STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

REQUEST FOR PROPOSALS
FOR
PHARMACY BENEFITS MANAGEMENT

RFP # 31786-00191

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1. INTRODUCTION

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

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

1.1. Statement of Procurement Purpose

The State intends to secure a contract with a single Pharmacy Benefits Manager (PBM) for all services in the attached *pro forma* contract (RFP Attachment 6.6) serving all plans offered by the State Group Insurance Program (SGIP). These services include, but are not limited to, pharmacy benefit account management, network and formulary management, utilization management (UM), custom clinical programs, and an online Point-of-Sale (POS) pharmacy claims processing system. The State is governed by the Public Health Service Act (PHSA), rather than ERISA, and will operate within the State of Tennessee's Any Willing Provider requirements.

In addition to the current plan offerings described in RFP section 1.1.2, which utilize the incumbent PBM's Standard Control with Advanced Control Specialty Formulary®, this procurement supports a new Copay PPO Plan being introduced exclusively to Local Education and Local Government groups effective January 1, 2027, which will feature a narrow, cost-efficient formulary with tightly managed coverage. Enrollment will be determined during this year's annual enrollment period occurring in October 2026. Participation in this plan option is not mandatory. It is highly likely that this plan option will also be offered to State Plan participants beginning in 2028.

The PBM shall establish and maintain its broadest available national pharmacy network, a Mail Order network, and a statewide Any Willing Provider pharmacy network that includes Retail-30 Pharmacies, 90-Day-At-Retail Pharmacies, Specialty Pharmacies, and vaccine-administering pharmacies. The POS system must support prospective and concurrent Drug Utilization Review (DUR), retrospective DUR, reporting capabilities, adjudication, and comprehensive Member services for Retail-30, 90-Day-at-Retail, Mail Order, Specialty, and vaccine pharmacy benefits.

The Contractor shall perform all services described in the Scope of Work in the *pro forma* contract (RFP Attachment 6.6). The State seeks a PBM partner capable of effectively managing the SGIP's pharmacy spend—an ongoing cost driver—by ensuring Members receive clinically appropriate and cost-effective therapy in the right setting. This RFP also reflects the State's compliance with recent PBM legislation. Refer to this link for additional details on legislation in the State of Tennessee with which the plan must comply: https://www.pcmanet.org/wp-content/uploads/2023/05/2025-Enacted-PBM-Laws-Snapshot_Tennessee-1.pdf

1.1.2. Background and Context

Benefits Administration (BA) currently provides prescription drug benefits through a contract with CaremarkPCS Health, L.L.C. that runs until December 31, 2027. Benefits for the contract under this RFP will go-live on January 1, 2028, and run through December 31, 2030, constituting a three (3) year PBM proposal requirement, with an option to renew for one (1) additional twenty-four (24) month term. Prescription drug benefits for the Plan requested under this RFP, and as

defined in the *pro forma* contract, (RFP Attachment 6.6), will be provided to approximately 305,000 members in three separate risk pools with coordinated governing bodies charged with the responsibilities of providing benefits to the Plan.

See the *2024 Annual Program and Financial Report*, State Group Insurance Program, for a description of program and plan information. The report can be accessed at https://www.tn.gov/finance/fabenefits.html. Go to the *Publications* tab, then click on *Reports*.

The State Plan provides self-funded medical coverage to approximately 146,919 total lives (138,992 State and Higher Education employees, 7,927 pre-65 retirees and their eligible dependents) through three health plan options: Standard PPO, Premier PPO and a Consumer Driven Health Plan (CDHP) paired with a Health Savings Account (HSA). As the employer, the State contributes monthly to premiums for enrollment in all plan options. Approximately $611.8 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2025. The State Plan provides benefits to State and Higher Education employees, retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and their dependents.

As a supplement to the medical plan, which includes pharmacy, the State offers a carved-out employee assistance program (EAP) and behavioral health benefit. An employee population health program is also available to all plan Members. Voluntary benefits include vision, dental, life insurance, and short- and long-term disability.

The Local Education Plan is a financially separate, self-funded program, offering medical coverage to approximately 128,395 total lives (123,012 Local Education employees, 5,383 pre-65 retirees and their eligible dependents) through five health plan options: Standard PPO, Premier PPO, Limited PPO, Copay PPO (new in 2027), and a Local CDHP paired with an HSA. Most employees in this plan are teachers; the balance is comprised of administrators, cafeteria workers, maintenance and other support personnel. Approximately $509.6 million in pharmacy claims (net plan costs) were paid under the available plan options during calendar year 2025. In addition to medical, pharmacy, behavioral health, and EAP benefits, Local Education agencies may offer the same vision and dental plans to Members. The Local Education Plan currently provides benefits to 134 Local Education agencies (public school systems) and educational co-ops.

The Local Government Plan is a financially separate, self-funded program, offering medical coverage to approximately 26,965 total lives (26,673 Local Government employees and 292 pre-65 retirees and their eligible dependents) through five health plan options: Standard PPO, Premier PPO, Limited PPO, Copay PPO (new in 2027), and a Local CDHP paired with an HSA. Employees eligible under the Local Government Plan include full-time, non-seasonal, non-temporary staff; elected members of county and municipal legislative bodies; utility board commissioners; county officials; and employees of qualifying quasi-governmental entities. Approximately $111.9 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2025. In addition to medical, pharmacy, behavioral health, and EAP benefits, Local Government agencies may offer the same vision and dental plans to Members. The Local Government Plan currently provides benefits to 375 local government and quasi-governmental entities in Tennessee.

The State currently uses the incumbent PBM's Standard Control with Advanced Control Specialty Formulary®. The new Copay PPO Plan, launching January 1, 2027, will use a narrow, cost-efficient formulary with tightly managed coverage. Drug exclusions for all Plans are governed by—and must align with—the State's Plan Document, which serves as the authoritative source for all State-specific exclusions. The State is open to adopting the PBM's standard UM processes for multiple formularies; however, all UM edits must receive prior approval from the State. Refer to Appendices 7.16 and 7.21 to review the July 1, 2026 formulary guidebooks, and Appendix 7.20 for current plan exclusions.

The State's pharmacy benefits include a Specialty Drug management program and a value-based design covering diabetic medications and supplies, statins, anti-hypertensives, and medications for depression, coronary artery disease (CAD), congestive heart failure (CHF), osteoporosis, asthma, and chronic obstructive pulmonary disease (COPD). A 90-day supply of these medications and supplies is available at a lower Copayment (or Coinsurance for CHPA/HSA or Local CDHP/HSA Members) when obtained through an in-network Retail-90 pharmacy or Mail Order. In addition, the value-based medications bypass the deductible for those enrolled in a CDHP.

The pharmacy benefit also includes active management of current high-impact pharmacy trend categories, including weight-loss medications, specialty therapies, biosimilars, and other high-cost or rapidly growing drug classes. Expectations include ongoing monitoring, utilization oversight, and strategies to promote clinically appropriate, cost-effective use of these therapies.

More information about the medical options provided to Members is shown in Appendix 7.1. Summaries of insurance coverage by plan and plan group as of August 1, 2026 are shown in Appendices 7.4 and 7.5. Additionally, monthly enrollment totals from January 2025 through July 2026 are shown in Appendix 7.23.

Plan pharmacy claims data (de-identified, basic cost and use data only) for July 2022 – July 2026 is included as Appendix 7.8. See Appendix 7.1 for grids reflecting the benefits and cost share for the State & Higher Education plans and the Local Education/Local Government plans for Plan year 2027. A full year of claims data representing July 1, 2025 through June 30, 2026 by individual claim line item is provided in Appendices 7.12. through 7.15. Appendix 7.11 provides background information on data sets and how potential respondents may merge them to respond to this RFP.

1.1.3.

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

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

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

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).
- Attestation Re Personnel Used in Contract Performance (Attachment A);
- Liquidated Damages (Attachment B);
- Reporting Requirements (Attachment C);
- Service Level Agreement Scorecard (Attachment D); and
- HIPAA BAA (Attachment E).

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

1.3. Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed,

color, religion, sex, national origin, or any other classification protected by federal, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4. RFP Communications

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

RFP # 31786-00191

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

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

Heather Pease
Procurement and Contracts Director
Tennessee Department of Finance & Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, TN 37243
Heather.pease@tn.gov
cc: vanessa.watson@tn.gov
Telephone: 615.917.4165

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

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

Lucian Geise, General Counsel
Tennessee Department of Finance & Administration
312 Rosa L. Parks Avenue, Suite 1900 Nashville, TN 37243
Phone number: 615.532.9617
FA.CivilRights@tn.gov

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

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events. Respondents should submit written questions and comments on Appendix 7.22 the written questions and comments template.

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

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

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

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

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

1.5. Assistance to Respondents With a Handicap or Disability

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

1.6. Respondent Required Review & Waiver of Objections

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

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

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

1.7. Pre-Response Conference

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective

Join by phone
+1 615-747-4911 Webex Call-In
+1-415-655-0001 US Toll
Global call-in numbers

Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

The conference will be held at:

Join from the meeting link
https://tn.webex.com/tn/j.php?MTID=m2943a21cacb27e3908d5837e02dec264

Join by meeting number

Meeting number (access code): 2309 617 8488

Meeting password: fmNpSgPF547

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

1.8. **Notice of Intent to Respond**

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

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

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

1.9. **Response Deadline**

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

2. RFP SCHEDULE OF EVENTS

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

EVENT	TIME (central time zone)	DATE
1. RFP Issued		September 1, 2026
2. Disability Accommodation Request Deadline	2:00 p.m.	September 9, 2026
3. Pre-response Conference	1:00 p.m.	September 10, 2026
4. Notice of Intent to Respond Deadline	2:00 p.m.	September 11, 2026
5. Written "Questions & Comments" Deadline NOTE: Submit written questions and comments on Appendix 7.22.	2:00 p.m.	September 25, 2026
6. State Response to Written "Questions & Comments"		October 23, 2026
7. Round 2 Written "Questions & Comments" Deadline NOTE: Respondents may submit no more than five (5) questions to the State in the 2nd round of Written Questions and Comments.	2:00 p.m.	October 30, 2026
8. State Response to Written "Questions & Comments" Round 2		November 20, 2026
9. Response Deadline	2:00 p.m.	December 7, 2026
10. State Opening of Cost Proposals		December 8, 2026
11. Cost Proposal Analysis		December 8, 2026-January 26, 2027
12. State Completion of Technical Response Evaluations		January 11, 2027
13. State Schedules Oral Presentations		January 18-19, 2027
14. Respondent Oral Presentations		January 28-29, 2027
15. Negotiations		February 8-10, 2027
16. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	February 25, 2027
17. End of Protest Period		March 4, 2027
18. State sends contract to Contractor for signature		March 5, 2027

19. Contractor Signature Deadline	2:00 p.m.	March 12, 2027

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

3. RESPONSE REQUIREMENTS

3.1. Response Form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2. Response Delivery

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

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

3.2.2.1. Digital Media Submission

3.2.2.1.1. Technical Response

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

"RFP #31786-00191 TECHNICAL RESPONSE ORIGINAL"

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

"RFP #31786-00191 TECHNICAL RESPONSE COPY"

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

3.2.2.1.2. Cost Proposal:

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

"RFP #31786-00191 COST PROPOSAL"

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

3.2.2.2. E-mail Submission

3.2.2.2.1. Technical Response

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

"RFP #31786-00191 TECHNICAL RESPONSE"

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

3.2.2.2.2. Cost Proposal:

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

"RFP #31786-00191 COST PROPOSAL"

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

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

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

"DO NOT OPEN… RFP #31786-00191 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

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

"DO NOT OPEN… RFP #31786-00191 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

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

"RFP #31786-00191 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

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

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

Heather Pease, Director of Procurements & Contracts
Department of Finance and Administration, Division of Benefits
Administration 312 Rosa L. Parks Avenue, Suite 1900
heather.pease@tn.gov
cc: vanessa.watson@tn.gov
Telephone: 615.253.1652

3.3. **Response & Respondent Prohibitions**

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

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

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

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

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

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

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

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

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

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

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

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

3.4. **Response Errors & Revisions**

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

3.5. **Response Withdrawal**

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

3.6. **Additional Services**

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

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

3.7. **Response Preparation Costs**

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

4. GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1. RFP Amendment

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

4.2. RFP Cancellation

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

4.3. State Right of Rejection

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

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

4.4. Assignment & Subcontracting

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

4.4.2. If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.14.).

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

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

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

4.5. Right to Refuse Personnel or Subcontractors

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

4.6. **Insurance**

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

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

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

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

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

4.8. **Disclosure of Response Contents**

4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Respondents are cautioned not to provide any materials in response to this RFP that are trade secrets, as defined under Tenn. Code Ann. § 47-25-1702 and any other applicable law. By submitting a response to this RFP, the respondent acknowledges and agrees that the State shall have no liability whatsoever for disclosure of a trade secret under the Uniform Trade Secrets Act, as provided at Tenn. Code Ann. § 47-25-1701-1709, or under any other applicable law. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

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

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

4.9. **Contract Approval and Contract Payments**

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

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

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

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

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

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

4.10. Contractor Performance

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

4.11. Contract Amendment

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

4.12. Severability

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

4.13. **Next Ranked Respondent**

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

5. EVALUATION & CONTRACT AWARD

5.1. Evaluation Categories & Maximum Points

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

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**10**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**35**
Oral Presentation (refer to RFP Attachment 6.2, Section D)	**5**
Cost Proposal (refer to RFP Attachment 6.3.)	**50**

5.2. Evaluation Process

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

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

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

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

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

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

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

5.2.1.3. Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP and will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

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

5.2.1.5 The Solicitation Coordinator will invite each apparently responsive and responsible Respondent to make an Oral Presentation.

5.2.1.5.1 The Oral Presentations are mandatory. The Solicitation Coordinator will schedule Respondent Presentation during the period indicated by the RFP Section 2, Schedule of Events. The Solicitation Coordinator will make every effort to accommodate each Respondent's schedules. When the Respondent Presentations schedule has been determined, the Solicitation Coordinator will contact Respondents with the relevant information as indicated by RFP Section 2, Schedule of Events.

