Member answered).

d. **AWP** - Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP amount is provided by commercial publishers of drug pricing data such as Medi-Span.

e. **Benefits Administration ("BA") -** The division of the Tennessee Department of Finance & Administration that administers the Public Sector Plans.

f. **Biosimilar Drug -** a type of biological product that is licensed (approved) by the FDA that is highly similar to a biological product already approved by the FDA not withstanding minor differences in clinically inactive components; and that there are no clinically meaningful differences between the biologic product and the reference product in terms of the safety, purity, and potency of the product.

g. **Brand Drug** – The innovator drug product submitted to the FDA for approval. A Brand Drug is a drug produced and distributed with patent protection or after the patent protection has ended, represents the original innovator drug before patent protection ended. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as MS generics and must not be included in the Single Source Brands bucket for the purpose of pricing or guarantee reconciliation.

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

i. **Clean Claim** - A claim received by the PBM for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the PBM.

j. **Clinical Fee** – The clinical fee (if applicable) paid to the Contractor for their management of clinical programs such as dose optimization programs, generics first programs, safety & monitoring reviews, and prior authorization, quantity limits, and Step Therapy edits as well as prior authorizations and appeals.

k. **Coinsurance** – That percentage of the charge for each drug dispensed to the Member that is the responsibility of the Member.

l. **Compound Prescription** – A prescription that is not commercially available in the strength or quantity prescribed by the physician and meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed and measured then prepared according to the prescriber's order. It excludes the addition of any flavoring to any prescription or medication requiring reconstitution (e.g. powdered oral antibiotics, topical acne preparations, etc.).

m. **Copayment** - That portion of the charge (flat dollar amount) for each drug dispensed to the Member that is the responsibility of the Member.

n. **Day(s)** – Calendar day(s) unless otherwise specified in the Contract.

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

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

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

r. **Disaster** - A negative event or act of nature that significantly disrupts business operations for more than twenty-four (24) hours.

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

t. **Dispensing Fee** – An amount paid by the Contractor to a participating pharmacy per claim for providing professional services necessary to dispense medication to a Member.

u. **Dispense as Written-9 ("DAW-9")** - An all-purpose code used whenever an existing code does not accurately describe the note required when a pharmacist or pharmacy technician enters the prescription into the POS system at the pharmacy. These codes are not to be used in any Rebate calculations or reconciliations, as they tend to be a catch-all category that provides no detailed value or information to the State or Pharmacy Benefit Manager.

v. **Decision Support System ("DSS")** - A database and query tool based on health care information and claims data which allows for analytics and executive decision making. Also known as an Executive Information System ("EIS").

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

x. **Formulary** – The list of clinically appropriate, cost-rational prescription drugs covered by the State health benefit plan/State employee health benefit plan, organized into different 'tiers' or levels indicating how much the Member cost share (Copayment/Coinsurance) will be for each drug.

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

z. **Generic Drug** – A prescription or an OTC drug that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA or a drug that is lawfully marketed as a DESI Drug. Generics shall include all drugs with an approved Abbreviated New Drug Application ("ANDA"), single-source generics drugs, MS Generic Drugs, products involved in patent litigation, house Generic Drugs and Generic Drugs that may only be available in limited supply. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as MS generics and must not be included in the Single Source Brands bucket for the purpose of pricing or guarantee reconciliation.

aa. **Generic Product Identifier ("GPI")** – A six-digit code, which includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.

bb. **House Generic Drug** - a Brand Drug submitted with a Dispense As Written ("DAW") 5 code in place of their generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug Discount

guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug.

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

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

1. For retail, Ingredient Cost means the lowest of
   - U&C Price;
   - MAC, where applicable; or
   - AWP less all applicable Discounts or other applicable reimbursement amounts negotiated with the participating Retail Pharmacy and that adheres to the guaranteed AWP Discount percentage set forth in the contractor's pricing.
2. For brands dispensed via the contractor's Mail Order Service and specialty pharmacies, Ingredient Cost means the Discounted price using the guaranteed AWP Discount percentage set forth in the price schedule(s).
3. For generics dispensed via the contractor's Mail Order Service and specialty pharmacies, Ingredient Cost means the lower of the MAC, where applicable, or the Discounted price using the default AWP Discount percentage set forth in the Price Schedule(s). Ingredient Cost does not include the Dispensing Fee, the Copayment, Coinsurance, deductibles or sales tax, if any.

ee. **Identical, Related or Similar ("IRS")** - Drugs that are identical, related or similar to drugs identified as LTE (less than effective) by the FDA.

ff. **Key Performance Indicators ("KPI")** - Performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Section C and Contract Attachment D.

gg. **Lock In** - A restrictive logic that limits claims at POS to selected prescribers or pharmacies. Members under this restriction are said to be "locked-in".

hh. **Less Than Effective ("LTE")** - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

ii. **Limited Distribution Specialty Drug -** those Specialty Drugs only available through select pharmacy providers as determined by the drug manufacturer.

jj. **Mail Order Service** – A service whereby medications are delivered via mail. Mail Order Service is typically used for maintenance drugs taken by Members on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or a chronic heart condition.

kk. **Maximum Allowance Cost ("MAC")** – A cost management program that sets upper limits on the payment for equivalent drugs available from multiple manufacturers. It is the highest unit price that will be paid for a drug and is designed to increase generic dispensing, to ensure the pharmacy dispenses economically, and to control future cost increases.

ll. **MAC List** – A list of Multi-source drugs that are reimbursed at an upper limit per unit price. The list is developed and maintained by the Contractor and is usually reviewed quarterly but

individual drug prices may be adjusted more frequently. MAC Lists vary among PBMs. Considerations for inclusion on the MAC list include: availability of the Generic Drug from multiple manufacturers; clinical implications of generic substitution; national availability of generic versions; price differences between the brand and generic; therapeutic equivalence; and volume of claims.

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

nn. **Member** - Eligible employees and their dependents, retirees and their dependents and/or survivors, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and their dependents, who are enrolled in the health plan options sponsored by the State, Local Education, and Local Government Insurance Committees.

oo. **Middle Tier** – A claims trading format which allows real time trading of deductibles, maximum out of pocket amounts and other such accumulator data between two or more contractors, for the purpose of maintaining in real time Member and family deductibles and maximum out of pocket costs (pharmacy and medical combined).

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

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

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

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

tt. **Paid Claim** – A claim that meets all plan established coverage criteria and is paid by the PBM and submitted to the plan for reimbursement.

uu. **Pass-Through Transparent Pricing** – An arrangement whereby the client receives the full value (100%) of the Contractor's negotiated Discounts and Dispensing Fees at retail, and the full value of Rebates. The contractor's only profits are the Administrative Fee and any clinical program fee, and any margin they make for mail prescriptions and specialty prescriptions filled through the Contractor's own Specialty Pharmacy. All financial negotiated Retail Pharmacy contracts and Rebate contracts are fully disclosed to and auditable by the client. The client is protected in this model by requiring guaranteed Discounts, fees, and Rebates from the PBM Contractor. Discounts and Rebates achieved on the client's behalf that exceed the financial guarantees are payable to the client. Dispensing Fees that are paid lower than the guaranteed are also passed through to the client. Hence, the financial guarantees are the minimum Discounts and Rebates the client will achieve and the maximum Dispensing Fees and Administrative Fees the client will pay.

vv. **PPACA** – the federal Patient Protection and Affordable Care Act, Public Law 111-148.

ww. **PPO** - Preferred Provider Organization.

xx. **Pharmacy Benefit Manager ("PBM")** – State's Contractor which provides pharmacy benefit management services.

yy. **Pharmacy and Therapeutics ("P&T") Committee** - A panel of experts consisting of physicians, pharmacists and clinical experts who assist PBMs in developing Formularies and preferred drug lists which are clinically appropriate and cost rational.

zz. **Physician Profiling**- A means of comparing prescribing behaviors (or other medical orders) among doctors in order to benchmark and/or improve quality of care by providing physicians with meaningful information on their clinical performances. Hence, the success of profiling should be measured by evidence of improvement over time in the structures, processes, and outcomes of care. Physician information is often sorted by specialty or diagnosis, and profiling can be used in a managed care setting as an incentive for quality improvement. Physicians are often given data such as that listed below at monthly or quarterly intervals:

- Formulary compliance
- Generic utilization
- mail/retail
- top drugs by cost
- top drugs by # of prescriptions
- total prescriptions
- total cost to the plan

aaa. **Plan Documents** - The legal publication that defines eligibility, enrollment, benefits and administrative rules of the Public Sector Plans and are posted on the BA website.

bbb. **PMPM** - Per Member Per Month

ccc. **Protected Health Information ("PHI")** - As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.

ddd. **POS** - Point-of-Sale.

eee. **Pre-Service Appeals** – an appeal from a covered plan member or prescribing clinician before the plan member initiates actual filling of a prescription at a retail, mail order, or specialty pharmacy. Such an appeal may come in the form of a prior authorization request from the prescriber in which case the Contractor will render an approval and prior authorization number and length of time the authorization is approved or a denial on the PA request.

fff. **Post-Service Appeals** – an appeal from a covered plan member or prescribing clinician after the plan member or prescribing physician's initial request for initial prior authorization is denied and the next level of appeal is then initiated.

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

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

iii. **Public Sector Plans ("Plan") -** Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees (e.g. health plan options, life insurance, other voluntary benefits). The Plan is available to eligible employees and dependents of participating State (Central State and Higher Education), Local Government, and Local Education agencies.

jjj. **Rebates -** All revenue received by the Contractor from outside sources related to the Plan's utilization or enrollment in programs also known as Total Manufacturer Value. Also, the amounts paid to the contractor (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on the Contractor's Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescription drugs by Members. These would include: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite pharmacy claims, low day supply claims, Generic Drug claims, Biosimilar Drugs, Formulary access fees, service fees, Rebate Administrative Fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse contractors, Discounts, credits, inflation protection, charge backs, commissions, and any fees received for sales of utilization data to a pharmaceutical manufacturer. Rebates will also exclude purchase Discounts (e.g. prompt pay Discounts) from mail and specialty products. Further, Specialty Drug manufacturer coupons cannot be considered manufacturer revenue and do not count toward the calculation or reconciliation of Rebates. DAW-9 claims are to be excluded from the calculation of Rebate guarantees.

kkk. **Retail Pharmacy** – A Retail Pharmacy establishment at which prescription drugs are dispensed by a registered pharmacist under the laws of each state.

lll. **Retail Pharmacy 90-Day Network or 90-Day-At-Retail** – A network Retail Pharmacy that offers a 90-day supply of medications for chronic conditions also known as maintenance medications. The Discounts, Dispensing Fees and Rebates are significantly better than retail and similar to mail.

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

nnn. **Secure File Transfer Protocol ("SFTP")** - SFTP is a secure file transfer protocol. It runs over the SSH (Secure SHell) protocol. It supports the full security and authentication functionality of SSH. SFTP can furthermore be used for file sharing, similar to Windows file sharing and Linux NFS. SFTP supports both interactive and automated file transfers.

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

ppp. **Specialty Drugs** – Specialty Drugs must meet at least two of the first four criteria (a thru d) below and the final criteria (e)-

1. Produced through DNA technology or biological processes
2. Targets a chronic or complex disease
3. Route of administration could be inhaled, infused or injected
4. Unique handling, distribution, and/or administration requirements
5. Requires a customized medication management program that includes medication use review, patient training, and coordination of care and

adherence management for successful use such that more frequent monitoring and training is required.

qqq. **Specialty Pharmacy** – A pharmacy that dispenses Specialty Drugs to patients focusing on additional services such as enhanced clinical management, increased adherence, guideline management, and enhanced distribution services.

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

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

ttt. **Step Therapy** - The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as preceding treatment option fails. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug and the Step Therapy rule was not met, the claim is rejected, and a message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.

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

vvv. **Total Manufacturer Value** – See Rebates

www. **Transparent** – An arrangement pursuant to which the Contractor discloses all sources of revenue, including revenue from network pharmacy contracts and from prescription drug manufacturers, directly attributable to and specifically derived from utilization of prescription drugs by the Contractor's plan Members. Pass-through Transparent Pricing is fully auditable by the client including all pharmacy and drug manufacturer contracts. Traditional Transparent pricing discloses retention of Spread but usually does not permit auditing of pharmacy or drug manufacturer contracts nor does it usually disclose the exact dollar amount of the Spread retained by the PBM.

xxx. **Usual and Customary ("U&C")** – Retail price charged by a participating pharmacy for the particular drug in a cash transaction on the date the drug is dispensed, as reported by the Retail Pharmacy. U&C shall include all applicable customer Discounts (e.g., generic promotion, special customer, senior citizen, frequent shopper, Discount club, Discount card program, etc.).

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

zzz. **Zero Balance Due or ZBD** - a Brand Drug submitted with a Dispense As Written (DAW) 5 code in place of their generic equivalent and where the pharmacy is reimbursed at a Generic

Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug Discount guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug. "House Generics" means a Brand Drug submitted with a DAW 5 code in place of their generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug Discount guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug.

A.3. Pharmacy Benefit and Policies

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

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

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

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

A.4. Plan Implementation

a. The pharmacy benefit for the Public Sector Plans will take effect and be fully operational on the go-live date specified in Contract Section A.30.

b. The Contractor shall implement the systems required to process all Plan pharmacy claims and all other services described herein. The Contractor shall work with the State to ensure that the program satisfies the functional and informational requirements as outlined by this Scope and in the Plan Document.

c. The Contractor shall provide a dedicated full-time implementation team. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of pharmacy benefit services for at least one other large employer (employers with pharmacy plans covering at least 100,000 lives). The Contractor's

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

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

e. The Contractor shall provide a project implementation plan as specified in Contract Section A.30. The plan shall be electronically maintained daily in Microsoft Excel or Microsoft Project. The plan shall detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily install the program no later than the go-live date specified in Contract Section A.30 and a description of the members on the transition team and their roles. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:

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

f. The Contractor shall schedule an on-site implementation meeting at the State of Tennessee offices in Nashville, TN as specified in Contract Section A.30.

g. The Contractor shall provide a comprehensive operational readiness review (pre implementation audit) to the State at least sixty (60) days prior to the pharmacy benefit go-live date, as long as the State and the Contractor have met all implementation milestones

necessary for the audit. The Contractor shall pay for the comprehensive readiness review to ensure the plan design, eligibility and financial contract terms have been set up correctly.

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

(1) Policy and procedures manual;

(2) Information systems;

(3) Any and all deliverables and reports;

(4) System testing for all plan options (PPOs, CDHPs, etc.) for correct member cost share (deductible, copayments and/or coinsurance) for generics, preferred brand drugs, non-preferred brand drugs at both mail order and retail pharmacies and at 30 day and 90 day supplies as well as maintenance tier medications at lower cost share for those filled in a 90 day supply; and

(5) Copies of Contractor's proposed member handbooks or welcome letters/kits and the front and back of the Contractors' proposed pharmacy benefits ID card for plan members for the term of this contract.

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

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

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

k. No later than forty-five (45) days post-implementation, the Contractor shall provide the State with an implementation performance assessment, which will be completed and provided back to the Contractor. This assessment will be used to document the State's satisfaction with the implementation process.

A.5. Staffing

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

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

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

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

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

f. At a minimum, the account manager shall meet in person with the State once a month and more often if requested by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference.

g. The Contractor shall survey the State annually during the contract period to determine the State's satisfaction with the ongoing account team. Results of the survey should be included in the State's mid-year review, if not sooner.

h. The Contractor shall train all Contractor staff and subcontractors regarding all applicable aspects of the Plan pharmacy program. The State shall approve the Contractor's

subcontractors or its staff as defined in Contract Section D.7. Core services are defined as those that touch or affect the Member, specifically Member customer services, Member call center, mail and Specialty Pharmacy services (if used by the Member), claims processing and adjudication, appeals processing at all levels. Also included are such services that affect the plan administrator such as the Contractor's account team that interacts with the State on a daily basis through telephone calls, emails, and face to face meetings, clinical advisors or pharmacists on the account team, and the Contractor's pharmacy & therapeutics ("P&T") committee which develops the Contractor's standard national drug Formulary.

i. At the State's request, the Contractor must replace staff members or subcontractors providing core services. The decision of the State on these matters shall not be subject to appeal.

j. Key personnel commitments (implementation or ongoing account manager and chief pharmacist) made in the Contractor's proposal shall not be changed unless the Contractor receives prior approval In Writing from the State. The Contractor shall notify the State at least fifteen (15) Business Days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact. The decision of the State on these matters shall not be subject to appeal.

k. Key staff on the Contractor's account team includes an Account Manager, Strategic Account Executive, and Clinical Pharmacist. The Strategic Account Executive has overall responsibility for the state contract and ensuring that all contract requirements are met, the majority of reports and other deliverables are provided and that the benefits are executed properly as well as providing long-term vision and feedback of plan benefits and working on fiscal notes with State staff. The Account Manager has responsibility for day-to-day operations and management of the pharmacy benefits, member issues, account issues, and interfacing with the State's service center team leads on member or eligibility issues that may arise. The Clinical Pharmacist is responsible for formulary development and discussion as well as assisting State staff on any clinical issues that may arise. If any of these key positions become vacant, Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement In Writing.