5.2.1.5.2 Respondent Presentations are only open to the invited Respondent, Proposal Evaluation Team members, the Solicitation Coordinator, and any technical consultants who are selected by the State to provide assistance to the Proposal Evaluation Team.

5.2.1.5.3 Oral Presentations provide an opportunity for Respondents to explain and clarify their responses and for the State to test to better understand the practical application of the good or service as applicable. Respondents must not materially alter their responses and Presentations will be limited to addressing the items detailed in RFP Attachment 6.2., Technical Response & Evaluation Guide. Respondent pricing shall not be discussed during Oral Presentations. Evaluators may adjust Respondents' Technical Response scores based on Oral Presentations.

5.2.1.5.4 The State will maintain an accurate record of each Respondent's Oral Presentations session. The record of the Respondent's Oral Presentations shall be available for review when the State opens the procurement files for public inspection.

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

5.2.2. **Cost Proposal Evaluation.**

Once the Solicitation Coordinator has determined that the Respondent is a Responsible Respondent as defined in Section 5.2, the Solicitation Coordinator will open for evaluation the Cost Proposal of each Respondent deemed by the State to be responsible for an initial check for completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide.

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

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

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

A. Discount, Rebate, pricing or other financial arrangements at the individual drug level between pharmaceutical manufacturers, pharmaceutical wholesalers/distributors, and pharmacy benefits managers, as defined in Tenn. Code Ann. § 56-7-3102 that a proposer:
i. Submits to the State in response to a request for proposals or other procurement methods for pharmacy-related benefits or services;
ii. Includes in its cost or price proposal, or provides to the state after the notice of intended award of the contract is issued, where the Respondent is the apparent contract awardee; and
iii. Explicitly marks as confidential and proprietary; and

B. Discount, Rebate, pricing or other financial arrangements at the individual provider level between health care providers and health insurance entities, as defined in Tenn. Code Ann.56-7-109, insurers, insurance arrangements and third-party administrators that a Respondent:
i. Submits to the state in response to a request for proposals or other procurement method after the notice of intended award of the contract is issued, where the Respondent is the apparent contact awardee, in response to a request by the state for additional information, and
ii. Explicitly marks as confidential and proprietary

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

5.2.3 **Clarifications and Negotiations:** The State reserves the right to award a contract on the basis of initial responses received; therefore, each response shall contain the Respondent's best terms and conditions from a technical and cost standpoint. The State reserves the right to conduct clarifications or negotiations with one or more Respondents. All communications, clarifications, and negotiations shall be conducted in a manner that supports fairness in response improvement.

5.2.3.1. Clarifications: The State may identify areas of a response that may require further clarification or areas in which it is apparent that there may have been miscommunications or misunderstandings as to the State's specifications or requirements. The State may seek to clarify those issues identified during one or multiple clarification rounds. Each clarification sought by the State may be unique to an individual Respondent, provided that the process is conducted in a manner that supports fairness in response improvement.

5.2.3.2. Negotiations: The State may elect to negotiate with one or more Respondents by requesting revised responses, negotiating costs, or finalizing contract terms and conditions. The State reserves the right to conduct multiple negotiation rounds or no negotiations at all.

5.2.3.3. Cost Negotiations: All Respondents, selected for negotiation by the State, will be given equivalent information with respect to cost negotiations. All cost negotiations will be documented for the procurement file. Additionally, the State may conduct target pricing and other goods or services level negotiations. Target pricing may be based on considerations such as current pricing, market considerations, benchmarks, budget availability, or other methods that do not reveal individual Respondent pricing. During target price negotiations, Respondents are not obligated to reduce their pricing to target prices, but no Respondent is allowed to increase prices.

5.2.3.4. If the State determines that it is unable to successfully negotiate terms and conditions of a contract with the apparent best evaluated Respondent, the State reserves the right to

bypass the apparent best evaluated Respondent and enter into terms and conditions contract negotiations with the next apparent best evaluated Respondent.

5.2.4. **Total Response Score.** The Solicitation Coordinator will calculate the sum of the Technical Response section scores and the Cost Proposal score and record the resulting number as the total score for the subject Response (refer to RFP Attachment 6.5., Score Summary Matrix).

5.3. **Contract Award Process**

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

5.3.2. Benefits Administration's executive director will determine the apparent best-evaluated Response using the scoring provided by the Proposal Evaluation Team. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the Solicitation Coordinator must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3 Benefits Administration's executive director will present the apparent best-evaluated Response recommendation before the State Insurance Committee, as applicable, for approval to enter into a contract with the best-evaluated Respondent.

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

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

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

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

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

RFP ATTACHMENT 6.1.

RFP # 31786-00191 STATEMENT OF CERTIFICATIONS AND ASSURANCES

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

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

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. No amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: "By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106." For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.
11. The Respondent attests that they are not a foreign adversary company within the meaning of Pub. Ch. 768 (2026) and that the Respondent is not knowingly selling an information and communications technology final product or service within the meaning of Pub. Ch. 768 (2026).

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

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

SIGNATURE: _____

PRINTED NAME & TITLE: _____

DATE: _____

RESPONDENT LEGAL ENTITY NAME:

RFP ATTACHMENT 6.2. — Section A

TECHNICAL RESPONSE & EVALUATION GUIDE

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

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

RESPONDENT LEGAL ENTITY NAME:	

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

Response Page # (Respondent completes)	Item Ref.	Section A— Mandatory Requirement Items	Pass/Fail
	A.4.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	
	A.5	Provide a current credit rating from Moody's, Standard & Poor's, Dun & Bradstreet, A.M. Best or Fitch Ratings, verified and dated within the last three (3) months and indicating a positive credit rating for the Respondent. OR in lieu of the aforementioned credit rating, provide an official document or letter from an accredited credit bureau, dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.)	
	A.6	Provide the Respondent's most recent independent audited financial statements. Said independent audited financial statements must: 1) reflect an audit period for a fiscal year ended within the last 36 months; 2) be prepared with all monetary amounts detailed in United States currency; 3) be prepared under United States Generally Accepted Accounting Principles (US GAAP); 4) include the auditor's opinion letter; financial statements; and the notes to the financial statements; and 5) be deemed, in the sole discretion of the State to reflect sufficient financial stability to undertake the subject contract with the State if awarded pursuant to this RFP. NOTES: ● Reviewed or Compiled Financial Statements will not be deemed responsive to this requirement and will not be accepted. ● All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof that the person or entity who renders an opinion regarding the Respondent's financial status is licensed, including the license number and state in which the person or entity is licensed.	
	A.7	Provide a copy of the Respondent's URAC (formerly known as Accreditation Review Commission) Pharmacy Benefit Management accreditation certificate or other proof that URAC Pharmacy Benefit Management accreditation will occur on or before the pharmacy contract effective date. The successful Respondent will be required to maintain URAC Pharmacy Benefit Management accreditation during the entire term of this contract, including runout.	
	A.8	Provide written confirmation that the Respondent has been operating as a Pharmacy Benefit Manager for a minimum of five (5) years.	
	A.9	Confirm that the Respondent has at least one (1) self-funded public sector client with at least 100,000 lives, two additional (2) employer clients with at least 50,000 lives, and at least 750,000 total covered lives.	

Response Page # (Respondent completes)	Item Ref.	Section A— Mandatory Requirement Items	Pass/Fail
	A.10	Confirm that Respondent satisfies all pharmacy network adequacy requirements set forth in A.8. of the attached *pro forma* contract as of the date of this response and that the Respondent will continue to satisfy all pharmacy network adequacy requirements set forth in A.8. of the attached *pro forma* contract on July 1, 2028, and thereafter. (See, Tennessee Public Acts Chapter 1111 as passed during the 114th General Assembly).	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

RFP ATTACHMENT 6.2. — SECTION B

TECHNICAL RESPONSE & EVALUATION GUIDE

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

RESPONDENT LEGAL ENTITY NAME:	

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

RFP ATTACHMENT 6.2. — SECTION B (continued)

Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc.*).
	B.12.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.13.	Provide a statement of whether the Respondent has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract; (b) the procuring State agency name; (c) a brief description of the contract's scope of services; (d) the contract period; and (e) the contract number.
	B.14.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) is presently debarred, suspended, proposed for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency; (b) has within the past three (3) years, been convicted of, or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above; and (d) has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.15.	Provide three references from three different persons, in accordance with the instructions in Attachment 6.4.
	B.16	Other than the mandatory URAC accreditation, provide information on any accreditations related to the services required under this contract for which your organization has been certified.

RFP ATTACHMENT 6.2. — SECTION B (continued)

SCORE ***(for <u>all</u> Section B—Qualifications & Experience Items above)*****:** *(maximum possible score = 10)*	
State Use – Evaluator Identification:	

RFP ATTACHMENT 6.2. — SECTION C

TECHNICAL RESPONSE & EVALUATION GUIDE

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

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

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

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

RESPONDENT LEGAL ENTITY NAME:						
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**		**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.1.	**Scope** (a) Describe your experience providing PBM services to large self-funded employer groups, including any work with public sector clients. (b) Briefly explain how your organization helps clients, and will help the State, address the following: 1. Rising medication costs, particularly specialty drugs and GLP-1 weight loss medications 2. State and federal policy requirements or mandates 3. Utilization of low-value or ineffective medications (c) Summarize your organization's national-level engagement in advocating for self-funded employers and contributing to policy development.			**6**	
	C.2.	**Plan Implementation** (a) Describe your experience with large-scale PBM implementations by completing the following table for your three largest implementations completed within the last 2 years:			**8**	
			Number of Covered Lives	Industry	Length of Implementation	Implemented on time – Yes or No
		Client 1				
		Client 2				
		Client 3				
		(b) Identify the three (3) most important implementation tasks and describe your ability to manage them successfully. (c) What do you view as the greatest implementation risk for this program, and how will you mitigate it? (d) Provide a project implementation plan that includes: 1. A brief description of each team member's role, including the implementation project lead. 2. The Implementation Project Lead's relevant experience, including any certifications, that will be assigned to the State account.				

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.3.	**Benefit Setup** (a) Describe how you will ensure the accurate benefits setup for all State-sponsored plans, including your formulary validation and claims accuracy testing processes. Explain what documentation you will provide to State staff to confirm accuracy before go-live, after any benefit change, and prior to January 1st of each plan year. (b) Briefly outline your approach for ensuring a seamless transition for Members. (c) Describe your experience with the following setup activities and confirm that your data includes them: 1. Loading historical claims and open Prior Authorizations (PAs) from the incumbent PBM, including how long these PAs will remain active. 2. Converting existing Mail Order Service program(s) to your Mail Order Service program (refill history, access, requirement of new prescriptions, etc.). 3. Transitioning and implementing UM programs approved by the State during implementation.		**7**	
	C.4.	**Staffing** (a) For the proposed account team provide: 1. A list of ongoing account team members and their roles (e.g., Account Manager, Clinical Pharmacist, Account Executive). 2. An organizational chart identifying key personnel assigned who will be assigned to deliver the goods or services required by this RFP. 3. The estimated number of hours each team member will devote to this contract. 4. Resumes for all listed team members, including title, education, current role, and employment history. (b) Confirm the account team's access to appropriate executive sponsors for issue escalation and resolution. Identify these executive sponsors and describe their roles within your organization. (c) Describe any compensation received by account team members for promoting or selling additional organizational services (e.g., specialty pharmacy, disease-state management, point solution management programs, etc.). (d) Describe your experience supporting states with legislative bill analysis and fiscal note the development. Identify which team members are involved and explain how you ensure tight deadlines are consistently met.		**6**	
	C.5.	**Claims Adjudication** Regarding the Respondent's claims adjudication system and processes: (a) Confirm the usage of a POS system that meets national security		**7**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		standards and includes data protection capabilities and can meet, or exceed, all contractual claims processing/adjudication requirements. (b) Confirm that your POS system is sufficiently flexible and fully customizable to meet the State's benefit design needs, including support for varying Copay and Coinsurance structures, different deductibles and maximum out-of-pocket (MOOP) amounts by coverage tier (e.g., employee only, employee + spouse, employee + children, employee + spouse + children), and multiple plan-specific requirements such as separate Specialty Drug MOOPs and standard MOOPs. Please confirm the system's capability to administer distinct Coinsurance amounts for specific drug classes (e.g., weight loss medications, Specialty Drugs). (c) Confirm the Respondent's ability to implement a coordination of benefits model, including possible reimbursement, for Members who have other prescription drug coverage; include how it would work from the Member's perspective. (d) Confirm initial and ongoing testing and auditing of the system for accuracy, timeliness, and quality of the Contractor's services; include frequency of ongoing testing.			
	C.6.	**<u>Claims Payment and Reconciliation</u>** Regarding the Respondent's claims payment processes confirm the following: (a) The Respondent's agreement to offer Pass-Through Transparent Pricing as defined in Contract Section A.2. **NOTE: DO NOT include any pricing in this response.** (b) The ability of system edits to prevent payment of incomplete or denied claims or claims for Members whose eligibility is not current. (c) Describe: 1. Your process for correcting pharmacy claims when errors occur due to a benefits setup issue or other incorrect processing. 2. How you reimburse Members when the incorrect adjudication results from an error caused by your organization. 3. How you reverse and reprocess incorrect pharmacy claims, make the necessary adjustments to Member deductibles and out-of-pocket maximums, and exchange this corrected data with other vendors, including the State's medical third party administrators (TPAs). (d) Describe any relationships you have with external prescription discount programs or any similar internal program you have that will allow you to comply with the requirement in *pro forma* Contract Section A.7.k.		**7**	
	C.7.	**<u>Compliance</u>** (a) Describe how your organization will ensure compliance with Public Chapter 1070 and Tenn. Code Ann. § 56-7-2359 as it relates to the		**8**	