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

m. The Contractor, if requested by the State, shall participate in review meetings with the State on a monthly basis for the first six (6) months and quarterly thereafter. In these meetings, the Contractor's account team and the State will review the operations and financial performance of the Plan pharmacy benefit. These meetings will take place at the State of Tennessee offices in Nashville, TN. However, at its discretion, the State may allow the Contractor to participate in such meetings by teleconference.

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

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

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

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

c. The POS system shall automate the entire pharmacy claims processing system and shall price and adjudicate claims online and in real time. The POS system shall adjudicate and process all retail, Specialty and Mail Order Service electronic POS and paper claims incurred during the Term in strict accordance with the State's pharmacy benefits as contained in the Plan Document, which is located on the State's website. (https://www.tn.gov/partnersforhealth/publications/publications.html) in the publications section (three (3) Plan Documents for the Plan).

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

e. The Contractor shall notify the State's pharmacy director, via e-mail and phone, immediately upon knowledge of unscheduled or unapproved downtime involving more than ten percent (10%) of production for fifteen (15) minutes or longer. The Contractor shall also provide the State updates at regular intervals during a sustained downtime. The State will be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide the State with a system downtime analysis describing root cause issues and actions to mitigate future downtime occurrences.

f. Enrolled network pharmacy providers such as retail pharmacies, Specialty Pharmacies, outpatient hospital retail pharmacies and Mail Order Service pharmacies shall be responsible for submitting Member claims through POS telecommunications devices. However, the Contractor shall also process paper claims within thirty (30) days of receipt when submitted by Members or by a prescriber on behalf of a Member.

g. The Contractor shall ensure that retail network claims submitted by network pharmacy providers will be paperless for the Members. The Contractor's agreement with network pharmacy providers shall obligate the network pharmacy providers to submit claims directly to the Contractor.

h. The Contractor's system's must provide Members a POS explanation of pharmacy benefits for claims processed through its mail service and Specialty Pharmacies, and concurrently provide online claims records for prescriptions dispensed through all channels, which lists the individual Member's pharmaceutical out-of-pocket expenses and the Plan sponsor's costs.

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

j. The POS claims system shall fully integrate the Prior Authorization, Quantity Limits, and Step Therapy programs, as described in Sections A.12.g and A.12.h, and have edits to verify eligibility, the current Formulary, and claim completeness as claims are submitted.

k. The Contractor shall confirm eligibility of each Member on the basis of enrollment information provided by the State, which applies to the period during which the charges were incurred. On a quarterly basis, the Contractor shall accurately process a minimum of ninety-eight percent (98%) of claims either filed directly by Members and/or their prescriber(s), in accordance with Contract Attachment B. The Contractor shall provide Plan pharmacy services only to eligible Members. The Contractor shall track Member utilization across all participating pharmacy providers (retail, mail, and Specialty) and shall report Member utilization to the State at the State's request.

l. The POS system shall generate a claim pay status of pay or deny. The system shall allow a pharmacy to initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function shall be available for claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes) and shall be accessible and operational no less than ninety-seven percent (97%) of this time. The Contractor shall not charge participating pharmacy providers any POS fees for services rendered under this contract. Network pharmacy providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The Contractor shall require all participating network pharmacy providers to have the POS function. POS system used by contracted pharmacies to process pharmacy claims shall be accessible and operational ninety-nine point five percent (99.5%) of the time.

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

n. At the POS, the Contractor shall identify and deny claims that contain invalid provider numbers. Pharmacy providers shall submit claims and be identified by their individual and specific NPI. Prescribers shall be identified on all pharmacy claims by their specific NPI or DEA Numbers, or any other identifying number as required by the State or HIPAA.

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

p. The Contractor's POS adjudication system must have the ability to reject claims when the Member's Plan coverage is secondary to another plan and notify Members and the Retail Pharmacy why the claim rejected. Secondary coverage claims must be submitted to the Contractor for possible reimbursement.

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

r. The Contractor shall maintain a dedicated toll-free number to support system operations (Help Desk). The Help Desk shall be available twenty-four (24) hours a day, seven (7) days a week to respond to questions and problems from pharmacy providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. The Contractor's Help Desk and representatives/operators shall be located in the contiguous United States.

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

t. Contractor's own Mail Order Service pharmacy (if applicable), when processing Member claims shall provide Members a POS explanation of pharmacy benefits ("EOB"), which lists the individual Member's pharmaceutical out-of-pocket expenses, the Plan costs, and any cost savings opportunities for the Member.

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

A.7. Claims Payment and Reconciliation

a. The Contractor shall adjudicate claims as payable only if said claims are (i) for Members (ii) for approved services (iii) dispensed by in-network pharmacy providers (or out-of-network providers, payable up to the MAC and minus any Member cost sharing) and (iv) and in accordance with the payment rules and other policies of the State. The State will only pay for approved and correctly Paid claims, not for rejected or reversed claims. Out of network claims shall be paid via direct Member reimbursement for (i) Members (ii) for approved services (iii) and in accordance with the payment rules and other policies of the State.

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

c. The Contractor shall pass directly to the Plan any contract terms negotiated with retail pharmacies (Discounts and Dispensing Fees) and pharmaceutical manufacturers (Rebates). Thus, the Contractor shall not receive any differential, or spread, between the pharmacy or manufacturer contracted rate and the Plan contracted rate. The Contractor shall provide a quarterly report to demonstrate the level of Pass-Through Transparent Pricing. The Contractor understands and agrees that this contract is deemed a '100% fully pass through, transparent contract' and agrees that the same costs charged to the Plan and Members, combined, are the same costs paid to network pharmacies. This will be audited on an annual basis by the State's benefits and actuarial consultants, in order to comply with Tenn. Code Ann. § 4-3-1021.

d. The Contractor shall be responsible for ensuring that any payments funded by or to the State are accurate and in compliance with the terms of this Contract, including items listed in Contract Attachment B; agreements between the Contractor and providers; and State and federal laws and regulations.

e. The Contractor shall ensure that every Paid Claim is attributed to one of the State's funding accounts. Currently there are six (6) accounts (55000 State Plan Actives, 56000 Local Education Plan Actives, 58000 Local Government Plan Actives, 51000 State Plan Retirees, 52000 Local Education Plan Retirees, and 53000 Local Government Plan Retirees). Any later adjustments of claims requested or initiated by either the State or by the Contractor shall be debited or credited to one of the State's funds and not to the funds that are paid to the Contractor in the way of Administrative Fees. Any adjustments or later claims processed that results in the State being owed money or the State owing money for a claim processed should be debited or credited against one of the State's funds and NOT against any Administrative Fees payments. Claims payment accuracy shall be ninety-eight percent (98%) or higher.

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

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

h. The Contractor shall follow the State of Tennessee's law(s) surrounding prompt payment to providers. In the absence of a prompt payment law for PBMs, the Contractor shall pay providers for one hundred percent (100%) of all Clean Claims within the lesser of thirty (30) days or the contracted turnaround time with the pharmacy.

i. Tenn. Code Ann § 4-3-1021 requires the BA to compile and prepare a report each year prior to July 1 using data from various audit reports completed for us during the previous year. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts either in BA, under contract with the State, or the insurance committees to ensure that each report is completed timely. Tenn. Code Ann § 4-3-1021(5) requires a reconciliation of the PBM's payments to pharmacies with the State's reimbursement to the PBM.

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

A.8. Pharmacy Network

a. The Contractor shall establish and maintain its broadest available national pharmacy provider network and a statewide any willing pharmacy provider network of retail, 90-Day-At-Retail, Mail Order Service, Specialty Pharmacies, and vaccine network administering pharmacies. These networks shall be adequate to provide covered pharmacy services and pharmacy location sites available and accessible in accordance with this contract and in compliance with Tenn. Code Ann § 56-7-2359.

b. The Contractor shall execute pharmacy provider agreements with any willing pharmacy providers for Retail, Mail Order Service, Specialty, and vaccine pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services and shall comply fully with all applicable laws and regulations.

c. The Contractor shall provide a list of the individual pharmacies (including at a minimum: name, NCPDP number, NPI, address, city, state, zip code, and telephone number) participating in the Retail, 90-day-At Retail, Mail Order Service, Specialty, and vaccine networks on the Contractor maintained splash page at least two (2) weeks prior to the State's annual enrollment period each year. The Contractor shall update these lists at least quarterly, and these lists shall appear in a prominent place on the contractor's splash page specific for the State's Members. Such list shall be easy to locate and utilize for all Members. The Contractor shall also include on the splash page a list of all drugs that have Quantity Limits, Prior Authorization requirements, and Step Therapy requirements. Those with quantity limits or morphine milligram equivalents (MME) per day limits should be listed by drug name and the thirty (30) day or ninety (90) day limit for each. Those with Step Therapy limits should list the drug that must be utilized prior.

d. The Contractor shall not require the State to mandate the use of Mail Order Service pharmacies or require Members to utilize one single pharmacy or a single chain or pharmacies for better pricing to the plan or lower Member cost share. Rather, the Contractor shall offer: (1.) a nationwide network of pharmacies for the thirty (30) network wherein Members may fill a prescription for their applicable thirty (30) cost share (Copayment or Coinsurance), (2.) a Mail Order Service pharmacy for ninety (90) prescription fills, (3.) a nationwide Retail Pharmacy network of pharmacies wherein Members can fill their ninety (90) prescriptions for the same cost share and the Plan would pay the same reimbursement rates for the medication as the Mail Order Service reimbursement rates (AWP minus x%), (4.) a statewide or nationwide network of Specialty pharmacies from which Members must choose a pharmacy to fill any Specialty Medication, and (5.) a statewide or nationwide network of pharmacies that include the ability to have a broad array of vaccines administered at the State-determined Copayment or Coinsurance (many of our vaccines are to be supplied at zero cost share).

e. Retail Network:

(1) The Contractor shall maintain a network of pharmacy providers to provide the covered services such that in urban areas, at least ninety percent (90%) of Members, on average, live within one and one half (1.5) miles of a Retail Pharmacy participating in the Contractor's network; in suburban areas, at least ninety percent (90%) of Members, on average, live within three (3) miles of a Retail Pharmacy participating in the Contractor's network; and in rural areas, at least ninety percent (90%) of Members, on average, live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network. The Contractor shall justify and document all exceptions, which are subject to prior approval In Writing by the State. Contractor shall ensure that any pharmacy providing services will process and charge Members either their Plan Copayment or Coinsurance or the lesser-of (if the actual cost of the drug is less than the Member's adjudicated cost share). In no instance shall the Contractor enforce a gag clause restricting a pharmacist

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

f. 90-Day-At-Retail Network:

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

g. Mail Order Service Network:

(1) The Mail Order Service pharmacy shall possess sufficient staff and facilities capable of mailing ninety-five percent (95%) or more of all Member prescription orders filled from clean prescriptions not requiring pharmacy intervention within two (2) Business Days and ninety-nine and nine-tenths percent (99.9%) of all prescriptions mailed to eligible Members shall be dispensed with the correct drug strength, dosage form, prescription directions, and prescribing physician's name. The Mail Order Service pharmacy shall possess a current license to dispense controlled drugs (Schedule 2, 3, 4 and 5 substances).

(2) The Contractor's Mail Order Service pharmacy will not be required to dispense prescriptions for greater than a ninety (90) day supply of covered drugs, per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances (see Section 6 of Public Chapter 1039 of 2018), and manufacturer's recommendations. Exceptions to the ninety (90) day limit include medications that may be packaged by the drug manufacturer in quantities of just over 90 days and that do not lend themselves to being split by the pharmacist (e.g. insulins); in those instances, the Mail Order Service pharmacy may fill using the packaging as is and charge a ninety (90) day Copayment to the Member. Prescriptions may be refilled providing the prescription states that refills remain. All prescriptions will be filled in accordance with Tennessee laws and regulations.

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

(4) The Contractor shall guarantee that the AWP applied to Mail Order Service claims must be the actual NDC or NDC-11 of the package size dispensed.

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

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

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

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

(9) The Contractor shall obtain open refill files from the State's current Mail Order Service contractor.

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

h. Specialty Network:

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

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

(3) Unless otherwise directed by the State, all drugs placed on the Contractor's Specialty Drug list shall meet the definition of Specialty Drugs in Contract Section A.2. The drug must meet at least two of the first four criteria (a thru d) and the final criteria (e).

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

(5) Contractor understands that the sole Administrative Fee (PMPM) and any Clinical Fee (if applicable) paid to the Contractor monthly constitutes all services payable under this Contract, including Specialty Drug management (Step Therapy, first fill counseling, recalls, Member adherence education, Prior Authorization, and similar industry standard PBM activities that relate to Specialty Drug management.)

(6) The Contractor shall guarantee that the AWP applied to Specialty claims will be the actual NDC or NDC-11 of the package size dispensed.

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

State Specialty Network Participation Criteria

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

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

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

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

(8) The Contractor shall notify affected Members by letter within fifteen (15) days after any Specialty Network Pharmacy drops out or leaves the Specialty Pharmacy Network. Upon notification that any Specialty Pharmacy is leaving the Specialty Pharmacy Network, the Contractor shall determine if any Members have utilized said pharmacy within the previous ninety (90) days and mail these Members a notification letter that the pharmacy is leaving the network on a specific date and also include with the letter a printed list of remaining contracted Specialty Network Pharmacies. The State has the right to review any such letter and make appropriate edits prior to approval

and mailing. In addition, the Contractor must notify the State's Director of Pharmacy Services In Writing within five (5) Business Days any time a Specialty Pharmacy leaves the Specialty Pharmacy Network.

i. The Contractor shall Lock In Members who meet the Contractor's Lock In guidelines into just one network pharmacy and one prescriber. The Contractor's Lock In guidelines shall be provided to the State for approval during plan implementation.

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

k. The Contractor shall annually provide the State with a GeoNetworks® report showing service and geographic access for the retail network and the 90-Day-At-Retail. The State will review the pharmacy network structure and shall inform the Contractor In Writing of any deficiencies. The Contractor shall develop a plan of action, approved by the State, to correct said deficiencies within sixty (60) days from the date the Contractor was first notified of the problem.

l. The Contractor shall generate and deliver to the State, within five (5) working days of the end of each quarter, a Quarterly Network Changes Report. This report shall include all additions to the network and all pharmacies no longer participating in the network.

m. The Contractor shall develop a nationwide Vaccine Network of pharmacies where Members may receive covered plan vaccinations including, but not limited to, influenza, shingles, hepatitis, measles, mumps, and rubella ("MMR"), tetanus, pertussis, and measles.

A.9. Formulary Management

a. The Contractor shall design, develop, implement, administer and maintain the Formulary in compliance with coverage defined in the Plan Documents by the deadline listed in Contract Section A.30. The Formulary shall include FDA approved drugs that have been evaluated for inclusion by the Contractor's P&T Committee. The Contractor shall be the exclusive Formulary administrator for the prescription drug benefit. .

b. By go-live date the Contractor shall assume responsibility for administering and maintaining the Formulary, including the PA criteria and clinical programs.

c. The Contractor shall implement the Formulary within five (5) working days after receipt of the State's approval In Writing. The Contractor shall allow Formulary customizations at the State's request at no additional cost to the State, including the ability to add over-the-counter ("OTC") products. The Contractor shall implement customized formularies within fifteen (15) working days after receipt of the State's request In Writing.

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

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

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

g. Final decisions for inclusion or exclusion from the Formulary shall be at the sole discretion of the State. At the time of Contract implementation, the State only excludes fertility medications from coverage; however, the State reserves the right to add to or amend this coverage in the future.

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

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

j. Formulary Design and Development:

(1) Based on the recommendations by the Contractor's P&T Committee, the Contractor shall design the Formulary to (i) maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most clinically effective as well as the most cost-effective (ii) ensure that the more costly drugs, which do not have any

significant clinical or therapeutic advantage over others in their class, are used only when medically necessary; have a higher Formulary tier; (in certain instances, these drugs may be excluded from the Formulary) and (iii) ensure that ninety-five percent (95%) or more of Mail Order Service prescriptions and ninety percent (90%) or more of retail prescriptions for MS drugs will be dispensed with a Generic Drug product.