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Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		State Group Insurance Program. (b) Describe your approach to coverage of all Affordable Care Act (ACA) required pharmacy benefits and all USPSTF "A" and "B" rated medications and vaccinations, and how you will ensure compliance with Section 2713 of the ACA. (c) Describe how you will ensure the State's compliance with all requirements of the 2021 Consolidated Appropriations Act and Transparency in Coverage rules, including federal reporting, Rx Data Collection, and gag-clause provisions. (d) For transparency, list all sources and amounts of revenue your organization and any PBM Affiliates will receive under this contract, as well as any commissions, TPA fees, or broker fees you will pay and to whom.			
	C.8.	**<u>Retail-30 Network</u>** Provide a Quest Analytics mapping report for your proposed national/statewide any willing provider Retail-30 network. Use the Member ZIP code file enclosed in Appendix 7.2, to demonstrate that your proposed network meets the criteria described in Contract Section A.8.e. Quest Analytics instructions and sample report are shown in Appendices 7.6 and 7.7. **NOTE: Respondents MUST use Appendix 7.2 for ZIP Code Classifications and the classifications listed (urban, suburban, rural). The ZIP code list and classifications must match in the Respondent's report. The Respondent must use Quest Analytics. Please see Appendices 7.6 and 7.7 for Instructions and Sample Report.**		**10**	
	C.9.	**<u>Networks</u>** (a) Complete the table below for the networks that you are proposing to utilize for the *pro forma* Contract. **Network** / **# of Pharmacies Nationally** / **# of Pharmacies in TN** Retail-30 Retail-90 Mail Specialty Vaccination **Total** (b) In Appendix 7.18 Proposed Networks - populate each of the four tabs with the contracted pharmacies in your networks that will be utilized for the *pro forma* Contract. The total number of pharmacies listed should match the total number of pharmacies nationally in RFP question C.9.(a). List the following for each individual pharmacy that you list on		**10**	

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Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		each tab of Appendix 7.18 Proposed Networks: 1. Pharmacy NCPDP identifier 2. Pharmacy name 3. Pharmacy street address 4. Pharmacy City 5. Pharmacy State (abbreviation) 6. Pharmacy Zip (c) Populate Appendix 7.19 Network Disruption with the requested information. (d) Explain the ongoing frequency of pharmacy network efforts including contract renegotiation and renewal with pharmacies. (e) List any major chain pharmacies that do **not** participate in your Retail-30, 90-day-at-retail or vaccination networks and specifically which network/s (e.g., 30-day, 90-day, or vaccine network) they are not in.			
	C.10.	**Mail Order** List the Mail Order Service facility that will be used for the *pro forma* Contract, including how long it has been in operation. Also, provide the following information: (a) Your ability to obtain and load open refill files from the State's current Mail Order Service pharmacy/PBM, if available. (b) The most recent quarterly average turnaround times or prescriptions that: 1. Required intervention (in days) 2. Did not require intervention (in days) 3. Were processed as rush orders.		**2**	
	C.11	**Specialty Pharmacy Network** (a) Describe your specialty pharmacy program and indicate whether it is managed internally as part of your PBM services or outsourced to a vendor. (b) If you operate your own specialty pharmacy describe: 1. Your shipping and handling practices for specialty products including how urgent first fills are managed (for example, whether a one-time fill at a retail pharmacy is permitted to ensure immediate access before transitioning the member to an in-network specialty pharmacy). 2. Your organization's willingness to ship medications to the Member's preferred location (e.g., physician's office, infusion center, etc.). (c) Confirm that specialty pharmacies in your specialty network do not auto-ship medications and will contact plan Members prior to each fill to confirm ongoing need and adherence, to help prevent waste and reduce plan costs. (d) If your own specialty pharmacy will serve SGIP members, explain how your organization will prevent any incentives to dispense specialty medications when a non-specialty option may be the more clinically		**7**	

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		appropriate choice for the Member.			
	C.12.	**<u>Formulary Management</u>** (a) List the qualifications (credentials and affiliations) of your Pharmacy & Therapeutics Committee members and describe the disciplines represented. Indicate whether any voting members are employees of your organization or its parent company. (b) Describe how often your formularies are updated and your process for adding new-to-market products to the formulary. (c) Describe where biosimilars are positioned on your formulary and any steps you are taking to increase their utilization. (d) Explain your organization's efforts to remove hyperinflated, low-value, or wasteful products from the formulary and how you can help the State reduce spend on products with limited clinical value or with lower-cost OTC or prescription alternatives.		**7**	
	C.13	**<u>Formulary Options & Disruption</u>** The State currently utilizes the incumbent PBM's Standard Control with Advanced Control Specialty Formulary® (see Appendix 7.16) with plan exclusions specifically listed in Appendix 7.20. Regarding the Respondent's formulary management policies, procedures, and processes: (a) Provide the following regarding the Respondent's formulary management policies, procedures and processes: 1. A copy and name of the standard formulary you propose for the State's current benefit plans, if selected as the best evaluated Respondent. This formulary must remain a standard formulary with exclusions as listed in Appendix 7.20, and must include UM components such as Prior Authorization, Step Therapy, and quantity limits; and 2. A copy, name, and full description of the narrower, cost-efficient formulary proposed for the new Copay PPO Plan. Include details on selection criteria, UM structure, any differences from the standard formulary, expected clinical and financial impact and any additional exclusions, limitations, or plan-specific rules that apply only to this formulary. (b) Provide a disruption analysis comparing the State's current formulary to the proposed standard formulary for existing plans. Respondents must complete the tables in Appendix 7.3.		**8**	
	C.14	**<u>Specialty Drugs</u> (See definition in Contract Section A.2.)** (a) Describe your organization's approach to managing specialty drugs and controlling costs while ensuring clinically effective care for Members, including how biosimilars are incorporated. (b) List the criteria and review frequency used to determine additions to your Specialty Drug List. (c) Identify any recommended clinical management or utilization programs		**8**	

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		(such as prior authorization, step therapy, quantity limits, etc.) used to assess the appropriateness of specialty therapies before dispensing. (d) If you operate your own specialty pharmacy, describe the clinical support available to Members taking specialty medications (such as nurse or pharmacist consultations, adherence programs, case management, and care-coordination efforts) and specify when this support is available (days and hours).			
	C.15.	**Benefit Coverage/Plan Design** (a) Describe your organization's strategy for managing manufacturer coupon card use and preventing Members from being financially incentivized to utilize a high-cost drug when lower-cost, other clinically appropriate alternatives are available. Include the reporting capabilities your organization offers to track and monitor manufacturer coupon use, such as visibility into coupon utilization rates, member cost-share impacts, high-cost drug trends influenced by coupon programs, and any alerts or dashboards used to identify inappropriate or excessive coupon-driven utilization. (b) Describe your organization's ability to offer point solution management programs for conditions such as weight management, insomnia, anxiety, depression or other clinical needs. If the State chooses to use one of these programs, clarify whether the *pro forma* Contract would suffice or if additional agreements are required, whether services are provided directly or through a subcontractor (and by whom), and whether these programs are typically optional buy-ups.		**6**	
	C.16.	**Clinical Programs** (a) Indicate whether the Respondent offers a therapeutic substitution program and a Generic Drug dispensing optimization program that the State may implement at its discretion. Describe the typical or average savings achievable for a plan this size when these programs are utilized. (b) Provide a detailed description of the Step Therapy programs available to the State to implement. These programs should focus on non-specialty and Specialty Brand Drug management and include, but not be limited to, the following therapeutic drug classes: cardiovascular drugs, lipid-lowering drugs, weight loss drugs, narcolepsy/excessive daytime sleepiness drugs, oncology drugs, and autoimmune injectable medications. (c) Confirm that the Respondent can implement a pricing review program to identify and apply the most cost-effective option available for eligible prescription medications at the point of sale as described in *pro forma* Contract Section A.12.I. (d) Describe the UM programs your organization recommends for the State. Include details regarding implementation timing, authorization workflows, communication methods and protocols for issuing		**8**	

RESPONDENT LEGAL ENTITY NAME:					
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		determinations, and your organization's approach to administering and monitoring these programs. Also provide the typical or average savings associated with each UM program. (e) Identify any additional cost-containment programs offered by your organization that you recommend the State consider. Provide a concise description of each program along with its potential value. (f) Confirm your organization's process for evaluating off-label utilization requests for both specialty and non-specialty medications.			
	C.17.	**Innovation** (a) Provide a one-page executive summary/cover letter highlighting your organization's key differentiators in the marketplace. (b) Describe the most significant innovation that your organization has developed and launched over the past two years. Include the value that the innovation has delivered for clients to date and is expected to deliver in the future. (c) List any innovative offerings that you plan to bring to the market over the next 2-3 years. Describe how these offerings will benefit clients or the industry.		**2**	
	C.18.	**Financials** Describe the following regarding financials: (a) The Respondent shall provide: Maximum Allowable Cost (MAC) Pricing Summary • Brief methodology, update frequency, and criteria for product inclusion/removal. • How MAC pricing is applied across retail, mail, and specialty. Key MAC Metrics • Percent of generic NDCs on the MAC list. • Percent of generic claims adjudicating to a MAC price. MAC List Management. • Number of MAC lists and high-level differences. • Confirmation that the State will receive the most aggressive MAC list and that MAC lists will be provided upon request. Generic Market Entry Timing • Timeframe for assigning MAC pricing when generics enter the market for major branded products. (b) The Respondent shall confirm adherence to the definition of Pass-Through Transparent Pricing as stated in *pro forma* Contract Section A.2.		**8**	
	C.19.	**Pharmacy Manufacturer Payments** (a) Explain how the State will be notified of Rebate or Manufacturer Payment contract changes that may have a material impact. Include details on the financial impact and disruption reporting you provide, how many days in advance of a decision the State will be notified, and any other relevant information about the notification process.		**9**	

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		(b) Confirm your ability to provide, with each Rebate payment (or prior to it), a detailed breakdown showing the total payment amount by drug at the NDC-11 level, including the applicable prior **quarters** and the **groups** (e.g., State actives, State retirees, Local Education actives, Local Education retirees, Local Government actives, Local Government retirees), delivered in Excel format. (c) Confirm your understanding of the contractual requirement to pay the State each quarter Manufacturer Payments as they are received over time.			
	C.20	**State Technical Requirements & Data & Information Technology** (a) Confirm ability to interface with the State's Edison ERP system for accurate, timely processing of 834 enrollment files daily (additions, changes, deletions). See Appendix 7.10. (b) Confirm ability to make manual enrollment updates upon the State's request, without relying on a revised file. The State will not re-issue another file with the changes included. (c) Confirm understanding that coverage ends **one day prior** to the termination date provided on the 834 files. For example, if the term date shows as 7/1/2026, the Member pharmacy benefits should cease on 6/30/2026. (d) Confirm ability to notify the State eligibility team when 300+ terms/drop-offs occur prior to the daily enrollment file and describe your process for communicating enrollment errors. (e) Confirm capability to transmit pharmacy data and provide daily/weekly/monthly data feeds to third parties as requested by the State at no additional cost to the State. (f) Confirm ability to exchange deductible and MOOP data with State TPAs for all plan types offered by the State, describe the process used to ensure accuracy, and indicate how frequently updates occur.		**8**	
	C.21.	**Privacy & Confidentiality** (a) Describe the safeguards your organization uses to protect Member privacy and confidentiality and to prevent unauthorized use or disclosure of Protected Health Information (PHI) created, received, transmitted, or maintained in connection with the Plan's pharmacy benefit. (b) Complete Appendix 7.17 (HIPAA Business Associate Assessment) and submit it with your technical response as a separate appendix/exhibit.		**3**	
	C.22.	**Appeals** (a) The Respondent shall attest that it will provide all Members with a three-level appeals process, consisting of two internal appeal levels within the Respondent's organization and a third-level review conducted by an independent review organization (IRO), in accordance with the requirements of the Patient Protection and Affordable Care Act (PPACA) and as outlined in *pro forma* Contract Section A.31. The Respondent shall confirm that it will bear all costs associated with		**3**	

RESPONDENT LEGAL ENTITY NAME:					
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		appeals at all three levels. (b) The Respondent also confirms that it will provide a detailed description of its external review process for non-clinical reviews, including how such reviews are initiated, conducted, and communicated to Members and providers.			
	C.23	**<u>Customer Services - General</u>** (a) Identify the number of toll-free lines the Respondent will maintain to support all call center functions outlined in *pro forma* Contract Section A.32. Specify whether separate numbers, or a single number, will be used for Members, pharmacists, and systems-related inquiries. (b) Provide a description of the operations of your call center(s). Include the location (city and state) of call center(s), hours of operation, staffing projections, and procedures for rerouting calls, including the circumstances which rerouting may occur. (c) Outline the Respondent's internal process for escalating customer issues and ensuring timely resolution. (d) Confirm whether the Respondent's Specialty, Retail, and Mail systems are fully integrated to provide customer service staff with access to a complete patient profile. Respond "Yes" or "No." If "No," explain the reason and describe any limitations this may create.		**6**	
	C.24	**Customer Service Call Center – Staffing and Training** (a) Describe the duration and scope of training provided to customer service representatives (CSRs) who will be trained on the State's benefit plan and policies prior to implementation and the process for training newly added CSRs throughout the contract term to ensure consistent knowledge of the State account. (b) Provide a sample of the quarterly customer service and call center performance reports that will be submitted to the State.		**3**	
	C.25.	**<u>Member Communication/Materials</u>** (a) Submit sample copies of standard member communication materials your organization provides, including but not limited to: • Formulary-related documents (such as tailored member notifications regarding changes in medication coverage, tier changes, or transitions to non-formulary status) • Member identification cards • Pharmacy benefit overview booklets • Welcome packets Please name the file: *[Your Organization's Name] Sample Employee Communication Materials*. (b) Provide examples of written notifications that would be mailed to members and prescribers for denied coverage determinations. Examples should include communications related to:		**4**	