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

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

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

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

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

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

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

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

A.10 Benefit Coverage/Plan Design

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

(1) Any updated benefit Plan design;

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

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

(4) Minimum/Maximum amounts with Coinsurance;

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

(6) Out-Of-Pocket maximum per Rx;

(7) Deductibles on brand name drugs only;

(8) Deductibles based on network;

(9) Therapeutic Class "Maximum Allowable Charges";

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

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

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

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

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

(15) Following requirements of the PPACA, provide for various coverages and benefit exceptions (Note that this is not an all-inclusive list; rather, it is a summary of *examples* to be followed and implemented):

i. Aspirin: zero Copayment for ages >= 45, Generic Drug only, OTC requires prescription

ii. Iron Supplements: ages 0-1; no PA; no quantity limits; brand, Generic Drug, and OTC requires prescription;

iii. Oral Fluorides: ages 0-6; no PA; no quantity limits; brand, Generic Drug, and OTC requires prescription

iv. Folic Acid: Females 0-55 only; no PA; quantity limit of 100 units per fill; Generic Drug only; OTC requires prescription

v. Tobacco Cessation: zero Copayment; limit of 2, 12 week courses of treatment (168 days); cover smoking cessation medications, and nicotine replacement products such as patches, gum, and lozenges (inhaler not covered), Rx or OTC requires prescription

vi. Immunizations at zero Copayment – "A" and "B" rated recommendations by the USPSTF.

vii. Vitamin D – both genders, ages >=65; brand and Generic Drug, no PA, OTC requires prescription

viii. Oral Contraceptives, emergency contraceptives, injectables; zero Copayment, Generic Drug only and Single-Source brands; no PA; requires prescription.

ix. Low dose Generic Drug statins (PBM determines which NDC or NDC-11) process and pay at zero Copayment

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

- The drug name(s), NDC, and full GPI;
- Drug manufacturer name;
- The total number of prescriptions filled;
- The total number of members filling a prescription for each drug;
- The projected financial impact and savings to the plan as a result of the program.

c. Each fall, no later than November 1, the Contractor shall provide to the State various test results documents of the following plan year's benefits set-up in the Contractor's claims adjudication platform broken down by generics, preferred brands, non-preferred brands, specialty drugs and by 30 (thirty) and 90 (ninety) day supplies. Such test results documents shall also provide State staff with the applicable deductibles and maximum out of pocket amounts by coverage level offered by the State. This exercise is to ensure proper benefit design set up for all health plan options.

A.11. PPACA

The Contractor will be responsible for ensuring that all pharmaceutical benefits and programs offered by the State and administered by the Contractor meet all current and future requirements of PPACA and shall advise the State on all such benefits and programs, including benefit design,

Formulary design and management, Copayment and/or Coinsurance structure, appeals of all levels, and any and all associated costs.

A.12. Clinical Programs

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

b. The Contractor's clinical program offering shall at a minimum include:
   (1) An evidenced-based approach;
   (2) Compliance (poor adherence);
   (3) Utilization management programs;
   (4) Information available via the web;
   (5) Outcomes data (savings and Member impact); and
   (6) Custom programs based on the State's specific utilization

At the request of the State, the Contractor shall provide additional clinical program offerings.

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

d. The Contractor shall provide a therapeutic substitution and Generic Drug dispensing program with provisions for written, phone, and/or face-to-face contact with prescribing physicians and Members in order to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. The Contractor shall report results of the program to the State on an annual basis. The Contractor shall receive prior approval In Writing from the State to implementing Member-targeted activities.

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

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

g. Step Therapy:

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

(2) At the State's request, the Contractor shall implement a Step Therapy program, targeting all brands, for the following drug classes: Proton Pump Inhibitor's (PPIs), Angiotensin II Receptor Blockers (ARBs), Angiotensin-Converting Enzyme (ACE) Inhibitors, Cholesterol lowering medications, Antidepressants, Anti-hyperlipidemics, Pain (Rheumatoid Arthritis/Osteoarthritis), Anti-asthmatics, and Narcotic and central analgesics. At the State's request, additional drug classes may be targeted for Step Therapy at any time and shall be implemented by the Contractor at no cost to the State.

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

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

h. Prior Authorization ("PA"):

(1) The Contractor shall disclose and share, In Writing, all PA criteria and procedures and decision trees to the State during plan implementation or at any time during the Term for any brand or Generic Drug medication, or any other medication covered as part of the Plan benefits offered through Contractor, if requested by the State.

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

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

(4) The Contractor shall ensure that call center staff evaluates ninety-nine percent (99%) of PA requests and notifies the prescribing physician within twenty-four (24) hours, In Writing. The Contractor shall implement an agreed upon set of edits and PA criteria on

the go-live date. Additional PA edits may be implemented at the State's direction at any point without additional cost to the State.

(5) The Contractor shall submit a quarterly PA report, which includes PA statistics including, but not limited to, the number of PAs submitted, the number approved and denied and the purpose of the PA (clinical edit, emergency override, etc.).

(6) The State, or its qualified auditor selected in the sole opinion of the State, shall have the ability at any time to do clinical auditing of Specialty claims approved by the Contractor for filling and payment. The State, or its qualified auditor, will be auditing to verify that the Contractor is following its own rules and not merely providing a verbal attestation or calling clinical staff and the prescriber's office and walking them through a series of "yes" or "no" questions to merely get to a "yes" for approval. Evidence based PA criteria are needed and must be adhered to when approving Specialty Drug claims for filling and payment.

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

i. The State has the ability to "opt-out" of any clinical program.

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

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

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

m. Manufacturer Specialty Drug coupons cannot be considered revenue and do not count toward Rebates or Rebate guarantees in the calculation and reconciliation of those.

n. The Contractor shall provide case management services to plan participants who fill Specialty Medications through the Contractor's own Specialty pharmacy. This shall include identifying and outreaching to Members with conditions such as cancer, rheumatoid arthritis, Hepatitis

C, Multiple Sclerosis, and Hemophilia (conditions listed here are examples only and not an all-inclusive list). Registered pharmacists shall work with the member, health care providers, primary caregivers and the state's contracted medical vendors to coordinate the most appropriate, cost-effective site of care and place-of-fill for Specialty Medications.

A.13. Prospective/Concurrent DUR

a. The Contractor shall furnish a fully automated prospective/concurrent DUR system that meets all applicable state and federal requirements. The DUR function shall meet minimum federal DUR regulations as well as the additional specifications in Contract Sections A.12 and A.13 and be flexible enough to accommodate any future edit changes required by the State. The Contractor shall recommend to the State, annually at review meetings, new DUR edits that improve quality and reduce pharmacy program costs.

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

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

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

i. Problems that involve potential drug overutilization;

ii. Problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given Member;

iii. Problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given Member;

iv. Problems that involve drug use contraindicated by other drugs on current or historical claims for a given Member (drug-to-drug interactions);

v. The level of severity of drug-to-drug interactions;

vi. Potentially incorrect drug dosages or a change to the quantity per prescription to ensure the most cost-effective strength is dispensed;

vii. Potentially incorrect drug treatments;

viii. Potential drug abuse and/or misuse based on a given Member's prior use of the same or related drugs; and

ix. Early refill conditions and provide, at the drug code level, the ability to deny these claims. The Contractor shall customize refill-too-soon edits.

(2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall

automatically generate DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden by the pharmacy.

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

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

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

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

A.14. Retrospective DUR (Retro-DUR)

a. The Contractor shall provide a Retro-DUR program supported by licensed clinical pharmacists. The Contractor shall develop, maintain and update a set of evidence-based clinical criteria, which the Contractor shall use to detect potential problems such as poly-pharmacy and related over-utilization, underutilization, drug-to-drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a Member's age or disease state. The Contractor's Retro-DUR system shall:

(1) Provide provider practice analyses that includes identification of key performance indicators such as Generic Drug dispensing rate, controlled substances, Formulary compliance, etc.;

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

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

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

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

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

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

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

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

e. DUR and Retro-DUR Reporting

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

i. Utilizing-Members data;
ii. Utilization by age demographics;
iii. Utilization by top twenty (20) therapeutic classes determined both by number of claims and by payment amount;
iv. Top twenty (20) drugs as ranked by claim count and by total payment;
v. DUR data including totals of DUR messages sent and savings associated with the top twenty (20) drugs associated with each DUR edit;
vi. Retro-DUR reviews, summary of the interventions and estimated cost savings information as associated with both Member and provider profile review and interventions;
vii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff; and
viii. Any additional reports included in the Contractor's standard DUR reporting package.

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

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

b. Total number of drugs pre and post intervention;
c. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention or within another time period as otherwise directed by the State;
d. Daily dose of drug in question pre and post intervention;
e. Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-to-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems;
f. Compliance with national guidelines (e.g. percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the Retro-DUR initiative;
g. Generic Drug medication utilization;
h. Emergency supply frequency;
i. Formulary compliance; and
j. Patient adherence as defined by medication possession ratio.

A.15. Financials

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

b. Ingredient Cost:

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

(2) If using various sources to price claims, the Contractor shall use the AWP that provides the lowest price available.

(3) The Contractor shall guarantee that in the event there are changes in the marketplace to the baseline measure used for the Ingredient Costs of drugs (e.g. AWP) the Contractor shall adjust accordingly to provide an equivalent price. The Contractor shall provide notice to the State and the conversion shall be agreed upon In Writing before any changes are made.

(4) The Contractor shall apply a MAC-list at Mail Order Service pharmacies and at 90-Day-At-Retail network pharmacies for Generic Drug medications. The list will have prices equivalent to or lower than the MAC-list applied to retail claims and effective MAC Discounts cannot be lower than effective non-MAC AWP Discounts. The Contractor shall use the same MAC List for network pharmacies (retail, Specialty and Mail Order Service Service) and the State and shall, upon State request, provide the most current MAC List to the State on a quarterly basis in a spreadsheet format. The Contractor will employ its

most aggressive MAC List which must include a minimum of ninety-five percent (95%) of all Generic Drugs. In addition, the MAC pricing schedule at Mail Order Service (including Specialty) will include the same or more favorable pricing (lower per unit prices) than at retail for every drug. The Contractor's MAC pricing schedule at Mail Order Service will include a comparable list of 300-400 low cost Generic Drugs included in retail Generic Drug programs at competitive pricing.

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

(6) The Contractor shall guarantee that actual reimbursement rate, in the aggregate, to network pharmacies for pharmaceuticals will not exceed the guaranteed Discount off AWP, plus the negotiated Dispensing Fee.

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

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

(9) The Contractor shall guarantee that the terms offered for Mail Order Service claims shall not vary based on the days' supply (claims processed for less than a ninety (90)-day supply).

(10) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the average network Discounts achieved and the guaranteed average Discount amounts for retail, 90-Day-At-Retail, Mail Order Service and Specialty for the previous calendar year. The Contractor will pay one hundred percent (100%) of any Discount guarantee shortfall to the State within forty-five (45) days of the close of each annual reconciliation period (with the State retaining one hundred percent (100%) of any savings above the guarantees). Further, should the Contractor miss the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten percent (10%) of the shortfall amount (Under-performance payment). The Contractor will not be able to offset or recoup any Under-performance Payment in any reconciliation.

c. Dispensing Fees

(1) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the Dispensing Fees paid and the guaranteed maximum average Dispensing Fee amount for the previous calendar year. The Contractor will pay the State one hundred percent (100%) of any shortfall for each guarantee within forty-five (45) calendar days from the close of each semi-annual reconciliation period (with the State retaining one hundred percent (100%) of any additional savings achieved above each minimum guarantee).

(2) The Contractor shall adhere to the additional requirements related to Dispensing Fees listed in Contract Section C.3.

d. The Contractor shall adhere to rate guarantee requirements listed in contract Section C.3.

A.16. Pharmacy Rebates

a. The Contractor shall adhere to the additional requirements related to pharmacy Rebates listed in Contract Section C.3.

b. The State, or its contracted benefits consultant and actuarial consulting firm, will audit the Rebates that are accrued and paid to the State. Contractor shall pass all Rebates and other remuneration through to the Plan. Rebates shall be one hundred percent (100%) auditable to the NDC or NDC-11 level. The Contractor shall provide, with each pharmacy Rebate check presented to the State, a report showing the amount of the check broken down by the groups that comprise the total check amount (e.g. currently fund accounts 55000 State Actives, 56000 Local Education Actives, 58000 Local Government Actives, 51000 State Retirees, 52000 Local Education Retirees, and fund 53000 Local Government Retirees), as well as the calendar quarter that the various Rebate amounts are attributable to. The Contractor shall not enter into any agreement with a pharmaceutical manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from pharmaceutical manufacturers as being considered Rebates. Further, the Contractor will not require the State to enroll in programs to receive manufacturer payments.

c. The State shall have the ability at any time to exclude or block from coverage one or more drugs for any reason without requiring any contract amendment or Contractor Rebate guarantee change.

d. Contractor agrees to pay the State the greater of one hundred percent (100%) of total manufacturer revenue or the minimum Rebate per brand guarantee. Furthermore, the Contractor agrees to pay the State the minimum guarantee sixty (60) days after the end of a reporting quarter (calendar quarter). True-up to one hundred percent (100%) will occur with the first rebate check of the following year. In essence, this means that instead of the State receiving approximately only twenty-five percent (25%) of the total yield in a calendar year, the State would receive approximately seventy-five to eighty percent (75%-80%) in that calendar year.

A.17. Market Check Provision

a. The Contractor shall provide most favored nation ("MFN") terms wherein it shall not provide any similar account more favorable pricing terms than that provided to the State. If there are changes to any of the MFN measurement components or methodology and those changes are reasonably designed to achieve greater comparability under this provision, the State will approve In Writing before those changes are implemented. The Contractor must agree to a market check to compare the economics of the resultant contract. The Contractor shall provide two (2) financial terms market checks. The first market check will be performed at month four (4) – April 2020 - and the second market check will be at month thirty (30) – June 2022 - to comparable arrangements in the marketplace, including but not limited to aggregate value of the Discounts, minimum Rebates, Dispensing Fees, and Administration Fee pricing terms, for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. The State's benefits consultant and actuarial consulting firm will determine similar employer groups for size and benefit structure to serve as comparison(s). If financial benchmark pricing indicates that the State's financial terms are no longer competitive, the Contractor shall offer to improve the State's pricing by, at least, the identified difference in value within forty-five (45) days of notification. The State's contracted benefits and actuarial consulting firm shall complete the market checks at the State's request, and with the full cooperation of the PBM Contractor. There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State. Any improved pricing as a result of the first market check shall be in place by January 2021 and any improved pricing as a result of the second market check shall be in place by January 2023.

A.18. Data Integration and Technical Requirements

a. The Contractor shall maintain an electronic data interface with the State's Edison System, for the purpose of processing Member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of PHI with the State. The State requires the use of second level authentication using the State's standard software product, which supports Public Key Infrastructure ("PKI"). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol ("SFTP") server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State uses public key encryption with Advanced Encryption Standard ("AES") to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor is expected, with adequate notice, to cooperate with the State to maintain the security of protected information according to all applicable state and federal standards.

b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

c. At least thirty (30) days prior to the go-live date specified in Contract Section A.30, the Contractor shall load, test, verify and make available online for use the State's eligibility information. The Contractor shall certify, In Writing, to the State that the Contractor shall utilize the eligibility files as provided by the State. The Contractor must not ask State to re-issue another file with the changes included; rather, Contractor must make manual changes to the file as needed and requested by the State.

d. Contractor must make changes to the eligibility file on a manual basis if requested by the State on an as-needed basis. Contractor must not ask State to re-issue another file with the changes included.

e. Contractor will receive eligibility files on a daily basis from the State.

f. Contractor must contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily eligibility file is loaded.

A.19 Data and Information Technology

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

(1) Daily Enrollment Update: To ensure that Members' enrollment records remain accurate and complete, the Contractor shall retrieve, via secure medium (see A.18.a), daily enrollment data electronic transfer files from the State, in the State's Edison 834 file format, see RFP Appendix 7.11 for Members who are maintained in the State's Edison System (files will include full population records for all Members and will be in the format of ANSI ASC X12N, Version 005010X220, with some fields being customized by the State). Contractor understands and agrees that daily eligibility files will be provided to the Contractor by the State, and the Contractor shall make manual changes to the eligibility file (e.g. a request may come across from the State if a data element is preventing the file from loading in the Contractor's system.) Contractor shall make all manual changes requested by the State, and the State will not reissue another eligibility file. The Contractor shall contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily eligibility file is loaded.

(2) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) Business Day of receipt of the daily file and one hundred percent (100%) shall be posted within five (5) Business Days of receipt of the daily file.

(3) The Contractor and/or its subcontractors, as applicable, shall resolve all discrepancies identified by the processing of the enrollment file within one (1) Business Day of identification.

b. The Contractor shall add new groups to all systems within three (3) Business Days of receipt of necessary documents. The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe required by the State. The Contractor shall document in an eligibility system modification log, the system error details, the proposed solution, and the final solution as required by the State. The Contractor shall update and submit this log quarterly (refer to Contract Attachment C, Reporting Requirements and Attachment B).

c. State Enrollment Data Match: Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of Members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the accuracy with which the Contractor is maintaining its database of Members.

(1) The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.

d. The Contractor shall reconcile, within ten (10) working days of receipt, payment information provided by the State (e.g. upon providing the State with a monthly invoice and the Contractor receives payment for this invoice, if the Contractor has questions or concerns about payment, Contractor must do so within ten (10) days). Upon identification of any discrepancies, the Contractor shall immediately notify the State.

(1) Contractor shall provide the State's DSS contractor with all of the State's claim data, data layouts, and data dictionaries in a timely manner and in the formats, layouts and specifications, including GPI and GCN for all prescription drug claims, specified by the DSS contractor in RFP Appendix 7.10.

(2) Contractor shall submit complete and accurate data to the State's DSS contractor by the fifteenth (15^{th}) day after the end of each month. Complete and accurate data is defined to be data that:

i. Contains records for all activity (e.g., pharmacy claims data, program participation) within the specified time periods;

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

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

iv. Is submitted in a single record format.

(3) Contractor shall provide the data files at no charge to the State or the State's DSS contractor. Any charge by the DSS contractor to set up the Contractor shall be borne by the Contractor.

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

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

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

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

e. The Contractor shall adhere to the additional requirements related to the State's DSS contractor listed in Contract Section C.3.

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

1. Date of birth: Data missing for ≤ 3% of claims;
2. Pharmacy provider ID missing: Data missing for ≤ 1.5% of claims; and
3. NDC or NDC 11 missing: Data missing for ≤ 1.5% of claims

g. The Contractor shall provide transmittal of pharmacy data via secure medium to any of BA's contractors including the TPAs, health management contractor(s), Behavioral Health/EAP contractor(s) or any other contractor or State fiduciary as identified by the State. Unless otherwise directed by the State, the Contractor shall provide, at no additional charge, daily data feeds of pharmacy claims to the third parties during the Term and following the Term until all claims incurred during the Term have been paid. This data shall be provided in the Middle Tier format which allows real time trading of deductibles, maximum out of pocket amounts and other such accumulator data. If so directed by the State, the Contractor shall pass a regular file to the State's TPAs showing an accumulator file of prescription drug payments by individual. Conversely, the Contractor shall be required to receive similar files from the State's TPAs for the same reason: to allow the State-sponsored plans to accurately maintain in real time Member and family deductibles and maximum out of pocket costs (pharmacy and medical combined). Contractor shall be expected to receive and send data and work with the State and its other Contractors on a regular basis to this end. At any time a deficiency or miscalculation exists either between the Contractor and one or more of the state's TPAs, the pharmacy Contractor must work with the TPAs to make the corrections necessary to the transmitted files in order to correct any and all deficiencies within ten (10) Business Days, unless otherwise approved by the State.

h. The Contractor shall load all current PAs, overrides, and open refills (Mail Order Service and retail) that exist for current Members from all existing PBMs no later than thirty (30) days prior to the go-live date.

i. At the State's request, the Contractor shall accept at least one (1) year of historical data from the State's previous PBM contractor. This includes, but is not limited to, pharmacy claims history, provider data, recipient data, preferred drug list, PAs, refills, lock-in and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's Mail Order Service and Specialty Pharmacy.

j. The Contractor shall store claims data online for a minimum of twenty-four (24) months after the claim has been adjudicated.

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

A.20. Provider Education

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

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

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

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

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

f. If requested by the State, the Contractor shall offer recommendations to the State regarding provider education.

A.21. Appeals

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

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

c. The Contractor shall decide Pre-Service Appeals within thirty (30) days and Post-Service Appeals within sixty (60) days. Ninety-five percent (95%) of Pre-Service Appeals shall be decided within thirty (30) days and ninety-five percent (95%) of Post-Service Appeals within sixty (60) days. The Contractor shall offer an expedited appeals process. If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed medications, then a request for an expedited consideration may be submitted by the Member, their duly authorized representative or treating physician. The Contractor shall determine if the request qualifies for an expedited review and shall respond with seventy-two (72) hours.

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

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

f. The Contractor shall ensure that the State's pharmacy benefit program is fully compliant with all aspects of the PPACA and as additional regulations are implemented. The Administrative Fees in Contract Section C.3 are to include all possible work to ensure that the State and its PBM contractor are compliant with the PPACA.

A.22. Customer Services

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

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

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

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

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

f. The Contractor's call center shall be equipped with TDD (Telephone Device for the Deaf) or TTY (Teletype) in order to serve the hearing impaired population.

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

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

i. The Contractor's call center shall maintain a first call resolution rate of ninety-two percent (92%) or greater.

j. The Contractor shall maintain an ASA of thirty (30) seconds and after answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.

k. The Contractor's call center shall maintain a (1) telephone service factor ("TSF") of 80-20 meaning that eighty percent (80%) of calls are answered within twenty (20) seconds and (2) open call/inquiry closure rate of ninety percent (90%) within five (5) Business Days.

l. The Contractor shall close ninety-five percent (95%) of open call issues within five (5) Business Days.

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

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

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

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

q. The call management system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to BA service center and other external call centers, as designated by the State. The Contract shall only refer or transfer calls to the BA's service center that are eligibility-related; benefits related questions or issues shall be handled by the Contractor's customer center staff.

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

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

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

u. The call management system shall enable the logging of all calls, including:

(1) The caller's identifying information (e.g., employee ID);

(2) The call date and time;

(3) The reason for the call (using a coding scheme approved by the State in advance and In Writing);

(4) The call center representative/operator that handled the call;

(5) The length of call; and

(6) The resolution of the call (and if unresolved, the action taken and follow up steps required).

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

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

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

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

A.23. Member Communication/Materials

a. The Contractor shall, as required by the State by the State, print and distribute all pharmacy benefit Member enrollment materials such as identification ("ID") cards, welcome packets, network directories, letters, administrative forms and manuals.

b. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, revision, printing, and distribution of all materials that are required to be produced. The Contractor shall ensure that up-to-date versions of all printed materials can be downloaded from the splash page. This provision excludes enrollment forms, which are the State's responsibility.

c. At the State's request, the Contractor shall notify Members, In Writing, of any pharmacy benefit plan changes (changes to Copayments/Coinsurance, Formulary changes, etc.) no less than thirty (30) days prior to the implementation of the change.

d. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit plan changes that have been initiated by the State during mid-year (or otherwise outside the annual enrollment period), shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor.

e. The Contractor shall ensure communications sent to Members are *specific* to the State's Plan design and not simply a rebranding/repackaging of standard book-of-business Member materials. Member handbooks or welcome kits/packets shall be customized for each of the various health plan options currently available to plan enrollees from one plan year to the next, including the specific Copayments or Coinsurance for the different drug tiers. Member Handbooks/welcome kits for the first plan year of the contract shall be mailed out to the entire all Members no later than twenty-one (21) days prior to go-live date.

As new plan Members join the program, they should receive a Member handbook/welcome kit and ID card no later than ten (10) days from the date their initial enrollment was passed to the Contractor on the Edison 834 eligibility file. Further, Member handbooks/welcome kits shall only be issued to Members who transition from one health plan option to another during each fall's annual enrollment (a change in health plan necessitates a new welcome kit, as the drug Copayments or Coinsurance will change and Members will need to receive from the PBM a welcome kit for the new year and their new health plan showing their new pharmacy benefits). Such new customized Member handbooks/welcome kits must be mailed no later than December 15th of each calendar year to this subset of Members.

Exemption of incidental pieces such as newsletters and health promotional pieces will be considered by the State if the Contractor guarantees that pieces will be generic in nature and do not address Plan eligibility issues or specific coverage issues. The welcome packet shall include, at a minimum, a welcome kit customized to the plan they are enrolled in along with the applicable drug Copayments or Coinsurance, an ID card, a URL to the customized splash page maintained by the Contractor, toll-free customer service number, Contractor's general website, general website logon information and a confidentiality statement. The State reserves the right to include text in various languages in order to assist those of limited

English proficiency with where to call for further assistance as required by the Federal Register Nondiscrimination in Health Programs and Activities 81 FR 31375, 45 CFR 92.

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

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

h. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) days prior to planned printing, assembly and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials. The State has and retains the ability to edit and customize all communication pieces mailed out by the Contractor to Members, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters or correspondence, if requested by the State.

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

j. The Contractor shall, to the extent practicable, use relatively large and legible fonts in its materials. Additionally, the Contractor shall make maximum use of graphics to communicate key messages to populations with limited literacy or limited English proficiency. The Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

k. Unless otherwise approved in advance by the State, the Contractor shall design all printed materials at the sixth (6th) grade reading level or lower using the Flesch-Kincaid Index or other suitable metric that the State approves in advance and In Writing. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a certification of the reading level of each piece of material.

l. The Contractor shall update web-based versions of all materials no less than quarterly. However, the Contractor shall produce corrected versions of the individual materials at the State's direction. Reimbursement for Member materials containing an error, which were approved by the State, shall occur as outlined in Section C.3 of the contract.

m. Member Identification Cards

(1) The Contractor shall provide eligible Members with ID cards and shall establish a process that allows enrollees to request replacement cards. The cost of creating and mailing ID cards shall be borne by the Contractor. The ID card shall bear in color the State's "ParTNers for Health" logo. The State has the final approval of ID card

appearance and text, including the use or partial use of any Contractor's name, if applicable. The State reserves the right to request the Contractor to change the look, appearance, and text of the pharmacy ID cards at any time during the Term upon thirty (30) days' notice to the Contractor. The State reserves the right to require the removal or inclusion of any wording (unlimited in any way) on the pharmacy ID card for Members.

(2) Initial Member ID cards must be mailed to all Members no later than twenty-one (21) days prior to the go-live date as long as all implementation milestones have been met. ID cards shall be mailed to Members no later than ten (10) days from receipt of the new enrollment or change in enrollment. ID cards shall contain unique identifiers for each Member, which shall be the employee's unique Edison ID (the full eight (8) digit number with leading zeroes and no additional characters) provided on the monthly eligibility file. Such identifier shall NOT be the Member's federal Social Security Number. The number used on the pharmacy ID card will be the number exactly as provided in the eligibility file. Ninety-five percent (95%) of welcome packets/ID cards shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information.

(3) On an annual basis, at least two (2) months prior to the State's annual enrollment period, the Contractor shall provide to the State, in electronic format, information regarding the pharmacy benefit. Such information shall include a network list, toll-free customer service number, Contractor's general website, general website logon information, information on the retail, 90-day-At Retail, Mail Order Service, and specialty networks, current Formulary, clinical program policies and procedures (Step Therapy, PA, etc.), a confidentiality statement, procedures for accessing services, and other updates and/or changes that may be helpful to Members.

(4) Ninety-five percent (95%) of welcome packets containing I.D. cards will be produced and mailed no later than twenty-one (21) days prior to go-live date.

n. The Contractor shall use first class postage rate for all mailings, unless otherwise directed by the State.

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

A.24. Website

a. The Contractor shall have available an up-to-date Contractor website dedicated to the Plan pharmacy benefit. The website shall be available and fully operational, with the exception of Member data/PHI at least twenty-one (21) days prior to the go-live date. The Contractor shall design the website to aid prescribers, pharmacists and Members in all aspects of the pharmacy program. The Contractor shall update documents posted to the website within five (5) Business Days of the State's approval of changes to said documents.

b. The Contractor shall submit the text and screenshots of the website to the State for review and approval at least one (1) month prior to the go-live date. Additionally, the Contractor shall obtain prior approval In Writing from the State for any links from the site to a non-governmental website or webpage.

c. The Contractor shall have the responsibility to host the website on a non-governmental server, which shall be located within the United States. The Contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from Members without disruption or delay.

d. In addition to the Contractor's own website where this information may also be incorporated and found once a Member logs in, the Contractor shall maintain a pharmacy splash page that the Contractor maintains and regularly updates as new forms or lists become outdated and new ones are available. The splash page shall be available and fully operational no later than two (2) weeks prior to the State's annual enrollment period each year. This splash page shall contain PDFs of documents such as the State's preferred drug list ("PDL"), a list of medications requiring PA as well as directions on how to go about doing that; a list of medications with quantity limits and a listing of those medications and their respective limits; a list of Specialty Medications; a list of medications subject to Step Therapy requirements and what the step drugs are; a list of the 90-Day-At-Retail nationwide network pharmacies (in state alpha order, then by city alpha order), a list of the pharmacies in the Specialty Drug network, a letter explaining the State's coordination of benefits ("COB") process, detail for each of the various plan options offered by the State including what the Members' cost sharing would be for thirty (30) and ninety (90) day drugs, and other similar PDFs. Information must be available on a Contractor-maintained splash page without it being necessary for the Member to log in. In addition, a Member must have the ability to check individual claims history by logging into the Contractor's main website. Both locations (Contractor cobranded website and the splash page) would carry at the top of the page the State's "ParTNers for Health" logo in color.

e. The customized splash page shall be a cobranded website with the Contractor's logo and the State's "ParTNers for Health" logo both displayed in a prominent location. At a minimum, the website shall be updated quarterly to include:

(1) a current listing of the most recent Formulary or preferred drug list (with a prominent effective date shown on page 1 of the PDL);

(2) a list of all pharmacies in the national network whereby Members can fill a thirty (30) day prescription;

(3) a list of all pharmacies participating in the special 90-Day-At-Retail network;

(4) a list of all Specialty Pharmacies (especially those in Tennessee). These listings shall include pharmacy name, address, city, state, zip code, and phone number;

(5) a list of all pharmacies participating in the nationwide vaccine network for flu and pneumonia shots at $0 Copayment;

(6) a separate list of drugs that are considered Specialty Drugs that the Member may only obtain in thirty (30) day supply increments, and a list of drugs that require PA, and a list of drugs that have quantity limits or Step Therapy requirements.

f. In association with the State's annual enrollment period each fall, the Contractor shall update the splash page, no later than two (2) weeks prior to the first day of the annual enrollment period, with all information, documents, and pharmacy related benefits pertinent to each new Plan year.

g. To ensure accessibility among persons with a disability, the Contractor's website shall comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D.

h. Unless otherwise approved by the State, the Contractor's website shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and Members. The Contractor shall utilize appropriate security measures, including password protection, to ensure the protection of Member data/PHI. Each area of the website shall contain information that shall answer the most common questions that each group would ask and documents required by each group to utilize the Plan pharmacy benefit. This shall include, but is not limited to a:

(1) Prescriber Page, which includes, but is not limited to:

i. An interactive Formulary, complete with hot-links from drugs to the PA criteria established for those drugs and also linked to drug specific PA forms and drug specific web-based PA application;

ii. A search function, which allows providers to enter a drug name and be routed to the drug in the interactive Formulary;

iii. Procedures for obtaining PAs, call center hours of operation and contact numbers;

iv. Printable education material specific to prescribers.

(2) Pharmacist Page, which includes, but is not limited to:

i. An interactive inquiry system using pharmacy providers' identifying number (NCPDP, NPI, etc.) to verify the status of pending payments, and other supported function(s) as deemed necessary by the State;

ii. An online listing of the Contractor's MAC drug list;

iii. Printable online pharmacy handbook and provider education material specific to pharmacists;

i. The website shall also have the following services/capabilities:

a. E-mail notification of next refill to Member, and

b. Cost comparison transparency tool, along with medication alternatives.

j. Contractor agrees to make any changes the State requests to the Contractor's online services agreement or terms and conditions agreement.

A.25. Reporting & Systems Access

a. The Contractor shall, upon State request, submit monthly operational/performance reports by which the State can assess the Plan's activity and performance. The Contractor shall submit reports electronically, and shall include information such as enrollment, utilization, prescription sources and types, Plan expenses, Member demographic information and other information as requested by the State. All standard reports shall be distributed to the State within forty-five (45) days of the end of the previous month. If the Contractor's ad-hoc reporting system that is made available to the State allowing the Director of Pharmacy Services to pull data in various forms and full ad-hoc capability, then the State may, in its sole authority, waive the requirement to provide this information.

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

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

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

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

f. The Contractor, as requested by the State, shall generate a file of Members on a monthly basis with a first fill during the previous month for any antidepressant or anti-anxiety medication. Contractor shall share via secure server or email this list of Members and

Edison I.D. numbers with the State's EAP/BHO contractor so that said contractor may communicate with the identified Members on the State's behalf by notifying them of the EAP/BHO program and its associated benefits.

g. The Contractor shall provide the State a compliance report (also known as a quarterly report card), no later than sixty (60) days following the end of each quarter, which captures performance related to the requirements. See item #12 in Contract Attachment C.

h. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Contractor's compliance with financial terms inclusive of AWP (or its equivalent), Discounted Ingredient Cost and Dispensing Fees. See item #10 in contract Attachment C.

i. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Rebate payments due to the State summarized at the NDC or NDC-11. See item #9 in Contract Attachment C.

j. The Contractor, if requested by the State, shall assess on a quarterly and an annual basis the prevalence and incidence of potential opioid abuse within the insured State Group Plan population and provide a written narrative with facts and data/numbers to the State on a quarterly and annual basis. This report shall also include a detailed monitoring of providers to understand where the risk is the greatest. If at any time, the State determines that this information is no longer useful, the State may direct the Contractor to cease assessment, measurement, and reporting.

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

A.26. Member Satisfaction Survey

The Contractor shall perform, following review and approval by the State, an annual Member satisfaction survey specific to the State's Plan. The Contractor shall conduct the survey once annually during each calendar year at a time approved by the State and shall involve a statistically valid random sample of Members. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. The survey question or questions should be specific to the services and touchpoints the Contractor has with our Members, rather than the benefits or benefits structure itself (i.e. Members should be rating the satisfaction they have with the Contractor and the services provided by the Contractor rather than their Copayments or Coinsurance which are not controlled by the Contractor.) Based upon the results of the survey, the Contractor and the State will jointly develop an action plan approved In Writing by the State, to correct problems or deficiencies identified through this activity. The level of overall customer satisfaction shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s).