RESPONDENT LEGAL ENTITY NAME:					
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		• Prior authorization denials • Step therapy denials • Quantity limit denials • Plan exclusions • Formulary exclusions (c) Benefits Administration has historically distributed quarterly emails to members with pharmacy benefits, using content supplied by the current PBM. Previous topics include CDHP/HSA Preventive Drug Lists, medication adherence campaigns, Retail-90 promotions, and tobacco cessation benefits. Confirm whether your organization can develop and distribute quarterly member emails directly—subject to State approval—if Benefits Administration provides member email addresses.			
	C.26	**<u>Member ID Cards and Welcome Packets</u>** (a) Confirm your organization's ability and commitment to fully meet all Member ID card requirements outlined in *pro forma* Contract Section A.23, including: • Providing physical and digital Member ID cards; • Maintaining a process for requesting replacement or duplicate cards via phone, Member Website (aka Member portal), and mobile application. • Incorporating the State's "ParTNers for Health" color logo, required front- and back-of-card data elements; • Ensuring that Member ID cards do not use Social Security Numbers and are approved by the State prior to production; • Reproducing corrected Member ID cards at no cost to the State when errors are attributable to the Contractor. (b) Describe how your organization will ensure adherence to the timeliness standards in *pro forma* Contract Section A.23, specifically: • Mailing initial Member ID cards and welcome packets no later than fourteen (14) Business Days prior to go-live; • Achieving at least 98% on-time production and mailing of ongoing welcome packets and ID cards within four (4) Business Days of receiving complete and accurate enrollment data; • Reporting quarterly mailing timeliness results as required in Contract Attachment D.		**4**	
	C.27.	**<u>Plan Microsite, Member Website and Mobile App</u>** (a) Describe how your organization will comply with all Plan Microsite requirements outlined in *pro forma* Contract Section A.24, including: customization for the State, obtaining prior written approval for all design elements (site map, layout, branding, content, documents, and external links), hosting the Plan Microsite within the contiguous United States, maintaining at least 99.9% uptime, and securing State approval of the domain name. Confirm your ability to update content within the required timeframes and ensure all posted materials meet all applicable state and federal regulatory requirements.		**7**	

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Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(b) Confirm your organization's ability to provide and maintain a Member Website and mobile application that meet all minimum functionality requirements specified in *pro forma* Contract Section A.24, including: secure availability 24/7/365 (except approved maintenance windows), access to digital Member ID cards, Member-specific benefits and accumulators, claims history, secure messaging or live-chat capabilities, PA status tracking, drug pricing tools, pharmacy network search, and Mail Order refill/order tracking. Describe your process for updating web-based materials within fifteen (15) business days of Plan changes and correcting content errors within three (3) business days. For example, refer to the current Pharmacy Benefit Manager's Plan Microsite at this link: http://info.caremark.com/stateoftn or the BCBS of Tennessee and Cigna microsites at this link: https://www.tn.gov/partnersforhealth/quicklinks.html (c) Describe how your organization will meet all security, privacy, and integration requirements outlined in *pro forma* Contract Section A.24, including maintaining a 100% secure web-based application, adhering to all State-approved security measures, ensuring compatibility and data linkage with other State-contracted vendor systems (including single sign-on, when requested), and supporting upload, transmission, and receipt of Member data. Confirm that neither your organization nor any subcontractors will require Members to accept online terms, conditions, or policies that conflict with State contract provisions or BAAs. (d) Confirm your organization's ability to ensure that the Plan Microsite, Member Website, and mobile application meet all federal and State accessibility laws and standards applicable to State government digital content, including full compliance with ADA requirements. Describe your processes for reviewing, verifying, and maintaining accessibility compliance for all posted content. Acknowledge your organization's responsibility for any fines, penalties, or damages that result from accessibility non-compliance by you or your subcontractors.			
	C.28.	**Reporting & Systems Access** (a) Provide a comprehensive overview of your reporting system, including the tools and dashboards that will be available to State staff for accessing cost and utilization data. Specify how many years of historical claims data will be available for State staff to view and confirm whether your system supports claims data reporting through the previous day. (b) Describe your ad-hoc reporting capabilities and the level of access State staff will have to develop and generate custom reports. Include information on the support available through an ad-hoc reporting liaison, including assistance with building ad-hoc queries and general system use.		**9**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(c) Outline your organization's capabilities to perform modeling and forecasting based on historical utilization patterns, including the types of analyses and projections typically available to clients. (d) As required in *pro forma* Contract Section A.25(b), describe how State staff will be provided with the necessary access to view, update, or manage eligibility in your online system. This should include your process for enabling State staff to manually add new Members and indicate how soon after the manual addition claims can be adjudicated for the Member. Provide details on your training program for State Benefits Administration staff, including training on viewing claims history and pulling at least one year of historical Member claims (e.g., pharmacy name, date of service, Member paid amount, and Plan paid amount) for Service Center support. Specify who will conduct the trainings and training duration. (e) Confirm whether your system allows end users to generate ad-hoc claims history reports that include the number of utilizers, ingredient cost, dispensing fees, and Member cost by drug name, NDC, GPI levels 2 through 14, as well as rebate-related information at the NDC-11 level.			

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.29.	**Audits (Internal) and Fraud** Describe or provide the following information regarding your organization's audit and fraud monitoring processes and capabilities: (a) Describe how often your organization audits plan program pricing and overall claims adjudication accuracy, including the methodologies used and the scope of routine reviews. (b) Provide an overview of your audit team, including the team's experience, credentials, and core capabilities. Describe the audit activities routinely performed on your retail pharmacy network, including monitoring pricing accuracy, network compliance, and identification of potential fraud, waste, or abuse. (c) Confirm your organization's ability to support audits that trace claims through the full system lifecycle to verify appropriate adjudication, pricing, and accurate application and crediting of Rebates. (d) Confirm your agreement to comply with Tenn. Code Ann. § 4-3-1021 and to cooperate fully with Benefits Administration, the State, and any State-designated auditors. This statute requires Benefits Administration to compile a report each July 1 using data from audit reports completed during the year. These audits are conducted by Benefit Administration's benefits consulting firm. The Contractor must participate timely and work cooperatively with actuaries and benefits analysts, both inside and outside the State, to ensure the timely completion of all required reports. (e) Describe your process for auditing benefit configuration to ensure that claims adjudicate to the correct Copay or Coinsurance amounts consistent with the client's benefit design intent, and that all formulary tiers and benefit structures are correctly established in the adjudication platform. Indicate how many audits are performed, how frequently they occur, and the types of discrepancies or issues typically reviewed.		**5**	
	C.30.	**Pharmacy Audits** Describe or provide the following information regarding your pharmacy audit processes: (a) Specify how often audits are performed across your retail, mail-order, and specialty pharmacy networks and identify the percentage of each network that is audited annually. (b) Indicate how many pharmacies located in Tennessee are audited each year. (c) Describe how your organization addresses pharmacies that exhibit consistent or repeat audit findings, including any corrective actions		**4**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		taken and whether such pharmacies may be removed from the network. (d) Explain your process for recouping funds identified through onsite pharmacy audits and confirm that 100% of these recoveries will be distributed to the State in accordance with *pro forma* Contract Section A.28. (e) Describe your processes to detect and prevent errors, fraud, waste, or abusive pharmacy utilization by Members, pharmacies, or prescribers, including any systems, algorithms, or manual review processes used to support these activities.			
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.				**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
		Total Raw Weighted Score / **Maximum Possible Raw Weighted Score** ***(i.e., 5 x the sum of item weights above)***	**X 35** *(maximum possible score)*	**= SCORE:**	
State Use – Evaluator Identification:					
State Use – Solicitation Coordinator Signature, Printed Name & Date:					

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION D: ORAL PRESENTATION. The Respondent must address ALL Oral Presentation Items (below).

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

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

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

RESPONDENT LEGAL ENTITY NAME:	

Oral Presentation Items	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
D.1. Data & Reporting Capabilities Demonstrate the following: (a) What standard and customizable reporting is available? (b) The availability of ad hoc reports. (c) Client viewing capabilities such as viewing member information, member claims, prior authorization overrides, accumulator information, test claim capabilities.		**9**	
D.2. Implementation & Change Management (a) What does your implementation timeline look like for new plans? (b) How do you ensure smooth transitions for members, prescribers, and pharmacies? (c) What communication and support resources are provided for Members and for the client?		**6**	
D.3. Innovation & Technology (a) What investments are you making in digital tools, pricing intelligence, fraud/waste management, and care navigation? (b) Demonstrate your Mobile app, Plan Microsite and Member website (member portal). (c) Describe how the organization currently uses AI and machine-learning tools across claims processing, clinical review, fraud detection, and member interactions, and explain the measures in place to ensure these tools remain transparent, compliant, and free from bias in their decision-making.		**3**	
Total Raw Weighted Score *(sum of Raw Weighted Scores above)*: The Solicitation Coordinator will use this sum and the formula below to calculate the score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.			

Total Raw Weighted Score / **Maximum Possible Raw Weighted Score** *(i.e., 5 x the sum of item weights above)*	**X 5** *(maximum possible score)*	**= SCORE:**	

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

RFP ATTACHMENT 6.3

COST PROPOSAL & SCORING GUIDE

The Respondent shall complete and submit its Cost Proposal in accordance with the instructions given in RFP Section 3.2.2.2.2 The Respondent shall use an XLS spreadsheet to prepare the Cost Proposal. This spreadsheet is found at the following website address, under the section labeled RFP # 31786-00191:

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

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

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

RFP ATTACHMENT 6.4.

REFERENCE QUESTIONNAIRE

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

The Respondent will be solely responsible for obtaining completed reference questionnaires as detailed below:

- Provide references from three (3) different persons who are not current State employees for projects similar in size and scope to the goods or services sought under this RFP.
- Respondents may provide references that represent active, current contracts or contracts completed within the last five (5) years.
- The individual providing a reference shall not be a current State employee.
- Obtain and submit the completed reference questionnaires following the process described below:

Emailed References:

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

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

(c) Instruct the reference to:

  (i) complete the reference questionnaire;

  (ii) sign and date the completed reference questionnaire;

  (iii) E-mail the reference directly to the Solicitation Coordinator by the RFP Technical Response Deadline with the Subject line of the e-mail as "[Respondent's Name] Reference for RFP **# 31786-00191**".

NOTES:

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

RFP # 31786-00191 REFERENCE QUESTIONNAIRE

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

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

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

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

E-Mail:

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

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(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

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

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What goods or services does/did the reference subject provide to your company or organization?

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

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

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

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

DATE: _____

RFP ATTACHMENT 6.5.

SCORE SUMMARY MATRIX

	RESPONDENT	*NAME*	*RESPONDENT*	*NAME*	*RESPONDENT*	*NAME*
GENERAL QUALIFICATIONS & EXPERIENCE (maximum: 10)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (maximum: 35)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
ORAL PRESENTATION (maximum: 5)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
COST PROPOSAL (maximum: 50)	**SCORE:**		**SCORE:**		**SCORE:**	
TOTAL RESPONSE EVALUATION SCORE: (maximum: 100)						

Solicitation Coordinator Signature, Printed Name & Date:

RFP ATTACHMENT 6.6.

RFP # 31786-00191 *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

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

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

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

A. SCOPE:

A.1. The Contractor, also known as the PBM, shall provide all goods or services and deliverables to Members and the State as required, described, and detailed below and shall meet all service and delivery timelines as specified by this Contract.

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

b. There will be a six-month Claims runout period during which the Contractor shall adjudicate Claims incurred during the service delivery period. The Contractor shall process all Member calls into the Contractor's call center from Members related to Claims that were incurred during the service delivery period throughout the Claims runout period. If a Member files a Paper Claim for a product or service that was incurred during the Term, and the Paper Claim is received during the Claims runout period, the Contractor shall process such Claims.

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

a. **340B Claim(s)** means a Claim for a Covered Product that was purchased through the 340B Drug Pricing Program and dispensed to a 340B eligible patient. 340B Claims are identified as and limited to:
i. Claims from a dispensing pharmacy with 340B Status code 39 in the NCPDP DataQ database;
ii. Claims from a dispensing pharmacy with 340B Status code 37 or 38 in the NCPDP DataQ database, only where the dispensing pharmacy submitted a 20 in any of the Submission Clarification Code (SCC) fields;
iii. Claims identified through Client's contracted 340B third party administrator(s) (TPA(s)). For avoidance of doubt, PBMs shall not independently identify claims as 340B Claims unless explicitly directed by Client to do so.

b. **Actual Acquisition Cost** means the actual amount paid by the Pharmacy Benefit Manager or its affiliated dispensing pharmacy to acquire a Covered Drug from a wholesaler, manufacturer, or other supplier, inclusive of all discounts, volume-based incentives, prompt-pay discounts, chargebacks, and any other price concessions received or to be received, whether direct or indirect. Actual Acquisition Cost shall not include dispensing fees, administrative costs, markups, or any amount unrelated to the purchase price of the Covered Drug itself. The PBM shall maintain and make available upon request auditable documentation supporting the Actual Acquisition Cost for any Covered Drug.

c. **Actual Net Drug Cost PMPM** means the result of the following calculation: (Ingredient Cost plus Dispensing Fees plus Sales Tax less Manufacturer Payments)/total months each member was eligible.

d. **Adjusted Claim** means a 30-day supply Claim equivalent, that shall be calculated as follows: Adjusted Claim = [Claim Days' Supply] / [30 days]. For avoidance of doubt, a Claim with a 90-day supply would constitute three (3) adjusted Rx. A Claim with a 10 (ten) day supply would constitute 1/3 (one-third) of an Rx.

e. **Administrative Fee** – means the portion of the Contractor's sole compensation for Pharmacy Benefit management services that is separate from, and in addition to, the required Clinical Fee. It is calculated on a Per Member Per Month (PMPM) basis and represents all payments due to the Contractor other than the Clinical Fee. The Administrative Fee includes all costs necessary for the Contractor to perform the services required under the Contract, including compliance with all applicable State and Federal laws including, but not limited to, appeals by Pharmacies to the Tennessee Department of Commerce & Insurance related to PBM claim reimbursement under Tennessee Public Chapter 1070.

f. **Agency Benefits Coordinator** means the individual within each agency or department who is the officially designated liaison between BA and employees.