A.27. SLA Scorecard and Performance

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

b. The Contractor shall be responsible for meeting or exceeding the KPIs throughout the Term. The Contractor and State shall review quarterly the Contractor's success in achieving its performance objectives for the prior quarter in which services were delivered. Such performance shall be measured in accordance with KPIs and desired outcomes outlined in the SLA Scorecard (Contract Attachment D).

A.28. Audits Authority

a. Notwithstanding the records provision contained in Contract Section D.11, with provision by the State of thirty (30) days' notice, and with the execution of any applicable third party confidentiality agreements, the State or its qualified authorized representative (experienced in conducting pharmacy audits) has the right to examine and audit the services, pricing (including Rebates), and any provision of this Contract to ensure compliance with all program requirements and contractual obligations. For the purpose of audit requirements, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. All eligibility and claims data belong to the State.

b. The State has sole authority to determine who to choose for any kind of audit: financial, pharmacy Rebates, or other. This includes state employees, state employees from the Comptroller's audit staff, and BA's consulting firm. This audit right extends to any subcontractors of the PBM (e.g. Rebate processor).

If the State contracts with a private entity to conduct an audit of Contractor, the State will require the auditing entity to negotiate a reasonable non-disclosure agreement with the Contractor that will ensure that the auditor is independent, has no conflict of interest with the Contractor and has acceptable procedures in place to ensure that no information derived from the audit of Rebate or network pharmacy contracts is used in, or accessible to, any consulting function the auditor may provide. The PBM shall not attempt to limit the State's audit rights in any way or timeframe; the State in its sole authority and with execution of any confidentiality document shall be allowed to audit the PBM on any contracted service, Discount, Pass Through Transparent Pricing provision, claims processing, customer service, or any other provision of this contract by whomever the State in its sole authority deems it appropriate.

In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period at any time. Previous audits of a set of claims, pharmacies, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year and any charges or fees in any form for any audits that the State chooses to exercise.

c. The State is responsible for the cost of the authorized third party representative for such audits.

d. The Contractor shall provide access, with thirty (30) days' notice from the State, at any time, and for three (3) years after final contract payment (longer if required by law), to the State or the State's authorized representative to examine and audit the services provided under this Contract.

e. Any claims extract that may be provided to the State Comptroller's audit staff for their audit purposes **must** include, among other standard fields, the adjudicated date (date the pharmacy was paid by the PBM) for each individual claim.

f. The Contractor shall comply with Tenn. Code Ann § 4-3-1021. This requires the BA to compile a report each July 1 using data from various audit reports completed during the year and publish the results in a report every July 1st to the Tennessee Speakers of the House and Senate, the Comptroller of the Treasury, and members of the Tennessee General Assembly. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts both in and outside the State to ensure that each report is completed timely. Compliance with this state law requires the BA to conduct various audits and similar activities of the Contractor throughout the year.

g. The State will have access to any data necessary to ensure the Contractor is complying which includes, but is not limited to, one hundred percent (100%) of claims data, which includes at least all NCPDP fields from the most current version and release; Retail Pharmacy contracts; pharmaceutical manufacturer; Mail Order Service and Specialty Pharmacy contracts to the extent they exist with other contractor(s); utilization management reviews; clinical program outcomes; appeals; information related to the reporting; etc.

h. Pharmacy Rebate audits can include, but are not limited to, review and examination of manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with pharmacy manufacturers, and program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. Upon request by the State, or its designated authorized independent auditor, the Contractor shall provide full disclosure of Rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line item detail by NDC or NDC-11 and line item detail by pharmaceutical manufacturer showing actual cost remitted and other related claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from the go-live date on January 1, 2020 until the termination of benefits shall be included in any kind of pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment/Coinsurance assigned by the State (or lack thereof), Spread or differential between drug tier Copayments/Coinsurance, or any kind of utilization.

i. The Contractor shall disclose to the State's authorized representative any Administrative Fees or other reimbursements received in connection with any Rebates, Discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments, which include volume of pharmaceutical use by, or on behalf of, the

State. In addition, the Contractor shall, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

j. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall also provide a response to all findings received within thirty (30) days, or at a later date based on the number and type of findings, as approved by the State.

k. The State is not responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing reports, documentation, systems access, or space.

l. If the outcome of the audit results in an amount due to the State, one hundred percent (100%) of the payment of such settlement will be made by the Contractor within thirty (30) days of the Contractor's receipt of the final audit report. The Contractor shall also pay the State interest on the overcharge by multiplying the amount of the overcharge by the Tennessee State Pooled Investment Fund's Gross Total Portfolio Average Earnings Rate for the month(s) in the overcharge period, times the number of days in the overcharge period(s), divided by 365 days. Any amount due the State which is not paid by the Contractor within thirty (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month. The Contractor may submit written comments on the audit report including explanations of or objections to the findings of the audit report. The State, in its sole discretion, may amend the audit findings or adhere to the original findings. The thirty (30) day payment period would be suspended and would not run between the time the State receives Contractor's comments and the time the State responds.

m. The Contractor must assist the State in identifying fraud and perform fraud investigations of Members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews shall include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the State and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

(1) Discontinue further investigation if there is insufficient justification; or

(2) Continue the investigation and report back to the State and the Division of State Audit; or

(3) Continue the investigation with the assistance of the Division of State Audit; or

(4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation;

n. The Division of State Audit may request a full claims extract for their audit purposes at any time. Contractor shall work with State Audit to supply them a full claims extract including (but not limited to) such variables as date filled, pharmacy name, address, and phone number, drug name and NDC or NDC-11, quantity dispensed, gross cost, plan cost, Member cost, prescriber name and NPI, adjudicated (paid date; the date that the actual pharmacy was paid) – all for each claim processed under this contract and provided in any claims extract to the Division of State Audit.

o. The Contractor shall refer all media and legislative inquiries of any type to BA, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas related to this Contract; in all such instances, the Contractor shall copy the BA on all correspondence.

A.29. Pharmacy Audits

a. The Contractor shall audit at least five percent (5%) of network pharmacies in Tennessee annually. The same audits performed on the Contractor's Retail Pharmacy network will be conducted on the Mail Order Service and Specialty pharmacies.

b. The Contractor shall establish and maintain a process to detect and prevent errors, fraud or abusive pharmacy utilization by Members, pharmacies or prescribers. The Contractor shall contact pharmacies with aberrant claims or trends to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State – upon the State's request. Each quarter or upon the State's request, the Contractor shall summarize findings from the reports and share with the State to address program revisions.

c. The State may request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a contractor acceptable to the State within ninety (90) days of the date the Contractor assumes full responsibility for the pharmacy benefits program go-live date.

A.30. Due Dates for Project Deliverables

Unless otherwise specified In Writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Plan Implementation		

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
1.	Pharmacy benefit go-live	A.4.a	January 1, 2020
2.	Kick-off meeting for all key Contractor staff	A.4.d	Within thirty (30) days after Contract effective date
3.	Implementation plan and timetable	A.4.e	Thirty (30) days after Effective Date
4.	On-site implementation meeting	A.4.f	April 15, 2019 (On or before)
5.	State readiness review	A.4.g	November 1, 2019 (On or before)
6.	Call center onsite visit	A.4.i	November 1-30, 2019 and again after go live date, January 1-30, 2020
7.	Implementation Performance Assessment	A.4.k	February 15, 2020 (On or before)
8.	Initial Formulary Submission	A.4(e)(8) and A.9(a)	Sixty (60) days before go-live date
Staffing			
9.	Account Team satisfaction survey	A.5.g	Annually in January
POS Claims Adjudication			
10.	Business continuity/Disaster Recovery results	E.9.b	December 1, 2019, and annually thereafter.
Pharmacy Network			
11.	Network lists available on website	A.8.c	December 1, 2019
12.	Updated network lists	A.8.c	Quarterly after go-live date
13.	Mail Order Service website operational	A.8.g.(10)	December 1, 2019
14.	GeoNetworks® report	A.8.k	Annually in January
15.	Quarterly network changes report	A.8.l	Within five (5) working days of the end of each quarter following go-live date
Formulary Management			
16.	Formulary compliance report	A.9.d	Quarterly after go-live date
Clinical Programs			
17.	Therapeutic substitution and Generic Drug dispensing program reporting	A.12.d	Annually in January
18.	Disclosure of PA criteria and procedures	A.12.h.(1)	December 1, 2020 (On or before)
19.	PA Reporting	A.12.h.(5)	Quarterly after go-live date
Retro-DUR			
20.	Profile review focus and methodology	A.14.b	Thirty (30) days prior to initial review start date

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
21.	DUR and Retro-DUR presentations	A.14.e.(1)	Up to four (4) times annually, as requested by the State
22.	Retro-DUR Outcomes	A.14.e.(2)	Quarterly after go-live date
Financials			
23.	Annual Ingredient Cost reconciliation	A.15.b.10	Annually during the first quarter of each calendar year for the previous calendar year
24.	Dispensing Fee annual reconciliation	A.15.c.(1)	Annually during the first quarter of each calendar year for the previous calendar year
25.	Rate Guarantees	C.3.n	Within forty-five (45) days following each quarter
Pharmacy Rebates			
26.	Rebate and Administrative Fee reporting	C.3.r	Quarterly after go-live date
27.	Rebate annual reconciliation	C.3.r	First quarter each calendar year
Data Integration & Technical Requirements			
28.	Eligibility file acceptance	A.18.c	December 1, 2019
29.	Daily enrollment update	A.19.a.(1)	Daily after go-live date
30.	Daily File Transmission Statistics	A.19.a.(2)	Within twenty-four (24) hours of receipt of weekly file
31.	State enrollment data match	A.19.c	Up to four (4) times annually, as requested by the State
32.	Duplicate data processing records	E.9.b.	On or before the Contract termination or cancellation
33.	Claims data transmission to DSS contractor	A.19.d.(2)	Fifteen (15) days following the end of each calendar month
34.	Claims data transmission to third parties	A.19.g	Daily, unless otherwise directed by the State
35.	Load PAs, overrides, and open refills	A.19.h	December 1, 2019
36.	Claims data transmission to State	A.19.k	Within sixty (60) days of notice of Contract termination
Provider Education			
37.	Provider education recommendations	A.20.f	Annually in January
Appeals			
38.	Contractor grievance procedures	A.21.b	December 1, 2019
Customer Services			
39.	Customer service/call center statistics	A.22.m	Quarterly after go-live date
Member Communication/Materials			

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
40.	I.D. cards	A.23.m.(2)	December 10, 2019
41.	Open Enrollment information	A.23.m.(3)	Annually in August
42.	Initial welcome packets	A.23.m.(4)	December 10, 2019
43.	Ongoing welcome packets	A.23.e	Within ten (10) days of receipt of enrollment
Website			
44.	Website go-live	A.24.a	December 10, 2019
45.	State review of website	A.24.b	December 1, 2019
46.	Splash page	A.24.d; A.24.f.	Two (2) weeks prior to the annual enrollment period
Reporting and Systems Access			
47.	Operational/Performance reports	A.25.a	Monthly, within fifteen (15) days of the end of the previous month
48.	Reporting system access	A.25.b	December 1, 2019
49.	Eligibility system access	A.25.b	December 1, 2019
50.	State staff systems training	A.25.b	December 1, 2019
51.	Compliance report	A.25.g	Sixty (60) days following the end of each quarter after go-live
52.	Financial terms compliance report	A.25.h	Sixty (60) days following the end of each quarter after go-live
53.	Rebate payments report	A.25.i	Sixty (60) days following the end of each quarter after go-live
54.	Open service issues	A.25.k	Monthly after go-live
55.	FedRamp, ISO 27000 or SOC2 Type II report	E.9	Within thirty (30) days of the contract effective date and annually thereafter (in addition to periodic requests for bridge reports from State Audit)
Member Satisfaction Survey			
56.	Member satisfaction survey	A.26	Annually
Pharmacy Audits			
57.	Network pharmacy audits	A.29.a	Annually
58.	Aberrancy findings	A.29.b-c	As requested by the State
59.	Field audit staff	A.29.c	January 31, 2020

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:

A.31. Warranty. Contractor represents and warrants that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and in conformity with standards generally accepted in Contractor's industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law.

A.32. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

B. CONTRACT TERM:

This Contract shall be effective on June 1, 2019 ("Effective Date") and extend for a period of seventy-three (73) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed WRITTEN DOLLAR AMOUNT ($NUMBER). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Contract Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated, beginning no earlier than January 1, 2020, based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Contract Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Contract Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

Service Description	Amount (per compensable increment)				
	1/1/20* – 12/31/20	1/1/21 – 12/31/21	1/1/22 – 12/31/22	1/1/23 – 12/31/23	1/1/24 – 12/31/24
FEES (Guaranteed Maximum PMPM)					
Administration Fee Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month
Clinical Fee Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month
DISPENSING FEES (Guaranteed Maximum Average Per Claim)					
Retail – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Retail – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
90-Day Retail – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
90-Day Retail – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Mail Order Service – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Mail Order Service – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All Brand Specialty Pharmacy Claims	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum					

Service Description	Amount (per compensable increment)				
	1/1/20* – 12/31/20	1/1/21 – 12/31/21	1/1/22 – 12/31/22	1/1/23 – 12/31/23	1/1/24 – 12/31/24
Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
MAIL ORDER SERVICE NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)					
All Brand Specialty Pharmacy Claims	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
REBATES PER CLAIM (Guaranteed Minimum Per Script)					
All Retail Claim Basis (Brand & Generic)	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All 90-Day Retail Claim Basis (Brand & Generic)	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All Mail Order Service Claim Basis	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim

Service Description	Amount (per compensable increment)				
	1/1/20* – 12/31/20	1/1/21 – 12/31/21	1/1/22 – 12/31/22	1/1/23 – 12/31/23	1/1/24 – 12/31/24
(Brand & Generic)					
All Brand Specialty Pharmacy Claims	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim

* Based on the go-live date listed in Contract Section A.29. If this go-live date is not met, the payment for services listed above will be delayed accordingly based on the modified go-live date.

c. The State reserves the right to review files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. If the Contractor submits a claims payment request and the State overpays the claim, then the State may withhold the overpaid monies.

d. After Contract Effective Date, the Contractor shall use the post-settlement AWP for this Contract's pricing terms.

e. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received. The Contractor may retain an additional twenty percent (20%) of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of claims paid as a result of work related illnesses or injuries relative to worker's compensation claims

f. The State will fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, at least weekly provided the Contractor's payment process includes timely settlement of ACH transactions. Unless otherwise provided In Writing and approved by the State, the Contractor shall notify the State of the week's funding requirement amount. The State requires the Contractor to ACH debit the appropriate funds from a designated State bank account. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.

h. The State will fund the Contractor monthly for the administration fee based on the State's record of eligible Members as of the first day of the month.

i. The Contractor shall guarantee that the Dispensing Fee per claim is based on Paid Claims only not claims that are reversed or rejected.

j. The Contractor shall guarantee that U&C priced claims will not be assessed a Dispensing Fee.

k. The Contractor shall guarantee that the average Dispensing Fee per claim, if any, shall not exceed the guaranteed maximum average. 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.

l. The Contractor shall guarantee that all Discounts and services and Administrative Fees are guaranteed for the life of this contract, including any optional contract extensions executed by the State.

m. The Contractor shall guarantee that the terms presented are for the entire Contract period, including any optional contract extensions, and do not require the State to implement any plan designs or programs that are different from the plan design and programs currently in place.

n. The Contractor shall guarantee that the terms presented are State-specific, not book-of-business averages or Discount guarantees.

o. The contractor shall guarantee that the guaranteed Discount off AWP shall not exclude any products from the calculations (e.g., ZBD claims, U&C claims, those Generic Drugs during their exclusivity period, "specialty" drugs processed at retail), with the exception of Compound Prescriptions and powders, which shall be excluded.

The contractor shall guarantee that the calculation of each pricing guarantee (AWP Discount, Rebates, Dispensing Fees) shall not include zero balance claims where the Member pays one hundred percent (100%) of the cost of the drug, regardless of Plan type Member is enrolled in (PPO, CDHP). The Contractor will calculate the achieved Discounts with the following formula: [1 minus (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 un-Discounted 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.

p. The Contractor shall individually measure the guaranteed minimum average Discounts and fees for the retail networks, Mail Order Service pharmacy program, specialty network and 90-day-at Retail Pharmacy network. Over performance in one network area shall not offset under performance in other network areas. The Contractor shall individually measure specific brand Discounts, Generic Drug Discounts and Dispensing Fee components of each contract guarantee. Over performance in one contract area will not offset under performance in other contract areas. The Contractor shall measure guaranteed Discounts and Dispensing Fees annually within ninety (90) days following each quarter and reconcile with the State annually during the first quarter of the following calendar year. The Contractor shall reimburse the State the difference between actual average Discounts and fees and the guaranteed minimum average Discounts and fees by cash or check only. Credits to the Plan are not acceptable unless otherwise approved by the State In Writing. The Contractor will pay one hundred percent (100%) of any Discount guarantee shortfall to the State within forty-five (45) days of the close of each annual reconciliation period with the State retaining one hundred percent (100%) of any savings above the guarantees. Further, should the Contractor miss the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the

State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten (10) percent of the shortfall amount (under-performance payment). The Contractor will not be able to offset or recoup any under-performance payment in any reconciliation. The Contractor shall measure each quarter the Rebate guarantee within ninety (90) days of the close of the measurement period with one hundred percent (100%) true-up at calendar year end.

q. The Contractor shall pay to the State one hundred percent (100%) of the Total Manufacturer Value collected based, directly or indirectly, on the State's claims. The Contractor shall provide the State with the greater of (i) one hundred percent (100%) of the Total Manufacturer Value, or (ii) the guaranteed Rebates.

r. The Contractor shall pay out to the State all Total Manufacturer Value earned by the State regardless of termination of this contract.

s. The Contractor shall remit to the State no less frequently than quarterly a check for all Total Manufacturer Value obtained on behalf of the State due to the use of pharmaceuticals by Members for the Rebates accrued during the claim period ending six (6) months prior to the Rebate payment date. Rebate and Administrative Fee reporting shall also be submitted quarterly based on the State's NDC or NDC-11 utilization to demonstrate the level of Rebate Pass-Through Transparent Pricing. The Contractor shall pay, on a quarterly basis the greater of the minimum Rebate guarantees or the actual collected Rebates for the previous calendar quarter. Such payment shall occur no later than sixty (60) days after the end of a calendar quarter with a true up to one hundred percent (100%) to occur no later than sixty (60) days after the end of the calendar year for the previous calendar year.

t. The Contractor shall reconcile all rebates for the previous calendar quarter within one hundred twenty (120) days after the end of that quarter and remit payment to the State. True-up for the whole calendar year shall occur within ninety (90) days after the end of the calendar year and payment for any amount still owed to the State must be made by the Contractor by the ninetieth (90^{th}) day after the end of the calendar quarter.

u. The State shall reimburse the Contractor for the following, selected actual costs in the performance of this Contract:

(1) Postage. The State shall reimburse the Contractor for the actual cost of postage for mailing materials produced at the specific request of the State. Postage for materials and mailings referenced in the contract (ID cards, welcome packets, welcome fliers etc.) are the sole responsibility of the Contractor.

(2) Printing / Production (refer to Contract Section A.23.d.). Subject to compliance with Section E.8., the State shall reimburse the Contractor an amount equal to the actual cost of document printing/production as required and authorized by the State.

Notwithstanding the foregoing, the State retains the option to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.

v. The Contractor shall reimburse, when necessary and appropriate, monies to plan Members when an overpayment has occurred by the Member.

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

x. The pricing guarantees are NOT contingent upon the State maintaining a minimum number of active or retiree Members.

y. The Contractor agrees that amounts owed to the State including Rebates, guarantee shortfalls, recoveries identified during claims audits, will be paid by the appropriate due date. Any amounts unpaid after the stated due date will bear interest at nine percent (9%) per year accruing after the due date until payment is received for all payments due to the State.

z. The Contractor will agree to pay Discount and Dispensing Fee shortfalls as well as minimum guaranteed manufacturer payments after the Effective Date.

aa. The Contractor will NOT require the State to make any Plan design changes or implement any new programs in order to receive or maintain Discount, Dispensing Fee or Rebate guarantees.

bb. The Contractor's overall effective Discount guarantees for brand and Generic Drug Specialty Drugs will include: new drugs added to the list of Specialty Drugs each year and Limited Distribution Specialty Drugs that the Contractor's Specialty Pharmacy has access to.

cc. Any Rebates received from manufacturers after the reconciliation will be applied to the next reconciliation and will be clearly noted in the next reconciliation.

dd. If the State chooses to implement POS rebates for any or all plan options, the Contractor will administer Rebates at the POS at the NDC-11 level.

ee. Payments from the State to the Contractor are allowed, if the State implements any Contractor value-based payment arrangements, as referenced in Contract Section A.10.b

C.4. At-Risk Performance Payments and SLA Scorecard:

a. The Parties shall conduct a scorecard assessment (Contract Attachment D), beginning after the go-live date, on a quarterly basis (every three months) during the Term.

b. Based on the SLA Scorecard, Contractor shall send the State an At-Risk Performance Payment (if applicable) quarterly (every three months) during the Term in accordance with Contract Attachment D. This payment is due within forty-five (45) days of the quarterly SLA scorecard assessment.

C.5 Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.6. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Contract Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Seannalyn Brandmeir, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 1900
Nashville, Tennessee 37243

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) The Contractor shall submit invoices for Clinical Fees no more often than monthly, with all necessary supporting documentation including the invoice number (assigned by the Contractor);

(2) Invoice date;

(3) Contract number (assigned by the State);

(4) Customer account name: Department of Finance and Administration, Division of Benefits Administration

(5) Customer account number (assigned by the Contractor to the above-referenced Customer);

(6) Contractor name;

(7) Contractor Tennessee Edison registration ID number;

(8) Contractor contact for invoice questions (name, phone, or email);

(9) Contractor remittance address;

(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;

(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;

(12) Applicable payment methodology (as stipulated in Contract Section C.3.) of each good or service invoiced;

(13) Amount due for each compensable unit of good or service; and

(14) Total amount due for the invoice period.

B. The timeframe for payment (or any Discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Contract Section C.5. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;

(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;

(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and

(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Contract Section.

C.7. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

C.8. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.9. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee, any amounts that are or shall become due and payable to the State of Tennessee by the Contractor.

C.10. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

D. MANDATORY TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient confirmation. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Seannalyn Brandmeir
Tennessee Department of Finance & Administration
Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, TN 37243
Seannalyn.Brandmeir@tn.gov
Phone: 615-532-4598
Fax: 615-253-8553

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered effective upon receipt or recipient confirmation as may be required.

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State

and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.

D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.

D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall have the right to immediately terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract.

D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed under this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

D.9. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the

state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to State officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from subcontractors shall be maintained by the Contractor and made available to State officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or

provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one Party are not employees or agents of the other Party.

D.16 Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless for any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements (see Contract Attachment D), as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

e. The Contractor shall not sell Public Sector Plan Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis. The State must approve, In Writing, the use of and sale of any of our member or plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Public Sector Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments, including the cost of credit protection. At the request of the State, the Contractor shall offer credit protection for those times in which a Member's PHI is accidentally or inappropriately disclosed.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq.*, the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception

of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25. State and Federal Compliance. The Contractor shall comply with all applicable state and federal laws and regulations in the performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 407.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, including all the terms and conditions of the Parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the Parties, whether written or oral.

D.28. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;

b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes:

i. Contract Attachment A Attestation Re Personnel Used in Contract Performance;

ii. Contract Attachment B Performance Guarantees and Liquidated Damages;

iii. Contract Attachment C Reporting Requirements; and

iv. Contract Attachment D HIPAA Business Associate Agreement

c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;

d. the State solicitation, as may be amended, requesting responses in competition for this Contract;

e. any technical specifications provided to proposers during the procurement process to award this Contract;

f. the Contractor's response seeking this Contract; and

g. any Contractor rules or policies including but not limited to internal rules, policies, and statements such as insurance policies filings by the Contractor with State regulators

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et. seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) Business Days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The parties agree that failure to provide evidence of insurance coverage as required is a material

breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

a. Workers' Compensation and Employer Liability Insurance

1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

i. Workers' compensation in an amount not less than one million dollars ($1,000,000) including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.

2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. § 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

i. The Contractor employs fewer than five (5) employees;

ii. The Contractor is a sole proprietor;

iii. The Contractor is in the construction business or trades with no employees;

iv. The Contractor is in the coal mining industry with no employees;

v. The Contractor is a state or local government; or

vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

b. Automobile Liability Insurance

1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).

2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars ($1,000,000) per occurrence or combined single limit.

c. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a claims-made basis. If this coverage is written on a claims-made basis, then:

i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services;

ii. Insurance must be maintained and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment, and

iii. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or prior to the Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.

2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) in the aggregate; and

3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession in an amount not less than five million dollars ($5,000,000) per occurrence or claim

and five million dollars ($5,000,000) annual aggregate, covering all acts, errors, omissions, negligence, infringement of intellectual property (except patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than five million dollars ($5,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's Subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's Subcontractors and that are subject to tax.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.

E.2. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required or permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.

The obligations set forth in this Section shall survive the termination of this Contract.

E.3. Software License Warranty. Contractor grants a license to the State to use all software provided under this Contract in the course of the State's business and purposes.

E.4. Software Support and Maintenance Warranty. Contractor shall provide to the State all software upgrades, modifications, bug fixes, or other improvements in its software that it makes generally available to its customers.

E.5. Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.6. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's Response to #31786-00143 (RFP Attachment 6.2 Section B.15) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a monthly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, service-disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at: https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.7. Liquidated Damages. If the Contractor fails to perform in accordance with any term or provision of this contract, only provides partial performance of any term or provision of the Contract, violates any warranty, or any act prohibited or restricted by the Contract occurs, ("Liquidated Damages Event"), the State may assess damages on Contractor ("Liquidated Damages"). The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for Contractor's failure to fulfill its obligations regarding the Liquidated Damages Event as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Liquidated Damages Event, and are a reasonable estimate of the damages that would occur from a Liquidated Damages Event. The Parties agree that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity.

E.8. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify and/or procure that Contractor is in full compliance with its obligations under this Contract in relation to PII. Upon termination or expiration of the Contract or

at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise available at law.

E.9. Contractor Hosted Services and Confidential Data.

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

(1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

(2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption technologies.

(3) The Contractor's processing environment containing Confidential State Data shall be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (iii) American Institute of Certified Public Accountants ("AICPA") Service Organization Controls ("SOC") 2 Type II certified. The Contractor shall provide proof of current certification annually and upon State request. The Contractor shall also provide, at the State's request, a copy of the report for any applicable Subcontractors.

(4) The Contractor must comply with the State's Enterprise Information Security Policies. This document is found at the following URL: https://www.tn.gov/content/dam/tn/finance/documents/Enterprise-Information-Security-Policies-ISO-27002-Public.pdf

(5) In the event that the operating system is an integral part of the application, the Contractor agrees to maintain Operating Systems at current, manufacturer supported versions. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(6) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. The Contractor shall make sure that the Application is at all times fully compatible with a manufacturer-supported Operating System; the State shall not be required to run an Operating System that is no longer supported by the manufacturer.

(7) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application, to ensure that security vulnerabilities are not introduced.

(8) With advance notice from the State, and no more than one (1) time per year the Contractor agrees to allow the State to perform logical and physical audits of the Contractor's facility and systems that are hosting Confidential State Data.

(9) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Penetration Tests" shall be in the form of software attacks on the Contractor's computer system, with the purpose of discovering security weaknesses, and potentially gaining access to the computer's features and data. The "Vulnerability Assessment" shall have the goal of defining, identifying, and classifying the security holes (vulnerabilities) in the Contractor's computer, network, or communications infrastructure. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Contractor's Processing Environment.

b. Business Continuity Requirements.

(1) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a business continuity and Disaster recovery ("BC-DR") plan. The BC-DR plan shall encompass all Information Systems supporting this Contract. At a minimum the Contractor's BC-DR plan shall address and provide the results for the following scenarios:

i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and

iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system.

(2) The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, Disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

i. "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

a. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by the State and the Contractor.

b. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a Disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: Seventy-two (72) hours.

ii. The Contractor shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recover Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements. The Contractor shall submit a written summary of its annual BC-DR test results to the State (see Contract Attachment C #2).

c. Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State.

The Contractor shall maintain a duplicate set of all records relating to this Contract in electronic medium, usable by the State and the Contractor for the purpose of Disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft-

protected facility located away from the storage location of the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation.

d. Upon termination of this Contract or upon notice of termination of this Contract prior to the Term date, the Contractor shall convey the original and the duplicate records medium and the information they contain to the State on or before the date of termination. In consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) Business Days after destruction.

E.11. Intellectual Property Indemnity. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State concerning or arising out of any claim of an alleged patent, copyright, trade secret or other intellectual property infringement. In any such claim or action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any settlement or final judgment, and the Contractor shall be responsible for all legal or other fees or expenses incurred by the State arising from any such claim. The State shall give the Contractor notice of any such claim or suit, however, the failure of the State to give such notice shall only relieve Contractor of its obligations under this Section to the extent Contractor can demonstrate actual prejudice arising from the State's failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State of Tennessee in any legal matter, as provided in Tenn. Code Ann. § 8-6-106.

E. 12. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

E.13. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

Larry B. Martin, CHAIRMAN **DATE**

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any Subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established Liquidated Damages associated with Contractor's obligations with respect to the Contract. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose liquidated damage assessments. Damages are included in this Attachment.

The Parties agree that the Liquidated Damages represent solely the anticipated damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party.

Payment of Liquidated Damages: It is agreed by the State and the Contractor that any liquidated damages assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of Liquidated Damages. If payment is not made by the due date, the Liquidated Damages amount may be withheld from future payments by the State without further notice.

1. Program Go-Live Date	
Guarantee	The pharmacy benefit for the Plans shall take effect and be fully Operational on the go-live date specified in Contract Section A.30. "Operational" is defined as the ability to accurately enroll Members, accept and process POS claims, accept and process Mail Order Service prescriptions, and provide all other PBM services outlined in the Contract.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond the go live date that the program is not operational up to thirty (30) Business Days.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide pharmacy benefits coverage to our Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
2. Implementation Plan	
Guarantee	The Contractor shall provide a project implementation plan, as required in Contract Section A.4, to the State no later than thirty (30) days after contract effective date, which includes all tasks with deliverable dates necessary to install the program by the go-live date.
Assessment	One thousand dollars ($1,000) for each Business Day beyond the deadline up to go-live date specified in Contract Section A.30.
Justification	This is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
3. Operational Readiness	
Guarantee	The Contractor shall resolve all noncompliance with contract terms identified by

	the State during its operational readiness review including all milestones required in Contract Section A.4.g, prior to go-live date.
Assessment	Ten thousand dollars ($10,000) if any findings are not resolved prior to go-live.
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to go-live and operations.
Measurement	Assessed and reported no later than three (3) months after go-live date.
4. Plan Design	
Guarantee	Plan design per written communications with Benefits Administration (including covered services, excluded services, Member cost share, and ingredient cost pricing) will be implemented correctly, as required in Contract Section A.4.
Assessment	Twenty-five thousand dollars ($25,000) per incorrect plan design setup such as, but not limited to, incorrect member cost share, incorrect covered services or excluded services.
Justification	Plan design information must be timely and accurate as to not cause confusion or financial hardship to Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed and reported three (3) months after go-live date and each successive plan year.
5. Eligibility Set-Up	
Guarantee	As required in Contract Section A.18.c, eligibility information must be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.30.
Assessment	Ten thousand dollars ($10,000) for each Business Day beyond the date specified in Contract Section A.18.c up to the go-live date.
Justification	Eligibility set-up is a critical step in providing Members pharmacy benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving prescription medication. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
6. Key Staff Vacancies	
Guarantee	As required in Contract Section A.5.k, if any Key Staff become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.
Assessment	One-thousand dollars ($1,000) for exceeding the sixty (60) day requirement.
Justification	With a vacancy in our Contractor team, the State must have the ability to know when a replacement will be hired and ready to fulfill the Contract obligations. Without Key Staff, the State does not have the ability to contact the Contractor with Member issues to seek timely resolution. This assessment and amount takes into account the increased State staff time as a result of not having Key Staff in place.
Measurement	Assessed, reported, and reconciled quarterly.
7. Network Access	
Guarantee	As required in Contract Section A.8.e.1, the Contractor shall maintain a network of pharmacy providers to provide the covered services that met the following access standards using a GeoNetworks® report:

	Access standard	Percentage	Measure
	Urban area	at least ninety percent (90%) of Members	Member(s) live within one and one-half (1.5) miles of a Retail Pharmacy participating in the Contractor's network
	Suburban area	at least ninety percent (90%) of Members	Member(s) live within three (3) miles of a Retail Pharmacy participating in the Contractor's network
	Rural area	at least ninety percent (90%) of Members	Member(s) live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network
Assessment	Fifty thousand dollars ($50,000) if any of the access standards listed above are not met.		
Justification	The Contract requires minimum access standards and without those, Members do not have access to pharmacies within the access standards and therefore the potential to go without prescription medication and increased financial hardship. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled annually using the GeoNetworks® report provided by the Contractor.		
8. Claims Data Submission			
Guarantee	The Contractor shall submit claims data to the State's DSS contractor no later than fifteen (15) days following the end of each month, or more frequently as approved by the State, as required in Contract Section A.19.d.1-7		
Assessment	Five thousand dollars ($5,000) per Business Day up to the twentieth (20th) Business Day.		
Justification	Timely submission of claims data ensures that the State and Members have accurate and timely information. The State relies on the claims data information for reporting and planning purposes. Members rely on this data for Plan information such as deducible and out of pocket maximum amounts. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled quarterly.		
9. Data Transmission to Third Party Contractors			
Guarantee	Unless otherwise directed by the State, the Contractor shall provide daily accumulator data feeds to the State's third party contractors listed in Contract Section A.19.g. until all claims incurred during the Term have been paid.		
Assessment	One thousand dollars ($1,000) for each daily data feed not provided.		
Justification	Data submissions to the State's third party contractors are critical for ongoing medical care and treatment for Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled quarterly.		
10. Splash page			