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

h. **Authorized Generic** means a drug that is:

   i. Marketed, sold, or distributed in the United States as a generic version of a Brand Drug, where such marketing, sale, or distribution is authorized under the Manufacturer's New Drug Application (NDA) or Biologic License Application (BLA) for the corresponding Brand Drug.
   ii. Marketed, sold, or distributed under a different labeler code, product code, trade name, trademark, or packaging (excluding repackaging of the listed drug for institutional use) than the Brand Drug. For identification purposes, Authorized Generics shall be classified using the Medi-Span Multisource code "M" and a Brand Drug code "B."

i. **Average Speed of Answer** means the average waiting time for a caller before they are answered by a call center service representative. For this definition, the term "answer" shall mean to begin an uninterrupted dialogue with the caller. If a call center representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be "answered" for purposes of this definition until the call center representative returns to the caller and begins an uninterrupted dialogue.

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

k. **Benefit(s)** means the services available to Members and the corresponding amounts that Members and the Program will pay for covered services under this Contract.

l. **Benefits Administration ("BA")** means the division of the Tennessee Department of Finance & Administration that administers the State Group Insurance Program.

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

n. **Brand Drug** means an FDA approved drug, or a drug that is designated by the FDA as a DESI (Drug Efficacy Study Implementation) drug or product, which is manufactured and distributed by an innovator drug company or its licensee, and which is set forth in Medi-Span's National Drug Data File as a Brand Drug identified by all of the products meeting at least one of the following criteria:
   (1) Assigned a Brand name code of "T" and Multisource code "M," and DAW not equal to 5
   (2) Assigned a Brand name code of "B" or "T" and Multisource code of "N," and DAW not equal to 5
   (3) Assigned a Brand name code of "B" or "T" and Multisource code "O" and DAW equal to 0, 1, 2, 7, 8, or 9

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

o. **Business Days** means traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Government Holidays are excluded.

p. **Claim(s)** means any electronic or paper request for payment or reimbursement that is submitted through the Contractor's claims adjudication system or otherwise processed in accordance with this Contract in connection with the State's Plan. A Claim may include transactions where the Member pays the full cost, and the State has no financial liability. A Claim does not include any request that is rejected due to system edits, or any request that is reversed or cancelled in the claims processing system. At the State's request, the term Claim may also include any product or service utilized by a Member through a Contractor-offered point solution in which the State elects to participate.

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

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

s. **Clinical Fee** means the fee paid to the Contractor for managing all clinical Programs, which apply to both non-specialty and Specialty medications. These Programs include Prior Authorization, appeals, dose optimization, Step Therapy, quantity limits, closing gaps in care, prospective/concurrent and retrospective safety reviews, safety and monitoring initiatives (including fraud, waste, abuse, and lock-in identification), drug recalls, therapeutic substitution and Generic Drug Programs that inform Providers and Members of clinically appropriate, lower-cost alternatives, all Specialty Drug management activities (such as adherence support, first-fill counseling, and case management for Members using the Contractor's Specialty Pharmacy), an

opioid management Program, a pricing review Program to ensure the most cost-effective option at the point of sale, and all clinical and utilization management Programs for Specialty Drugs and self-administered injectables. The Clinical Fee also includes all nursing services and related charges.

t. **Coinsurance** means the percentage amount of allowable charges paid by the Program and by the Member to a Provider for service provided to the Member.

u. **Compound Drug** means a mixture of two (2) or more ingredients in which at least one ingredient is an FDA-approved federal legend drug, and where the resulting preparation is not otherwise generally available in an equivalent commercial form or strength. A Compound Drug is prepared in response to a prescriber's prescription to create a medication tailored to the specialized and medically required needs of an individual patient. A Compound Drug is identified by the compound indicator on the Claim feed.

v. **Continuity of Therapy** means the continued coverage of a medication that is not on the PBM's formulary.

w. **Coordination of Benefits or COB** means a Claim for which more than one health insurance program, policy, or other form of coverage – whether governmental or non-governmental — provides Benefits, and for which the State serves as the secondary or tertiary payor.

x. **Copayment or Copay** means the portion of the charge represented as a flat dollar amount for a pharmaceutical product or service that is the responsibility of the Member.

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

z. **Days' Supply** means the number of days a drug is intended to be taken as prescribed and as submitted to PBM by the dispensing Pharmacy.

aa. **DEA Number** means the unique registration number issued by the United States Drug Enforcement Administration (DEA) to an individual practitioner, Pharmacy, or other authorized entity, permitting the prescribing, dispensing, or handling of controlled substances in accordance with applicable federal laws and regulations.

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

cc. **Denied Claim** means a Claim submitted by a Pharmacy or other authorized provider that is not approved for payment by the PBM because it fails to meet applicable coverage criteria, eligibility requirements, clinical or utilization management criteria, billing or formatting requirements, or any other standards established under the Plan, applicable law, or PBM policies and procedures.

dd. **Dependent** means the child or spouse of an employee, retiree or individual qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA").

ee. **DESI** means any drug subject to the FDA's Drug Efficacy Study Implementation (DESI) review program—specifically, those drugs originally approved by FDA on safety (but not efficacy) grounds prior to the enactment of the Kefauver-Harris amendments in 1962, and any Identical, Related or Similar (IRS) versions thereof that, as determined under FDA or CMS criteria, have been classified as *less-than-effective* (DESI indicator code 5 or 6), unless such drug or IRS version has since received FDA approval via a new drug application (NDA) or abbreviated new drug application (ANDA) demonstrating both safety and efficacy.

ff. **Discount(s)** means the percentage difference between the applicable Average Wholesale Price (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, Over-the-Counter (OTC) products, and any other services provided by such Pharmacy to Members. Discounts exclude the Dispensing Fee, Copayment, and any applicable Sales Tax. For purposes of Discount calculations and any related pricing or guarantee reconciliation, Single-Source Generic Drugs shall be treated as Multisource Generic Drugs and shall not be considered Brand products.

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

hh. **Drug Manufacturer or Pharmaceutical Manufacturer** means a manufacturer of pharmaceutical products or any organization that engages in manufacturing, requests/solicits a manufacturer to create, develop, or produce medications with the intent of distribution. Drug Manufacturer shall include PBM or PBM Affiliates to the extent PBM or PBM Affiliates partner with a third party to create, develop, produce, manufacture, market, or co-brand pharmaceutical products.

ii. **Drug Utilization Review ("DUR")** means a POS Claim edit or series of edits implemented by the PBM to promote safe, appropriate, and cost-effective medication use. DUR edits evaluate a Claim against established clinical, safety, eligibility, and utilization criteria for the purpose of identifying potential drug-related issues, including but not limited to therapeutic duplication, drug–drug interactions, dosage appropriateness, contraindications, and utilization limits.

jj. **Edison** means the State's enterprise resource planning system, which supports human resources, payroll, insurance, contracting, procurement and other agency functions.

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

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

mm. **Gene and Cell Therapy** means FDA-regulated biologic products that use genetic material, living cells, or genetically modified cells to achieve a therapeutic effect, as regulated by the FDA's Center for Biologics Evaluation and Research (CBER).
These therapies include:

1. Gene Therapy:
   The administration of genetic material to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. Mechanisms may include, but are not limited to:
   i. Replacement of a disease-causing gene with a functional gene,
   ii. Inactivation of a malfunctioning gene, or
   iii. Introduction of new or modified genetic material into the patient's cells.
2. Cell Therapy:
   The administration or transfer of autologous or allogeneic living cells—including stem-cell–based, non-stem-cell–based, or genetically modified cells—for the purpose of repairing, replacing, regenerating, or improving damaged tissues or biological function. This includes ex vivo manipulated cellular products such as engineered immunotherapies.

Included within this definition are:

- In vivo gene delivery technologies, including viral and non-viral vector delivery systems; and
- Ex vivo genetically modified cellular products, including chimeric antigen receptor (CAR-T) therapies and other engineered autologous or allogeneic cells.

Excluded from this definition are:

- Conventional organ and tissue transplants without genetic modification; and
- Human cells, tissues, and cellular/tissue-based products (HCT/Ps) that meet the same-surgical-procedure exception and do not involve genetic manipulation.

nn. **Generic Code Number ("GCN")** means the standardized identifier assigned by First Data Bank, or any successor nationally recognized drug pricing compendium, to designate a specific drug entity by strength, formulation, and route of administration. The GCN is used for drug classification, pricing, and formulary management purposes with the Pharmacy benefit Program.

oo. **Generic Drug** means an FDA approved drug, or a drug designated by the FDA as a DESI (Drug Efficacy Study Implementation) drug or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as identified in Medi-Span's National Drug Data File. A product shall be classified as a Generic Drug if it meets any of the following criteria:

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

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

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

qq. **Group Purchasing Organization** ("**GPO"**) means any entity that aggregates the purchasing power a group of businesses to obtain discounts or rebates from pharmaceutical manufacturers. These services may include contracting with manufacturers for Formulary Rebate or any similar service conducted on behalf of PBM. Any entity who provides the same or similar services as the PBM on behalf of PBM under this Contract shall also be considered a GPO. For purposes of this Agreement, rebate aggregators or any similar/competing entity shall also be a GPO.

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

ss. **Home Infusion Pharmacy ("HIF")** means a Retail Pharmacy-based, decentralized patient care organization with expertise in United States Pharmacopeia ("USP") 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. These Pharmacies are identified by a National Council for Prescription Drug Program's ("NCPDP") dispenser type code 06.

tt. **House Generics** means a Brand Drug submitted with a Dispense As Written ("DAW") 5 code in place of the generic equivalent and where the Pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. House Generics will be identified using Medi-Span Multisource code M, N, O, or Y and a Dispense as Written (DAW) code 5.

uu. **Indian Health Services, Tribal or Urban Indian Health ("I/T/U")** means a Retail Pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization as defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603.

These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code 08.

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

ww. **Ingredient Cost** means defined for the Contract according to the criteria below:

(1) For Retail Pharmacies and Mail Order or Specialty Pharmacies not owned by or affiliated with the Contractor, Ingredient Cost means the lowest of:
- Usual & Customary ("U&C") Price, where applicable; or
- MAC, where applicable; or
- Mutually agreed-upon baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) less all applicable Discounts or other reimbursement amounts negotiated with the Participating Pharmacy.

(2) For Low-Volume Pharmacies, Ingredient Cost means the lowest of:
- Usual & Customary (U&C) Price, where applicable; or
- National Average Drug Acquisition Cost (NADAC);
- Mutually agreed-upon baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) less all applicable Discounts or other reimbursement amounts negotiated with the Participating Pharmacy.

(3) For Mail Order or Specialty Pharmacies owned by or affiliated with the Contractor, Ingredient Cost means Actual Acquisition Cost.

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

xx. **Identical, Related or Similar ("IRS")** means drugs that the FDA has determined to be identical, related or similar to products designated as Less Than Effective (LTE) under the Drug Efficacy Study Implementation (DESI) program.

yy. **In Writing** means 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.

zz. **Key Performance Indicators ("KPI")** means performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Contract Attachment D.

aaa. **Less Than Effective ("LTE")** means drugs that the FDA has determined lack of substantial evidence of effectiveness for all labeled indications and for which no compelling medical necessity has been established.

bbb. **Limited Distribution Drug** means a drug that is available only through a restricted network of Pharmacies as designated by the manufacturer, FDA, or other applicable regulatory authority. Such drugs may be dispensed solely through Pharmacies authorized or certified to meet these specific distribution, storage, or patient-management standards.

ccc. **Lock-In** means a restrictive logic that limits Claims at POS to selected prescribers or Pharmacies. Members under this restriction are said to be "locked-in."

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

eee. **Low-Volume Pharmacy** means an ambulatory Pharmacy that fills fewer than 65,000 prescriptions per calendar year, as determined under Tennessee's TennCare standards (Tenn. Comp. R. & Regs. 0780-01-95-.10). Such Pharmacies are eligible for an enhanced professional dispensing fee per Tenn. Code. Ann. § 56-7-3206(f).

fff. **Mail Order Pharmacy or Mail Order** means a Pharmacy that utilizes automated or centralized dispensing processes at one or more non-retail locations and delivers prescriptions to customers through mail or other third-party delivery services. A Mail Order Pharmacy does not operate a physical, customer-facing storefront. If such a Pharmacy dispenses both Specialty Drugs and non-specialty drugs, it shall be considered a Mail Order Pharmacy only with respect to the dispensing of non-specialty drugs, and a Specialty Pharmacy with respect to the dispensing of Specialty Drugs. Mail Order Pharmacies are identified by the National Council for Prescription Drug Programs (NCPDP's) dispenser type code 05.

ggg. **Manufacturer Administrative Fee(s) ("MAF")** means fees for services rendered to pharmaceutical manufacturers in relation to administrative duties in connection with aggregation, allocating, collecting, and invoicing for rebates. These include any fee paid by a pharmaceutical manufacturer to a PBM, PBM Affiliates, or a GPO in relation to administrative duties in connection with the collection of Formulary Rebates.

hhh. **Manufacturer Payments** means any and all compensation, financial benefits, or remuneration received by the PBM, any PBM Affiliate, or any GPO from a Pharmaceutical Manufacturer that is in any way attributable to the State's Claims or utilization, Manufacturer Payments include, without limitation, Discounts; credits; Rebates (regardless of categorization), market share incentives, chargebacks, commissions, Inflation Protection payments or adjustments , access fees, MAF, and any administrative and management fees. Manufacturer Payments also include any fees received for the sale or provision of utilization data to a Pharmaceutical Manufacturer. For avoidance of doubt, Manufacturer Payments do not include Other Pharmaceutical Manufacturer Revenue that is not attributable in any way to the State's Claims utilization.

iii. **Material Change** means one or more of the following circumstances:

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

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

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

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

(5) Client-initiated change to benefit design or formulary (including utilization management) that impacts Rebates negatively by more than five hundred thousand dollars ($500,000) per year. Such a change initiated by the State is limited to changes to the Pharmacy

Benefit Program, plan design, or formulary alignment. In the event a modification to financial guarantees is necessary, the parties will mutually agree on an appropriate adjustment which shall be economically neutral to the impact of the change, such agreement not to be unreasonably withheld.