Guarantee	The Contractor's splash page shall be available on the internet, fully operational and updated annually no later two (2) weeks prior to the State's annual open enrollment period, as required in Contract Sections A.24.d and A.24.f.
Assessment	One thousand dollars ($1,000) per Business Day until operational or updated.
Justification	This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled annually.
11. Member Satisfaction Survey	
Guarantee	Approved Member Satisfaction survey(s) as required in Contract Section A.26, must have an overall customer satisfaction rating equal to or greater than eighty-five percent (85%) in the first year, and ninety percent (90%) in all subsequent year(s) within the Term.
Assessment	Twenty thousand dollars ($20,000) for each year that the standard is not met.
Justification	This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled annually.
12. URAC Accreditation	
Guarantee	As required in Contract Section A.3.d, the Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.
Assessment	Twenty thousand dollars ($20,000) per incurrence the accreditation is not maintained.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive URAC accreditation. This assessment and amount takes into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Assessed, reported, and reconciled annually.
13. Reporting	
Guarantee	The Contractor shall distribute to the State all reports required in Contract Sections A.1 through A.30 within the time frame specified in the Contract.
Assessment	One thousand dollars ($1,000) for each report not delivered to the State within the time frame specified in the contract.
Justification	The State relies on reporting in making sure operations, services, KPIs, and desired outcomes provided by the Contractor. These are reported to our contract compliance and program director, reviewed and assessed, if applicable. The data provided in required reports is the foundation for future Plan design and decisions made by the State.
Measurement	Assessed, reported, and reconciled quarterly.
14. Unauthorized Usage of Information	
Guarantee	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.
Assessment	One hundred dollars ($100) per impacted Member unless that cannot be determined in which case the assessment shall be one hundred dollars ($100) per head of contract.
Justification	The State has a responsibility to protect Member information. The Contractor shall not use our Member information for pecuniary gain and the Contractor attested to this during the procurement process. This scenario causes confusion and potential harm to Members if they enroll in incorrect pharmacy

	benefit plans because of the Contractor's actions.
Measurement	Assessed, reported, reconciled upon identification of occurrence.
15. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment C, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Justification	The guarantee and assessment estimates the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per incident basis. This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours; 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours; 3. Program Director associated with this contract time and work estimated at fifteen (15) hours; 4. Executive Director's time and work estimated at one (1) hour; 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours.
Measurement	Assessed, reported, assessed, and paid after each occurrence.
16. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment C, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Justification	The guarantee and assessment estimates the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.

	A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally-required media release to media outlets across the State.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis. This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty(130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours; 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours; 4. Executive Director's time and work estimated at eighteen (18) hours; 5. Department attorney time including legal review estimated at thirty (30) hours; 6. Service Center staff time and work answering Member questions/concerns estimated at one-hundred (100) hours; 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.
Measurement	Assessed, reported, assessed and paid after each occurrence.

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format approved by the State, and shall be of the type and at the frequency indicated below. The State reserves the right to modify reporting requirements as deemed necessary to monitor contract implementation. The State will provide the Contractor with at least sixty (60) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

a. Monthly reports shall be submitted by the 15th of the following month;

b. Quarterly reports shall be submitted by the 20th of the following month; and

c. Annual reports shall be submitted within ninety (90) days after the end of the calendar year.

Reports shall include, at a minimum (not an all-inclusive list; refer to contract for all specifics):

1. **Account Team Satisfaction Survey**, submitted annually in January.
2. **Business Continuity/Disaster Recovery results**, December 1, 2019 and annually thereafter
3. **GeoNetworks Report**, submitted annually in January.
4. **Quarterly Network Changes Report**, submitted within five (5) Business days of the end of each calendar quarter after go-live date.
5. **Formulary Compliance Report**, submitted quarterly after go-live date.
6. **Therapeutic substitution and Generic Drug dispensing program report,** submitted annually in January.
7. **Prior Authorization (PA) reporting,** submitted quarterly after go-live date.
8. **Rebate and Administrative Fee reporting,** submitted quarterly after go-live date.
9. **Rebate Annual Reconciliation,** submitted during the first quarter of each calendar year.
10. **Financial Reporting,** quarterly at the end of each calendar quarter and annually during the first calendar quarter showing Contractor's financial targets (e.g. AWP minus %, Dispensing Fees, etc.) and outcomes.
11. **Operational/Performance Reporting,** monthly within fifteen (15) days of the end of the previous month.
12. **Compliance Report (aka report card),** submitted each calendar quarter showing for the previous quarter the Contractor's outcome for each of the measurements in the Contract Attachment B of this Contract, as well as any payment amount due for that quarter (if applicable).

13. **Rebate Payments report,** submitted at least sixty (60) days following the end of each calendar quarter after go-live date.

14. **FedRamp, ISO 27000 or SOC2 Type II report,** submitted within thirty (30) days of the Effective Date, annually thereafter, and in addition to periodic bridge reports as requested by the State.

15. **Pass Through Pricing Report,** submitted quarterly after go-live date as referenced in Contract Section A.7.c.

16. **Other Reports,** as specified in this Contract and using templates prior approved In Writing by the State.

Service Level Agreement Scorecard

Below is the SLA Scorecard and associated KPIs used to measure the Contractor's performance against the desired outcomes. Evaluated, scored, and reconciled quarterly via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard each calendar quarter documenting the Contractor's outcome for each of the KPI for the previous quarter, in which services were delivered, as well as any At-Risk Performance Payment due (if applicable).

It is agreed by the State and the Contractor that any At-Risk Performance Payment assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of fees at risk. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

KPI	Description	Performance Requirement	Vendor Performance	Score if Met	Quarterly Score
POS System Availability	POS system, used by contracted pharmacies to process pharmacy claims, as required in Contract Section A.6.l, shall be accessible and operational ninety-nine point five percent (99.5%) of the time.	99.50%	99.5% or greater 98.0-99.4% 96.0-97.9% Less than 96%	9 6 3 0	
POS System Processing	As required in Contract Section A.6.d, the Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within five (5) seconds.	99.50%	99.5% or greater 98.0-99.4% 96.0-97.9% Less than 96%	5 3 1 0	
Claims Processing Accuracy	Claims processing accuracy, as required in Contract Section A.6.k, shall be ninety-eight percent (98%) or higher.	98%	98% or greater 96.0-97.9% 94.0-95.9% Less than 94%	6 4 2 0	
Claims Payment Accuracy	Claims payment accuracy, as required in Contract Section A.7.e, shall be ninety-eight percent (98%) or higher.	98%	98% or greater 96.0-97.9% 94.0-95.9% Less than 94%	6 4 2 0	
Claims Payment Turnaround	As required in Contract Section A.7.h, one hundred percent (100%) of direct reimbursement Clean Claims (either electronically through POS	100%	100% 98.0-99.9% 96.0-97.9%	6 4 2	

	or through Member submitted paper claims) shall be paid within the lesser of thirty (30) days or the contracted turnaround time with the pharmacy.		Less than 96%	0	
Generic Drug Substitution - Mail Order	As required in Contract Section A.9.j.1, ninety-five percent (95%) or more of Mail Order Service prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	6 4 2 0	
Generic Drug Substitution - Retail	As required in Contract Section A.9.j.1, ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	90%	90% or greater 88.0-89.9% 86.0-87.9% Less than 86%	8 4 2 0	
PA Evaluation	As required in Contract Section A.12.h.4, the Contractor's call center staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.	99%	99% or greater 97.0-98.9% 96.0-96.9% Less than 95%	6 4 2 0	
Eligibility Discrepancies	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within one (1) business day of identification, as required in Contract Section A.19.a.3.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	6 5 4 0	
Pre-Service Appeals	Ninety-five percent (95%) of Pre-Service Appeals shall be decided within thirty (30) days, as required in Contract Section A.21.c.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	4 3 2 0	
Post-Service Appeals	Ninety-five percent (95%) of Post-Service Appeals within sixty (60) days, as required in Contract Section A.21.c.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	4 3 2 0	

Telephone Coverage	The Contractor shall provide uninterrupted telephone coverage for twenty-four (24) hours a day/seven (7) days a week for claims, systems and customer service and pharmacy provider inquiries, as required in Contract Section A.22.a. Excluded from this are contracted-planned down times or Force Majeure Events as listed in Contract Section D.24.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	8 6 4 0	
Average Speed of Answer	The Contractor shall maintain an ASA of thirty (30) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.22.j.	30 second average	30 Sec Avg 29-29.9 Sec Avg 28-28.9 Sec Avg Less than 28 Sec Avg	8 6 4 0	
Member Communications	All materials, including but not limited to: ID cards and letters produced by the Contractor shall be reviewed and approved by the State prior to printing, assembly, and/or distribution, as required in Contract Section A.23.h.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	8 4 2 0	
Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-five percent (95%) of welcome packets and ID cards shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.23.m(2).	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	6 4 2 0	
Claims Data Quality	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.19.f. Date of birth: Data missing for ≤ 3% of claims Pharmacy provider ID missing: Data missing for ≤ 1.5% of claims NDC or NDC 11 missing: Data missing for ≤ 1.5% of claims	3 measures met	3 measures met 2 measures met 1 measure met 0 measures met	4 2 1 0	
Total Quarterly Score					

Calculated Performance Payment	

Quarterly Score	At Risk Performance Payment
>=96	0% of previous quarter Administrative Fees
91 - 95	.25% of previous quarter Administrative Fees
86 - 90	.50% of previous quarter Administrative Fees
81 - 85	.75% of previous quarter Administrative Fees
76 - 80	1% of previous quarter Administrative Fees
71 - 75	1.5% of previous quarter Administrative Fees
66 - 70	2% of previous quarter Administrative Fees
61 - 65	3% of previous quarter Administrative Fees
<61	4% of previous quarter Administrative Fees

HIPAA BUSINESS ASSOCIATE AGREEMENT
COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Finance and Administration, Division of Benefits Administration** (hereinafter "Covered Entity") and _____ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge that they are subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name:	**Execution Date:**
_____	_____

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Contract(s) are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, make this Agreement.

DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Electronic Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 "Genetic Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 "Information Holder" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.10 "Marketing" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.11 "Personal information" shall have the meaning set out in its definition at T.C.A. § 47-18-2107.

1.12 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.13 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.14 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.15 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.16 "Security Incident" shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

1.17 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate is authorized to use PHI for the purposes of carrying out its duties under the Services Contract. In the course of carrying out these duties, including but not limited to carrying out the Covered Entity's duties under HIPAA, Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. Business Associate is subject to requirements of the Privacy Rule as required by Public Law 111-5, Section 13404 [designated as 42 U.S.C. 17934] In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Associate shall use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement, Services Contract(s), or as Required By Law. This includes the implementation of Administrative, Physical, and Technical Safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably

anticipated threats or hazards, utilizing the technology commercially available to the Business Associate. The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its Workforce.

2.4 Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential information, to agree, by written contract with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

2.5 Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.6 Business Associate shall require its employees, agents, and subcontractors to promptly (up to 48 hours) report, to Business Associate, immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the breach.

2.7 As required by the Breach Notification Rule, Business Associate shall, and shall require its subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.7.1 Business Associate shall provide to Covered Entity notice of a Potential or Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach.

2.7.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.7.3 Covered Entity shall make the final determination whether the Breach requires notification and whether the notification shall be made by Covered Entity or Business Associate.

2.8 If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of Covered Entity, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 30 Business Days from Covered Entity notice to provide access to, or deliver such information.

2.9 If Business Associate receives PHI from Covered Entity in a Designated Record Set, then Business Associate shall make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least t 30 Business Days from Covered Entity notice to make an amendment.

2.10 Business Associate shall make its internal practices, books, and records including policies and procedures and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.11 Business Associate shall document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.

2.12 Business Associate shall provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 30 Business Days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the PHI was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure. Business Associate shall provide an accounting of disclosures directly to an individual when required by section 13405(c) of Public Law 111-5 [designated as 42 U.S.C. 17935(c)].

2.13 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.13.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.13.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.13.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for PHI from Covered Entity.

2.14 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.15 If Business Associate receives a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for PHI in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.16 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate shall fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule and Public Law 111-5. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its

computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation to certify its compliance with the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) Business Days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly (up to 48 hours) report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

3.5 Business Associate shall make its internal practices, books, and records including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

3.7 Notification for the purposes of Sections 2.8 and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

State of Tennessee
Benefits Administration
Attn: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

With a copy to:

State of Tennessee
Benefits Administration
Contracting and Procurement Manager
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 532-4598
Facsimile: (615) 253-8556

3.8 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

_____
_____
_____
_____
_____
_____
_____
_____

Business Associate shall notify Covered Entity of any change in the key contact during the term of this Agreement in writing within ten (10) Business Days.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contract(s), provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity. Business Associate's disclosure of PHI shall be subject to the limited data set and minimum necessary requirements of Section 13405(b) of Public Law 111-5, [designated as 42 U.S.C. 13735(b)]

4.2 Except as otherwise limited in this Agreement, Business Associate may use PHI as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached immediately upon becoming aware.

4.4 Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use PHI to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1).

4.6 Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of member's personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.7 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreement with any subcontractor or agent which Business Associate provides access to Protected Health Information.

4.8 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of PHI.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, Section 7.3 below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This

provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of PHI is unfeasible, Business Associate shall extend the protections of this Memorandum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191, including any amendments required by the United States Department of Health and Human Services to implement the Health Information Technology for Economic and Clinical Health and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
State of Tennessee
Department of Finance and Administration
Benefits Administration
ATTN: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556
E-Mail: benefits.privacy@tn.gov

With a copy to:
ATTN: Seannalyn Brandmeir
Procurements & Contracting Manager
At the address listed above
Phone: (615) 532-4598

BUSINESS ASSOCIATE:

Facsimile: (615) 253-8556
E-Mail: seannalyn.brandmeir@tn.gov

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) Business Days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

8.10 Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

	Date:
Larry B. Martin, Commissioner of Finance & Administration	**Date:**

EXPRESS SCRIPTS®

2014 Formulary Details and Formulary Exception Process

Adam Kautzner, Sr. Director, Drug Trend & Formulary Solutions

Jeff Eichholz, Sr. Director, Formulary Development and Appeals

July 30, 2013

Key Agenda Items

- Detailed review of not covered drugs and impact
- Formulary exception process preserves patient access
- The positive ramifications from 2014 formulary design

Unprecedented change has occurred in our industry
We must adapt to successfully lead our clients and patients into the future
Carefully dissecting the market allowed us to define our 2014 strategy

How Drugs Will Process

- Not covered drugs will not adjudicate
  - Reject 70 – NDC Not Covered
  - Alternatives provided in secondary messaging
- Other non formulary drugs continue to process as 3rd tier
- No grandfathering except where clinically required
  - Inflammatory Conditions-only GF class
  - Patient Prior Authorizations will be termed as of 12/31/13
- Standard Formulary Exception Process

Important 2014 National Preferred Factors

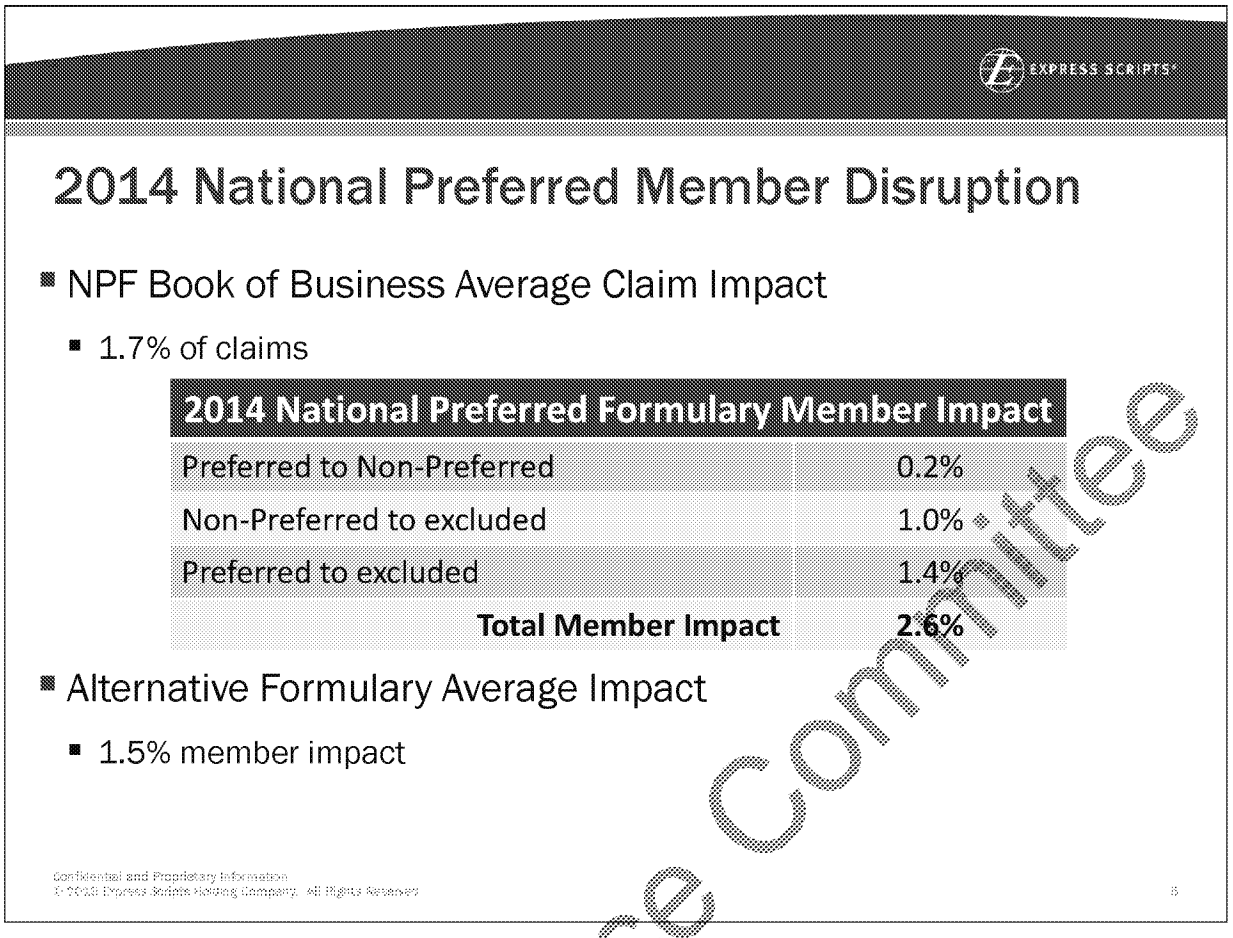
- We are following normal course of business timeline

2014 National Preferred Formulary

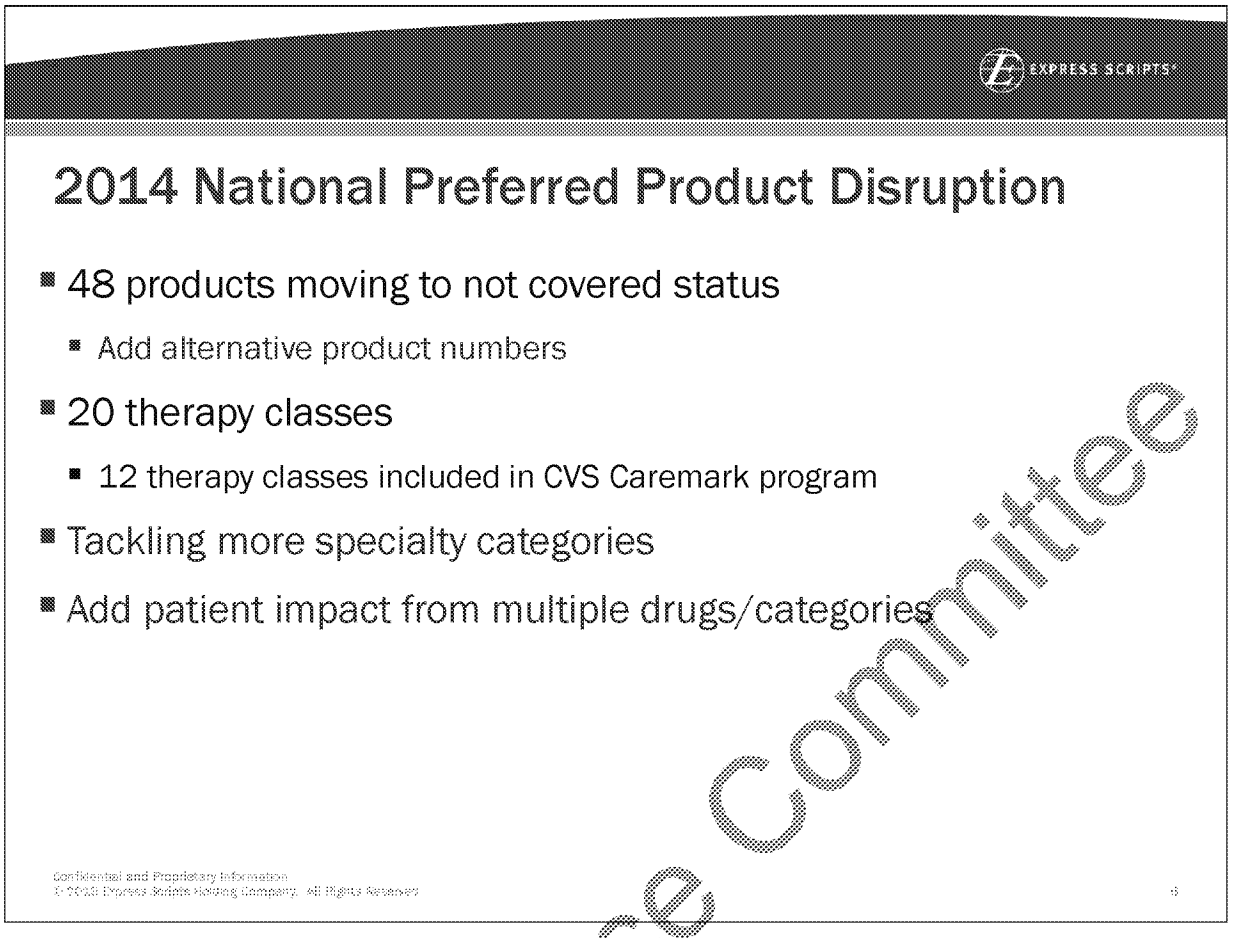
What it isn't	What it is

- Clients not accepting 2014 National Preferred Formulary changes have options

Will remain on current formulary unless opted out
Alternative Formulary
High Performance Formulary



Typical disruption is 1-2% with some peaks and valleys in some years. Had less recently but will be a little higher than normal for 2014.



Typical disruption is 1-2% with some peaks and valleys in some years. Had less recently but will be a little higher than normal for 2014.

Diabetic Classes

Therapy Class	Drug(s) Excluded	Formulary Alt.	CVS Targeted Class
Insulin	Novolog/Novolin Apidra	Humalog/Humulin	Yes
Diabetic Test Strips	Roche, Bayer, Abbott, Nipro	Johnson&Johnson (One Touch)	Yes
DPP4	Jentadueto, Tradjenta, Kazano, Nesina	Januvia, Janumet, Onglyza, Kombiglyze	Yes
GLP-1	Victoza	Byetta, Bydureon	No

Indicates non-preferred products changing to excluded products

Apidra formulary on PPF. Novo formulary on both in 2013
Roche formulary on PPF and NPF
Jentadueto and Tradjenta formulary on PPF and NPF

Asthma/Pulmonary Classes

Therapy Class	Drug(s) Excluded	Formulary Alt.	CVS Targeted Class
Pulmonary Anti-Inflammatory/Beta Agonist Combo	Advair	Dulera, Symbicort	Yes
Pulmonary Anti-Inflammatory	Flovent, Alvesco	Asmanex, Pulmicort Flexhaler, Qvar	Yes
Short-Acting Inhaled Bronchodilators	Maxair Autohaler, Proventil HFA, Xopenex HFA	Proair HFA, Ventolin HFA	Yes

Indicates non-preferred products changing to excluded products

Advair formulary on both
Alvesco formulary on PPF

Specialty Classes

Therapy Class	Drug(s) Removed	Formulary Alt.	CVS Targeted Class
Pegylated Interferons	Peg-Intron	Pegasys	No
Follitropins (Infertility)	Bravelle, Follistim AQ	Gonal-F	No
Biologics-Injectable TNF Antagonist*	Cimzia, Simponi, Stelara, Xeljanz	Enbrel, Humira	No
Growth Hormones	Tevtropin, Nutropin, Omnitrope, Saizen	Humatrope, Norditropin, Genotropin	Yes
Beta Interferons Multiple Sclerosis	Betaseron	Extavia, Rebif, Copaxone, Avonex	No

Indicates non-preferred products changing to excluded products

*Mandatory Grandfathering

Peg Intron formulary on PPF and NPF
Bravelle and Follistim AQ formulary on PPF
Stelara formulary on PPF and NPF
Nutropin formulary on NPF
Betaseron formulary on NPF and PPF

Other Classes

Therapy Class	Drug(s) Removed	Formulary Alt.	CVS Targeted Class
Angiotensin Active+HCT Combo	Edarbi/Edarbyclor, Teveten/HCT, Micardis/HCT	generics Benicar/HCT	Yes
Epinephrine Autoinjectors	Auvi-Q	Epipen/Jr	No
Erectile Dysfunction	Levitra, Staxyn	Cialis, Viagra	Yes
Narcotic Analgesics	Avinza, Exalgo, Kadian	generics, Nucynta ER, Opana ER, Oxycontin	No
Nasal Steroids	Beconase AQ, Omnaris, Rhinocort Aqua, Veramyst, Zetonna	generics, Nasonex, Qnasl	Yes

Indicates non-preferred products changing to excluded products

Micardis/HCT formulary on PPF
Avinza formulary on PPF
Rhinocort Aqua and Veramyst formulary on PPF

Fortesta formulary on PPF

Formulary Exception Criteria

- Formulary Exception Criteria allows access to medications
  - Criteria clinically reviewed and approved
- Standard Exception Criteria
  - Added for all NPF Clients
  - Added for all drugs
- Standard set up will default to benefit design for non-preferred products
  - Custom set up available to default to benefit design for formulary products

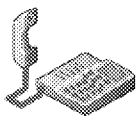
Preferred Drug Lists Developed for Large Populations
Clinical needs of every patient may not be met

Clinical Prior Auth vs. Formulary Exception

- Placeholder

Preferred Drug Lists Developed for Large Populations
Clinical needs of every patient may not be met

Formulary Exception Process



Physician/Pharmacist/
Member Calls or Faxes in
for a Formulary Exception

Inflation Predictability

- Pharma Contracting led initiative over multiple years
  - Great progress made for 2014
- Limits annual inflation on a drug with a contractual cap
- Manufacturers exceeding cap must pay additional rebate for excessive increases
  - Payment split to client dependent on rebate arrangement
- Now a component of deciding formulary status
  - 80% of preferred alternatives in excluded classes
- Reporting currently not available for clients

Inflation Predictability(IP) Examples

Inflation Predictability

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%			

- Resetting vs. Non-Resetting Inflation Predictability
  - Determines drug price at start of subsequent years
    - Resetting - $110
    - Non-Resetting - $105

Inflation Predictability(IP) Examples

Resetting Inflation Predictability

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$110	5%			

Non-Resetting Inflation Predictability

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$105	5%			

Inflation Predictability(IP) Examples

Resetting Inflation Predictability

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$110	5%	$115.50	$121	$5.50
3	$121	5%			

Non-Resetting Inflation Predictability

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$105	5%	$110.25	$121	$10.75
3	$110	5%			

Manufacturer Copayment/Discount Cards

- Availability continues to increase at a rapid rate
  - Over 400 drugs now have copayment cards
- All manufacturers on excluded drug list have them
- Circumvent the formulary process by lowering patient cost
- Increasingly sophisticated with insertion into pharmacy systems
- Rx must be adjudicated to process card as secondary payer
- Current solutions have been less effective until now
  - Utilization Management
  - Home Delivery

Copayment Coupons/Discount Cards

- Plan Sponsor's Copayment Structure
  - Generics $8, Preferred Brands $20, Non-Preferred Brands $35

	Drug A (Non-Preferred Brand)	Drug B (Generic)
Rx Drug Price	$250	$50
Patient Copayment	$35	$8
Copay Card Discount	$30	Not Applicable
Final Patient Cost	$5	$8
Final Plan Cost	$215	$42

- Plan Sponsor incurs $173 more in cost
- Patient has no incentive to convert

Key Takeaways

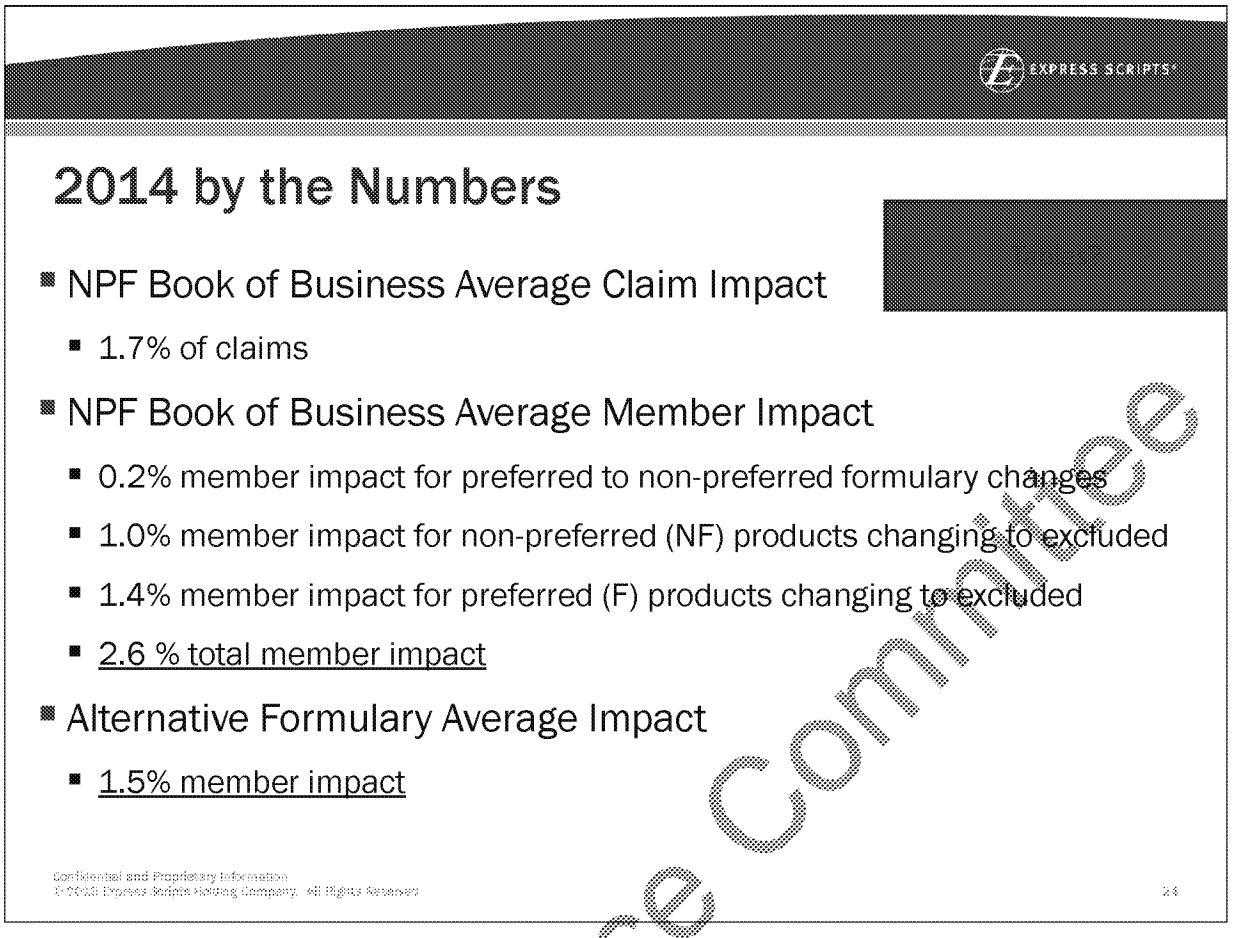
- Drug targets include some commonly used products
- Formulary exception process will be standard and preserves patient access
- Inflation Predictability and Copayment Card elimination are major steps forward

Appendix for slide versions

Important 2014 National Preferred Factors

- 2014 NPF Formulary is not a closed formulary
- Change to clients' existing formulary
  - Clients do not need to make a decision
  - Not a new formulary
  - Not a benefit design change
- Clients not accepting 2014 National Preferred Formulary changes have options
- We are following normal course of business timeline

Will remain on current formulary unless opted out
Alternative Formulary
High Performance Formulary



Typical disruption is 1-2% with some peaks and valleys in some years. Had less recently but will be a little higher than normal for 2014.

Inflation Predictability(IP) Examples

Resetting

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$110	5%	$115.50	$121	$5.50
3	$121	5%	$127.05	$133	$5.95

Average Annual IP Payout $5.48/Rx

Non-Resetting

Year	Drug Price Start of Year	Contractual IP %	Max Price from IP	Drug Price End of Year	IP Payout
1	$100	5%	$105	$110	$5.00
2	$105	5%	$110.25	$121	$10.75
3	$110	5%	$115.50	$133	$17.50

Average Annual IP Payout $11.08/Rx