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

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

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

jjj. **Maximum Allowable Cost ("MAC")** means the maximum reimbursement amount established by the PBM for a Generic Drug or Multisource Brand Drug included on the PBM's MAC List. A copy of the MAC List shall be provided to the State prior to execution of this Contract and upon the State's reasonable request. The PBM shall use a single uniform MAC List for Retail Pharmacies, Mail Order Pharmacies, and Specialty Pharmacies (i.e., the same drugs and the same number of drugs). The MAC price points applicable to Mail Order and Specialty Pharmacies shall be equal to or lower (i.e., more deeply discounted) than the MAC price points applicable to Retail Pharmacies for the same drugs or generic class numbers.

kkk. **MAC List** means the list of Generic Drugs and Multisource Brand Drugs for which the PBM establishes a MAC. The MAC List is developed and maintained by the Contractor and typically reviewed on a regular basis, with individual drug price points subject to adjustment as needed. Considerations for inclusion on the MAC List include, but are not limited to, national availability of generic versions; the number of manufacturers supplying the product; price differences between Brand and Generic versions; therapeutic equivalence; clinical considerations related to substitution; and utilization volume.

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

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

nnn. **Member-Submitted Claim(s) or Paper Claim(s)** means a Claim for prescription drug Benefits that is submitted to the PBM in a non-electronic format, including any claim submitted on a physical form or document rather than through an approved electronic claims processing system. These Claims include any submission that requires manual entry, review, or adjudication by the PBM, as well as Claims for which the Member paid the full amount and subsequently submitted the Claim to the PBM for reimbursement. These Claims are identified by the Claim type code 03 (Pharmacy submitted Paper Claim) or 04 (Member-submitted Paper Claim).

ooo. **Member Website** means the Contractor's website which requires the Member to log in, containing information specific to the Member and the Plan.

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

qqq. **Multisource ("MS")** means a Drug Product that is available from more than one FDA-approved manufacturer and is not protected by patent exclusivity or other market exclusivity that limits its availability to a single source. A Multisource drug includes generic products rated as therapeutically equivalent by the FDA (e.g., products assigned an "A" rating in the FDA's Orange Book, the public database that identifies drug products approved on the basis of safety and effectiveness) and may also include brand products for which equivalent generic versions are commercially available.

rrr. **National Average Drug Acquisition Cost ("NADAC")** means the publicly available pricing benchmark published by the Centers for Medicare & Medicaid Services (CMS) that reflects the average acquisition cost that Retail community Pharmacies pay to purchase prescription outpatient drugs. NADAC values are derived from national Pharmacy survey data and are updated regularly by CMS. When referenced in this Agreement, NADAC shall mean the most current NADAC price available as of the date the applicable Claim is adjudicated, unless otherwise specified.

sss. **National Council of Prescription Drug Programs ("NCPDP")** means the National Council for Prescription Drug Programs, an independent, standards-development organization that creates and maintains industry standards for electronic Pharmacy transactions, including but not limited to claims processing, eligibility verification, Coordination of Benefits, and electronic prescribing. References in this Contract to "NCPDP standards" shall mean the most current, applicable standards published by NCPDP, as updated by NCPDP.

ttt. **National Drug Code ("NDC" or "NDC-11")** means the unique, three-segment identifier assigned by the U.S. Food and Drug Administration (FDA) that identifies drug products distributed in the United States. The NDC consists of a labeler code, product code, and package code, which together specify the manufacturer or labeler, the specific drug formulation, strength, and dosage form, and the package size or type.

uuu. **National Provider Identification Number ("NPI")** means the unique, 10-digit identification number assigned to health care providers, health care organizations, and other qualified entities by the Centers for Medicare & Medicaid Services (CMS) under the Health Insurance Portability and Accountability Act (HIPAA). The NPI serves as a standard identifier for use in electronic health care transactions and does not contain embedded information about the provider. References to an NPI in this Contract shall mean the valid and active NPI associated with the applicable provider or entity as recognized in the National Plan and Provider Enumeration System (NPPES).

vvv. **Net Drug Cost PMPM Guarantee** means (Ingredient Cost plus Dispensing Fees plus Sales Tax less Manufacturer Payments) divided by the total number of months each Member is eligible based on the Member enrollment files provided by the State each month for payment. The Net Drug Cost PMPM Guarantee and reconciliation will include all Claims other than Gene and Cell Therapy Claims. The Net Drug Cost PMPM Guarantee amount should not be reduced by Member Cost Share.

www. **Formulary Exclusions** means any drug or related item that is not classified as a Covered Product or Formulary Exclusion under this Agreement. All determinations that a product is a Non-Covered Product shall require approval by the PBM's Pharmacy and Therapeutics (P&T) Committee.

xxx. **Off-Invoice Wholesaler Remuneration** means any reconciliation payment or financial consideration received by the PBM from a wholesaler that is not reflected on a product invoice, is not associated with a specific NDC, and therefore cannot be attributed to an individual client. Such remuneration includes, but is not limited to, true-up payments, distribution fees, operational performance or efficiency fees, and price-protection credits.

yyy. **Other Pharmaceutical Manufacturer Revenue** means any revenue received by the PBM or PBM Affiliates from Pharmaceutical Manufacturers that is not otherwise categorized under this Agreement. Such revenue may include, but is not limited to, Off-Invoice Wholesaler Remuneration, Pharmacy Purchase Discounts (including Mail Order volume-based discounts), Transmission Fees, and Specialty Service Fees.

zzz. **Over-the-Counter Claim(s) or OTC Claim(s)** means a prescription Claim for products that do not ordinarily require a prescription for a Member to purchase but that the State has elected is required to include as Covered Products under the prescription drug benefit. For purposes of this Agreement, OTC Claims are identified by an ‘O’ or 'P' designation in Medi-Span’s Rx-OTC Indicator Code.

aaaa. **Out-of-Network Pharmacy** means a pharmacy that does not have a contractual agreement with the Contractor to provide Covered Services to Members. An Out-of-Network Pharmacy may submit Claims for reimbursement in accordance with applicable plan terms.

bbbb. **Paid Claim** means a Claim submitted by a Pharmacy or other authorized provider that has been adjudicated and approved by the PBM for payment in accordance with applicable Plan terms, eligibility requirements, clinical and utilization management criteria, reimbursement methodologies, and all other standards established under the Plan, applicable law, or PBM policies and procedures.

cccc. **Pass-Through Transparent Pricing** means a pricing structure in which the Contractor passes through 100 percent of its contracted Pharmacy reimbursement rates and all Manufacturer Payments to the State. At Retail Pharmacies and Mail Order or Specialty Pharmacies not owned by or affiliated with the Contractor, the amount billed to the State for all Pharmacy Claims will equal the amount paid by the Contractor to the dispensing Pharmacy - the Contractor shall charge no more than the amount paid to the Pharmacy for each drug plus a Dispensing Fee. At Mail Order or Specialty Pharmacies owned by or affiliated with the Contractor, the Contractor shall charge the cost of drugs based on the pharmacy’s Actual Acquisition Cost, plus a Dispensing Fee. The Contractor shall be contractually prohibited from making Spread or a profit on the Retail, Mail Order, or Specialty discounts. All Manufacturer Payments received by the PBM that relate to the State’s claims or utilization are fully passed through to the State. The PBM’s sole permissible sources of profit under this model are the Administrative Fee, Other Pharmaceutical Manufacturer Revenue not directly attributable to the State’s claims or utilization, and any approved Clinical Fees.

dddd. **PBM Affiliate(s)** means an entity:

(1) which is directly or indirectly, through one or more intermediaries, controlling such party;
(2) which is under the same direct or indirect ownership or control as such party;
(3) which is directly or indirectly, through one or more intermediaries, owned or controlled by such party;
(4) owned by the PBM or its parent company(ies) and any entities that are directly or indirectly owned by any entity in the upstream ownership chain of the PBM, including but not limited to the parent or any other owners of the parent.

For purposes of this definition and the Agreement, “control” (including the terms controlling, controlled by or under common control with) means (a) the possession, direct or indirect, (b) the power to direct or cause the direction of the management or policies of an entity, or (c)

the ability to direct an entity's affairs or to control the composition of its board of directors or equivalent body, whether through (i) 50% of more of voting securities, (ii) partnership or membership interests, (iii) by contract or (iv) any other means. Further, a GPO shall also be considered a PBM Affiliate only to the extent it meets the above definition.

eeee. **Per Member Per Month ("PMPM")** means the total cost or fee calculated on a per-member, per-month basis for all eligible Members enrolled during a given month. For purposes of this contract, PMPM shall be determined by dividing the applicable total monthly costs, fees, or amounts by the number of eligible Members for that same month, regardless of whether a Member utilized Pharmacy Benefits during that period.

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

gggg. **Pharmacy Discount Card(s)** means a prescription drug saving program operated by a third party that negotiates discounted prices with Retail Pharmacies often through arrangements with PBMs. These programs provide individuals with access to discounted prescription drug prices and are typically made available to the public at no cost through a physical card, digital card, or mobile application.

hhhh. **Pharmacy Purchase Discount(s) or Volume Discount(s)** means discounts received by PBM or its PBM Affiliates, either at time of purchase or retrospectively, from Pharmaceutical Manufacturers or wholesalers, that are attributable to or based on products purchased by PBM-affiliated dispensing Pharmacies. These discounts relate to the acquisition cost of products and are separate from Rebates associated with claims submitted under this Contract.

iiii. **Pharmacy and Therapeutics ("P&T") Committee** means an independent, multidisciplinary panel of clinicians—typically including physicians, pharmacists, nurses, and academicians—recognized as experts in their fields. They regularly evaluate new drugs, pipeline therapies, selected therapeutic classes, and safety issues. Their evidence-based recommendations determine formulary status, utilization policies, and drug management protocols, all conducted with transparency, documentation, and oversight to prevent conflicts of interest.

jjjj. **Plan Cost Share** means the portion of the total cost of a Claim that is paid by the Plan in accordance with the State's benefit design, after application of any applicable Member Cost Share requirements.

kkkk. **Plan Document(s)** means the legal publication that defines eligibility, enrollment, Benefits, and administrative rules governing the State's Group Insurance Program.

llll. **Plan Microsite** means the webpage(s) dedicated to and customized to the State's specifications which are developed and displayed by the Contractor for this Contract, which does not require individuals to log in, and contains information specific to the Plan when accessed via a dedicated URL.

mmmm. **Plan Year** means January 1 through December 31 of the same calendar year.

nnnn. **Post-Service Appeals** means an appeal submitted by a covered Member or the Member's prescribing clinician after a service has been provided or a drug has been dispensed, following an adverse determination such as non-payment of a claim or denial of a Prior Authorization. A Post-Service Appeal requests reconsideration at the next level of review after the initial adverse determination has been issued.

oooo. **Pre-Service Appeals** means an appeal submitted by a covered Member or the Member's prescribing clinician before a service is provided or a drug is dispensed, following an adverse determination such as the denial of an initial Prior Authorization request. A Pre-Service Appeal requests reconsideration at the next level of review prior to the Member receiving the service or medication.

pppp. **Pricing Source** means the primary benchmark(s) used to define drug ingredient costs, such as Medi-Span and its supplements (e.g., Price Rx), or other nationally recognized third-party pricing sources selected by the PBM.

qqqq. **Prior Authorization ("PA")** means a utilization management requirement under the Pharmacy Benefit Program where certain prescription drugs require written or electronic approval from the PBM before the service is rendered or drug is dispensed, in order for coverage and payment to be authorized.

rrrr. **Program(s)** means the Pharmacy Benefit management services provided under the provisions of this Contract.

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

tttt. **Protected Health Information ("PHI")** means Individually identifiable health information that is transmitted by electronic media, maintained in electronic media; or transmitted or maintained in any other form or medium.

uuuu. **Public Key Infrastructure ("PKI")** means 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.

vvvv. **Purple Book** means the Purple Book database that contains information on all FDA-licensed (approved) biological products regulated by the Center for Drug Evaluation and Research, including licensed Biosimilar and interchangeable products, and their reference products. It also contains information about all FDA-licensed allergenic, cellular and gene therapy, hematologic, and Vaccine products regulated by the Center for Biologics Evaluation and Research.

wwww. **Quantity Dispensed** means the total number of units (e.g., tablets, capsules, milliliters) of a product actually dispensed for a Claim as submitted to the PBM by the dispensing Pharmacy.

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

Discounts) from Mail Order and Specialty Drugs, the value of drug manufacturer coupons, or the value from any other patient assistance programs.

yyyy. **Retail Pharmacy or Retail** means any licensed community Pharmacy that is not a Mail Order Pharmacy or a Specialty Pharmacy. This includes any independent Pharmacies, supermarket Pharmacies, chain Pharmacies, and mass-merchandiser Pharmacies that hold a state license to dispense medications to the general public.

zzzz. **Retail-30** means a network Retail Pharmacy that dispenses up to a 30-day supply of medications.

aaaaa. **Retail-90 or 90-Day-At-Retail** means a network Retail Pharmacy that dispenses a 90-day ('mail at retail') supply of medications.

bbbbb. **Retrospective DUR ("Retro-DUR")** means a post-payment review of Pharmacy Claims data designed to meet Drug Utilization Review objectives. This analysis is conducted after the service has been rendered and payment processed, using pre-established clinical, safety, and utilization standards. Retro-DUR identifies trends such as therapeutic duplication, drug–disease or drug–drug interactions, over- or under-utilization, inappropriate duration or dosage, and instances of fraud, abuse, or medically unnecessary care.

ccccc. **Sales Tax** means a tax imposed by local, state, or federal government at the point of sale on a Claim that is collected by the dispensing Pharmacy.

ddddd. **Service Level Agreement ("SLA") Scorecard** means 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 KPI.

eeeee. **Single-Source Generic(s)** means Generic Drugs that are manufactured by one generic drug manufacturing company. For the avoidance of doubt, Single Source Generics will be reconciled with Generic Drugs for any financial guarantees.

fffff. **Specialty Drug(s)** means pharmaceuticals, biologics, or biotechnology-derived products that meet at least one of criteria (1) or (2) and all of criteria (3) through (5) to be designated as a Specialty Drug:

(1) Produced through biotechnology, genetic engineering, or other complex biological processes.
(2) Use in the treatment or management of complex, chronic or rare conditions requiring specialized clinical oversight.
(3) Require unique handling, storage, distribution, or administration such that they cannot be safely or appropriately dispensed through a standard Mail Order Pharmacy.
(4) Require coordinated clinical support, including medication management, adherence monitoring, patient training and/or ongoing clinical assessments.
(5) Are not devices, supplies, medical foods, or durable medical equipment.

Only drugs that are newly FDA-approved and launched, or drugs not on the market as of January 1, 2028, may be considered for addition to the Specialty Drug price list after that date, unless the Specialty Pharmacy gains access to a previously unavailable Limited Distribution Drug which is classified as a Specialty Drug.

ggggg. **Specialty Pharmacy** means (a) an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of Members, and does not have a physical Member-facing storefront, (b) the PBM

Specialty Pharmacies, (c) a pharmacy that dispenses a Limited Distribution Specialty Drug, and (d) any other Pharmacy that the parties agree in writing is a Specialty Pharmacy for purposes of this definition. If such a Pharmacy dispenses Specialty Drugs and non-specialty Drugs, such Specialty Pharmacy shall constitute a Specialty Pharmacy only with respect to the dispensing of Specialty Drugs and shall constitute a Mail Pharmacy (in the case of clause (a) of the preceding sentence) or a Retail Pharmacy (in the case of clause (b) and (d) of the preceding sentence) with respect to the dispensing of non-specialty Drugs.

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

iiiii. **Spread** means a term applicable to Traditional Pricing in which the PBM retains the difference between the amounts negotiated with Pharmacies and the financial terms offered to the client. For example, the PBM may secure a higher Discount from Pharmacies than it passes on to the client, keeping the difference—or "Spread"—as profit. In the traditional model, the Spread represents the PBM's profit margin, and the actual amount of this profit may not be fully disclosed to the client.

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

kkkkk. **State, Local Government, and Local Education Insurance Committees** means 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.

lllll. **Step Therapy** means a utilization management process in which drug therapy begins with the most cost-effective and clinically appropriate first-line medication and progresses to alternative therapies only if the initial treatment is ineffective or otherwise not appropriate. 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 criteria have not been met, the Claim is rejected and a message is sent to the Pharmacy indicating that the patient must first use the designated first-line therapy before coverage of the second-line medication can be approved.

mmmmm. **Subrogation Claim** means, unless the context indicates otherwise, subrogation shall mean the process used to seek reimbursement from the responsible party for a Claim paid by the Plan.

nnnnn. **Territory Pharmacy** ("**TER**") means a Retail Pharmacy located in a United States territory, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands. These Pharmacies are identified by ISO 3166 state codes AS, GU, MP, PR, and VI.

ooooo. **Third Party Administrator ("TPA")** means the State's contracted medical administrator responsible for processing medical Claims and providing other administrative services under the contract.

ppppp. **Total Claim Cost** means the sum of the Ingredient Cost, the applicable Dispensing Fee, and any applicable Sales Tax.

qqqqq. **Transmission Fees** means fees paid by Participating Pharmacies that directly or indirectly arise from Claims or Covered Drugs dispensed to Members. These fees shall not constitute Pharmacy Rebates. if (a) the aggregate amount does not exceed $0.15 per Claim, (b) the fees represent fair

and reasonable compensation for services actually performed by the PBM for a Participating Pharmacy, and (c) the PBM's receipt and retention of such fees comply with all applicable laws.

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

sssss. **URAC** means an independent, nonprofit organization that promotes health care quality through accreditation and certification programs. Originally incorporated as the Utilization Review Accreditation Commission, the organization adopted the shortened name URAC in 1996 as its accreditation programs expanded to include health plans, preferred provider organizations, PBMs, and other health care entities.

ttttt. **Vaccine** means a Claim in which the dispensed product is a Vaccine used for preventative inoculation to confer immunity against a specific disease, typically using an inactive or otherwise non-harmful form, fragment, toxin, or DNA of the disease agent to stimulate antibody production. The purchase price of a Vaccine includes the Ingredient Cost, Dispensing Fee, and the professional service fee to administer the Vaccine, which is directly tied to the bona fide service of administering the Vaccine to the Member at a Participating Pharmacy. Vaccine Claims are identified by a Medi-Span GPI-2 of '17' or '18' or an AHFS Therapeutic Class Code of 80120000 or 80080000.

uuuuu. **Veteran Affairs Pharmacy** ("**VA")** means a Retail Pharmacy operated by or under the jurisdiction of the U.S. Department of Affairs, where drugs are dispensed and pharmaceutical care is provided to enrolled veterans by licensed pharmacists. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code 09.

vvvvv. **Wholesale Acquisition Cost ("WAC")** means the manufacturer's list price for a drug when sold to wholesalers or direct purchasers, before any discounts, rebates, or other price concessions are applied.

wwwww. **Zero Balance Due** means Claims where the network price is less than both the U&C price and the Plan Copay, where the Member is charged the lesser of U&C and the Plan Copay (ignoring the network price).

A.3. Pharmacy Benefit and Policies.

a. The State is responsible for determining all Pharmacy Benefits and related policies. If the Contractor needs clarification on any benefit, policy, or operating guideline required to perform its duties, the Contractor shall request clarification In Writing. The State will respond In Writing, and the Contractor shall comply with the State's final determination.

b. The State is responsible for clarifying or revising the Plan Documents that define the Pharmacy Benefits available to Members. Because the Program cannot address every possible benefit situation, the Contractor shall seek the State's written clarification whenever a benefit is unclear or not addressed. The State has the exclusive and final authority to interpret the Plan Documents.

c. Unless otherwise directed by the State In Writing, the Contractor shall not interpret statutes, regulations, Plan Documents, or policy materials on its own. Rather, the Contractor shall submit In Writing to the State's designated contact within one (1) Business Day of identifying the issue.

d. The Contractor shall maintain full URAC Pharmacy Benefit Management accreditation status for the entire term of this contract.

A.4. Plan Implementation.

a. The Pharmacy Benefit and Program(s) for the Plan shall become effective and fully operational on the go-live date specified in Contract Section A.35. The Program shall not be considered operational until all required implementation activities have been completed and are functioning in pursuant to the terms of the Contract without material deficiencies. Partial implementation or availability of only certain required services shall not constitute operational status unless expressly accepted In Writing by the State. Operational status shall be determined solely by the State based upon successful completion of implementation testing and verification that all contractual implementation requirements have been satisfied.

b. The Contractor shall implement all systems necessary to process all Plan Pharmacy Claims and to provide all services described in this Contract. The Contractor shall work collaboratively with the State to ensure that the Program meets all functional and informational requirements as outlined by this Scope and in the Plan Documents.

c. The Contractor shall provide a dedicated, full-time implementation team. Each implementation team member shall have prior experience serving on an implementation team for Pharmacy benefit services for at least one other large employer (defined as an employer with a Pharmacy plan covering at least 100,000 lives). At minimum, the implementation team shall include: an implementation project lead to oversee the implementation; a full-time licensed pharmacist designated to this Contract; and a full-time account manager designated to this Contract, who will serve as the primary contact with the State for all matters related to implementation and ongoing operations. In addition, the Contractor shall assign an information systems project coordinator to coordinate activities among the Contractor, the State's existing contractors, and all affected State agencies other than Benefits Administration (including Edison, Strategic Technology Solutions, and the Department of Human Resources) as well as other State contractors (including the current PBM, TPAs, DSS contractor, etc.).

d. All key Contractor project staff shall attend a project kick-off meeting, in person or virtually with State approval, at the State of Tennessee offices in Nashville, TN within thirty (30) days of 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 written project implementation plan within thirty (30) days of the Effective Date. The plan shall be electronically maintained and accessible to the State and shall detail all aspects of implementation required to ensure the Program is fully installed no later than the go-live date specified in Contract Section A.35. The implementation plan shall include a description of the team members and their roles, all tasks and deliverable dates, and a detailed timeline of all work required from both the Contractor and the State. The implementation plan shall require approval In Writing by the State. At a minimum, the implementation plan shall include:
    (1) Identification and timing of significant responsibilities and tasks;
    (2) Names and titles of key implementation staff;
    (3) Identification and timing of State responsibilities;
    (4) Data requirements, including type and format;

(5) Data conversion plan, including testing procedures;
(6) Identification and timing for testing, acceptance, and certification of eligibility received through Edison;
(7) Identification and timing for testing and certification of Claim payment and reconciliation processes;
(8) Timing and testing of benefit design setup;
(9) Formulary development consistent with the State's Pharmacy benefit;
(10) Customer service line/call center opening and staff training;
(11) Plan Member communications;
(12) Communications with network Pharmacies regarding Plan participation;
(13) Schedule of in-person meetings and conference calls;
(14) Transition requirements with the incumbent PBM; and
(15) Staff assigned to attend and present at annual enrollment or educational sessions, as required.

f. The Contractor shall provide a comprehensive operational readiness review to the State at least sixty (60) days prior to the go-live date, provided that all implementation milestones necessary for the review have been met. The Contractor shall bear all costs associated with the readiness review to ensure that Plan design, eligibility and financial Contract terms have been accurately implemented.

The State's review may include, but is not limited to, an onsite evaluation of the Contractor's operational readiness for all required services, as well as desk reviews of documentation including:

(1) Policy and procedures manual;
(2) Information systems documentation;
(3) All deliverables and reports;
(4) System testing for all Plan options (Preferred Provider Organizations (PPO), Consumer Directed Health Plans (CDHP), etc.) to verify correct Member Cost Share (deductible, Copayments and/or Coinsurance) for Generic Drugs, preferred Brand Drugs, non-preferred Brand Drugs at both Mail Order and Retail Pharmacies, for 30-day and 90-day supplies, including reduced Member Cost Share for maintenance tier medications filled as 90-day supplies; and
(5) Copies of proposed Member handbooks or welcome letters/kits and front and back images of proposed Pharmacy Benefits ID cards.

g. At its discretion, the State may conduct an additional pre-implementation review of the Contractor's progress toward fulfilling IT and telecommunications requirements, including the verification that customer service representatives have been adequately trained in all aspects of the State's Plan and can provide accurate information to Members.

h. The Contractor shall conduct status meetings regarding project development, implementation progress, and Contractor performance at least weekly during implementation and daily during the first month after the go-live date, unless otherwise approved or requested by the State. Thereafter, ongoing operational meetings shall occur on a schedule specified by the State, but no less than once a month. Meetings may be conducted by phone, virtually, or in person at the State's offices, as determined by the State. The Contractor's account manager, pharmacist, and appropriate systems staff shall participate. All costs incurred by the Contractor in

connection with such meetings shall be the responsibility of the Contractor. At the State's discretion, monthly meetings may be replaced with virtual meetings on an as-needed basis.

i. No later than forty-five (45) days post-go-live, the State shall conduct an implementation performance assessment survey to evaluate the Contractor's performance during implementation. Results shall be shared with the Contractor, including identification of any deficiencies. The Contractor shall respond within fifteen (15) Business Days of receipt with a corrective action plan, as necessary, and shall implement all recommendations or corrective actions within the timeframes agreed upon by the State.

A.5. Staffing.

a. The Contractor shall provide an ongoing, full-time designated account team responsible for daily operational support, strategic planning, and analysis. All account team members shall have prior experience administering Pharmacy Benefits for large employers.

b. The account team shall be available to the State from 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday.

c. The Contractor shall designate a full-time licensed pharmacist as part of the account team. This pharmacist shall have more than five (5) years of executive-level pharmacy benefits manager experience and shall provide the State with clinical and pharmacological expertise related to Formulary development, Pharmacy benefit design, and utilization management activities, including PA, Step Therapy, and other management strategies. At the State's request, the pharmacist shall participate in calls with the State's population health contractor and/or TPA case managers to review complex Member issues, polypharmacy cases, and similar matters. These discussions shall typically occur virtually on an as-needed basis.

d. The Contractor shall designate a full-time account manager as part of the account team. The account manager shall also serve on the implementation team to ensure a seamless transition from implementation to ongoing operations. The account manager shall have the authority to manage all services under this Contract and shall respond promptly to changes in benefit design, Claims processing procedures, or administrative issues identified by the State. The account manager shall remain readily available by telephone and email throughout the Business Day to respond to inquiries from the State's director of pharmacy services and other State staff.

e. The account manager shall participate in all ongoing operational meetings as required in A.4.h. and shall meet in person with the State at least annually or more frequently if requested. The State may permit virtual participation as its discretion.

f. The Contractor shall designate a strategic account executive with overall responsibility for Contract performance, ensuring that all Contract requirements, deliverables, reporting, and benefit administration obligations are met, and providing long-term strategic guidance and fiscal analysis to the State.

g. The Contractor shall designate a benefits relationship manager responsible for leading the documentation, configuration, and implementation of the State's prescription benefits . The benefits relationship manager shall serve as the primary liaison to the State, translate State requirements into system configuration directives, oversee benefit setup and updates, facilitate

necessary meetings, and ensure accurate and timely deployment of all benefit design elements. The benefits relationship manager must possess expertise in formulary management, utilization management, reimbursement, and claims adjudication, and must proactively identify and resolve benefit-related issues to support high service performance.

h. The State shall conduct an annual account team satisfaction survey to evaluate the Contractor's performance. Results, including any deficiencies, shall be shared with the Contractor. The Contractor shall respond within fifteen (15) days with a corrective action plan, if necessary, and shall implement all required corrective actions.

i. The Contractor shall train all Contractor staff and subcontractors on all applicable components of the Plan's Benefits Program. The State must approve the Contractor's subcontractors and staff as described in this Contract section.

j. At the State's request, In Writing, the Contractor shall replace staff members or subcontractors who provide core services. Core services include those that directly affect Members (customer service, call center, Mail Order and Specialty Pharmacy services, Claims adjudication, and appeals processing) and those that directly affect Plan administration (the account manager, strategic account executive, pharmacist and benefits relationship manager). The State's decision regarding required personnel changes shall not be subject to appeal.

k. The Contractor shall notify the State at least fifteen (15) Business Days in advance, or as soon as feasible, of proposed changes to key personnel commitments (implementation manager, account manager, strategic account executive, and pharmacist). If a key position becomes vacant, the Contractor shall provide a replacement with comparable experience and credentials within sixty (60) days unless the State grants an exception In Writing. The Contractor shall submit detailed justification and proposed substitutions for State approval. The State reserves the right to require personnel changes, and such decisions shall not be subject to appeal.

l. The Contractor shall not employ or contract with individuals or subcontractors listed 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.

m. Contractor shall support Benefits Administration staff throughout the year with legislative inquiries and potential legislation proposed by the Tennessee General Assembly. This support may include section-by-section bill reviews, written analyses, and cost estimates, which may also be required for State, Local Education, and Local Government plans. Responses may be due within 48 hours when requested by the State.

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

a. The Contractor shall provide an integrated electronic POS Claims adjudication system for Retail, Mail Order, and Specialty Pharmacy services that meets all requirements of the State and Plan.

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

c. The POS system shall automate the full Pharmacy Claims process and price and adjudicate Claims online and in real time. It shall process all Retail, Specialty, and Mail Order electronic POS and Paper Claims incurred during the Term in strict accordance with the State's Pharmacy Benefits as outlined in the Plan Documents, available on the State's website. (https://www.tn.gov/partnersforhealth/publications/publications.html)

d. The Contractor shall process at least ninety-nine-point five percent (99.5%) of POS Claims each day within five (5) seconds, excluding scheduled maintenance. Processing time shall be measured from the moment the Claim is received by the Contractor's processor to the moment adjudication results are transmitted and shall include all steps required to complete adjudication. For compliance, the daily percentage of Claims processed within five (5) seconds shall be calculated by dividing the number of such Claims by the total number of Claims processed in the same 24-hour period.

e. The Contractor shall notify the State's pharmacy director by e-mail and/or phone immediately upon becoming aware of any unplanned or unapproved downtime affecting more than ten percent (10%) of production for fifteen (15) minutes or more. During any extended downtime, the Contractor shall provide the State with regular status updates. Appropriate recovery options shall be presented to the State as they become available.

f. Participating Pharmacies are responsible for submitting Member Claims through POS telecommunications devices. The Contractor shall also process Paper Claims within thirty (30) days of receipt when such claims are submitted by Members or by a prescriber on a Member's behalf.

g. The Contractor shall ensure that Retail network Claims submitted by Participating Pharmacies are paperless for Members. The Contractor's agreements with network Pharmacy Providers shall require those providers to submit Claims directly to the Contractor.

h. The Contractor's system shall provide Members with a POS explanation of Pharmacy Benefits for Claims processed through Retail, Mail Order, and Specialty Pharmacies. The system shall also offer online access to Claims records across all dispensing channels, including details on the Member's out-of-pocket costs, the Plan's costs, and any available cost-savings opportunities.

i. The Contractor shall work with the State's TPAs, as needed and upon request, on matters related to Subrogation Claims and shall provide any required data or support.

j. The POS Claims system shall fully integrate the PA, quantity limits, and Step Therapy programs, as described in Contract sections A.12.g and A.12.h, and have edits to verify eligibility, Formulary status, and Claim completeness at the time of submission.

k. On a quarterly basis, the Contractor shall accurately process at least 99.9% of Retail Claims and at least 99.99% of Mail Order and Specialty Claims, whether submitted by Members or their prescribers, in accordance with Contract Attachment D. Claims Processing Accuracy shall be calculated by dividing the weighted number of error-free Claims by the total number of Claims in the population. The Contractor shall report this metric on the SLA scorecard and

include a separate document with each submission showing the detailed calculation ("show your work").

l. The Contractor shall track Member utilization across all Participating Pharmacies upon the State's request.

m. The POS system shall generate a pay or deny status for each Claim and allow Pharmacies to initiate reversals (voids) of submitted Claims. The telecommunications system supporting POS functions shall be available to Pharmacies twenty-four (24) hours a day, seven days a week, except during scheduled and State-approved maintenance. Network Pharmacy Providers shall be responsible for their own POS hardware, software, and telecommunications connections, and the Contractor shall require all participating network Pharmacies to maintain POS capability. The POS system used by contracted Pharmacies shall be accessible and operational at least 99.90% of the time, excluding scheduled maintenance.

n. The Contractor shall assign a unique identification number to each Claim and its supporting documentation and use this number for research and audit purposes. The Contractor shall ensure that all Claims are fully processed (approved or denied) and shall maintain safeguards to protect the confidentiality of Member information.

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

p. The Contractor shall identify and deny Claims (unless otherwise directed by the State) that include NDC or NDC-11 numbers associated with Non-Covered Product drug codes, DESI LTE drug codes, IRS-to-DESI LTE drug codes, or any terminating or obsolete drug codes. Such Claims shall be rejected with situation- specific messaging and appropriate error codes.

q. The POS system must reject Claims when the Member's coverage is secondary and notify both the Member and the Pharmacy of the reason. The Contractor shall process secondary Claims for possible reimbursement, as appropriate.

r. At Contract end or termination, the Contractor shall process all Claims incurred during the Contract term without additional administrative fees and apply the pricing applicable for the year in which the service occurred. The Contractor shall pay all Rebates on Claims incurred before termination. Claims run-out shall continue for six (6) months after December 31, 2032, unless otherwise directed by the State.

s. The Contractor shall maintain a 24/7 dedicated toll-free Help Desk located within the contiguous United States to support system operations and respond to Pharmacy Providers' inquiries.

t. All Claims shall be processed on the same adjudication platform approved at implementation. The Contractor shall not transition the State to another platform during the Term without prior approval In Writing by the State and a pre-migration readiness assessment and Claim audit to test that the set up and benefits will be processed correctly. The cost of the migration audit shall be paid for by the Contractor.

u. Any payment card data processed on behalf of the State shall comply with the current version of PCI DSS.

v. POS system messages shall not steer Members or Providers to use a specific Pharmacy.

A.7. Claims Payment and Reconciliation.

a. The Contractor shall adjudicate Claims as payable only when they: (i) are submitted for eligible Members; (ii) involve approved services; (iii) are provided by in-network Pharmacies or Providers, or by Out-of-Network Pharmacies when payable up to the Ingredient Cost minus any applicable Member Cost Share; and (iv) comply with all payment rules and policies established by the State. The State shall pay only for approved and correctly Paid Claims and shall not pay for rejected or reversed Claims. Out-of-network Claims paid in full by the Member shall be reimbursed directly to the Member when they: (i) are for eligible Members; (ii) involve approved services; and (iii) and comply with the State's payment rules and policies.

b. The Contractor shall either pay the Claim or notify the Provider that the submitted Claim is: (i) a Denied Claim, specifying all reasons for denial; or (ii) a transaction that cannot be approved or denied due to insufficient information and/or documentation, specifying all information and/or documentation required from the Provider to complete adjudication. An incomplete transaction may be resubmitted with the necessary information to complete the Claim.

c. The Contractor, the GPO, and any PBM Affiliates shall pass through to the Plan the full value of all contracted rates negotiated with Participating Pharmacies—including, but not limited to, Discounts, Dispensing Fees, and any other contracted terms—as well as all contracted amounts from Pharmaceutical Manufacturers, including Rebates, MAF, and other Manufacturer Payments. Accordingly, the Contractor shall not retain any differential or Spread between the contracted rates with Pharmacies or manufacturers and the rates contracted with the Plan. The Contractor shall, at the State's request, demonstrate its level of Pass-Through Transparent Pricing.

d. The PBM represents and warrants that its agreements with any GPO will include and will continue to include throughout the term of this Contract, provisions or obligations that are substantially similar to any provision or obligation in this Contract that directly or indirectly relates to services performed, or that may be performed, by a GPO as defined herein.

e. The Contractor shall be responsible for ensuring that all payments made by or to the State are accurate and comply with this Contract, the Contractor's agreements with Providers; and all applicable State and Federal laws and regulations.

f. The Contractor shall ensure that every Paid Claim is assigned to one of the State's funding accounts. Any subsequent Claim adjustments initiated by either the State or the Contractor shall be debited or credited to one of the State's funds, and not to the Administrative Fees paid to the Contractor. Any adjustments or late-processed Claims that result in amounts owed to or by the State shall likewise be applied only to the State's funds and not to Administrative Fees.

g. Claims Payment Accuracy shall be at least ninety-nine-point nine percent (99.9%) for Retail, Mail Order, and Specialty, based on the Contractor's internal quality review. Accuracy shall be calculated as the total number of Claims audited and determined to have no adjudication errors of any kind (i.e., any processing inaccuracy resulting in an incorrect charge to the State or its Members), divided by the total number of Claims audited.

h. The Contractor shall notify the State within thirty (30) calendar days of any retroactive termination and shall identify all Claims paid on behalf of the affected Member during the retroactive period. The Contractor shall assist the State in recovering such Claims as required.

i. The Contractor shall reimburse Pharmacies for Claims using its own funds and accounts. For all Claim payments under this Contract, the Contractor shall issue payments—whether by check or Automated Clearing House (ACH) electronic funds transfer—drawn on the Contractor's own bank account. The Contractor shall maintain appropriate security and quality controls over the design, printing, and mailing of checks, including all fraud prevention features. Additional payment requirements are outlined in Contract Section C.3. Claims paid by the Contractor shall be reimbursed by the State's Office of Business and Finance (OBF) upon receipt of sufficient documentation and reports from the Contractor to verify the accuracy of the reimbursement request. The State will reimburse the Contractor only for Paid Claims. Claims that have been processed and adjudicated but not yet paid by the Contractor to Pharmacies are not eligible for reimbursement.

j. The Contractor's Pharmacy payment process shall comply with all applicable state prompt pay laws per Tenn. Code Ann. § 56-7-109. Payment reports provided to the State shall support the State's reconciliation of payment details and the recording of accounting entries.

k. The Contractor shall, at the State's request and with prior approval, perform POS drug price comparisons with one or more prescription Discount programs to enable Members to obtain lower prices when available. Any amount paid by the Member under such programs shall be seamlessly applied to the Member's deductible and/or out-of-pocket maximum.

l. The Contractor shall charge nothing back to the State more than six (6) months after the close of a calendar year. This includes any errors found by the Contractor.

m. The Contractor will not back-bill or retroactively charge the State for Contractor coding errors.

A.8. Pharmacy Network.

a. The Contractor shall contract directly with Retail, Mail Order, and Specialty Pharmacies to operate and maintain a comprehensive network in compliance with Tenn. Code Ann. § 56-7-2359. The Contractor shall establish and maintain its broadest available national Pharmacy network, including statewide any willing Provider networks for Retail-30, Retail-90, Specialty, Vaccine administering Providers, and a Mail Order network. These networks must be sufficient to provide covered Pharmacy services and ensure location access in compliance with this Contract and all applicable Tennessee laws. The Contractor shall process varying Member Cost Share amounts (including Copayments, Coinsurance, deductibles, and maximum out of pocket amounts) based on the Pharmacy type and network utilized by the Member. The Contractor shall offer:

(1) A statewide any willing Provider/national network of Pharmacies for the thirty (30)-day supply network, allowing Members to fill prescriptions at their applicable thirty (30)-day Member Cost Share (Copayment or Coinsurance).

(2) A Mail Order Pharmacy network for ninety (90)-day prescription fills.

(3) A statewide any willing Provider/national Retail-90 network, enabling Members to fill ninety (90)-day prescriptions at the same Member Cost Share as Mail Order, with the Plan reimbursed at the same rates as Mail Order.

(4) A statewide any willing Provider/national Specialty Pharmacy network from which Members must select a Pharmacy to fill any Specialty Drug.

(5) A statewide any willing Provider/national network of Pharmacies offering a broad range of Vaccines administered at the State-determined Cost Share.

b. The Contractor shall execute network participation agreements with any willing Pharmacy Providers for Retail, Specialty, and Vaccine Pharmacy services, provided such Providers maintain all federal, state and local licenses, certifications, and permits—without restriction—and comply fully with all applicable laws and regulations. The Contractor shall also offer a Mail Order option for Members obtaining an extended supply of non-specialty drugs at the applicable Member Cost Share.

c. The Contractor shall provide, on the Contractor's Plan Microsite, a link to a search tool containing current network Pharmacy information—at a minimum including the Pharmacy's name, NPI, address, city, state, zip code, and telephone number— for all Pharmacies participating in the Retail-30, Retail-90, Mail Order, Specialty, and Vaccine networks. The Contractor shall update all network Pharmacy lists at least quarterly and shall provide these lists to the State on a quarterly basis.

d. The Contractor shall not require the State to mandate the use of Mail Order Pharmacies, nor shall the Contractor require Members to utilize a single Pharmacy or a single chain of Pharmacies.

e. Retail-30 Network: The Contractor shall maintain a network of Pharmacy Providers that ensures the following access standards for covered services:

(1) in urban areas, at least ninety percent (90%) of Members, on average, must reside within one and one half (1.5) miles of a Retail Pharmacy participating in the Contractor's network;
(2) in suburban areas, at least ninety percent (90%) of Members, on average, must reside within three (3) miles of a Retail Pharmacy participating in the Contractor's network; and
(3) in rural areas, at least ninety percent (90%) of Members, on average, must reside within ten (10) miles of a Retail Pharmacy participating in the Contractor's network.

Any exception to these access requirements must be fully justified and documented by the Contractor and are subject to the State's prior approval In Writing. The Contractor shall also ensure that any Pharmacy providing services processes and charges Members either the applicable Member Cost Share or the "lesser-of" amount when the Actual Cost of the drug is lower than the Member Cost Share. The Contractor shall not, under any circumstances, prohibit a pharmacist from informing a Member of a lower-cost drug alternative or from collecting the lesser-of amount if it is below the Member Cost Share.

f. Retail 90 Network: The Contractor must establish and maintain the Retail-90 network for the Plan and shall not, under any circumstances, attempt to direct Members to any specific Pharmacy. Neither the State nor the Contractor may influence or attempt to influence a Member's choice of Pharmacy for filling a prescription, except for Specialty Drugs referenced in Contract Section A.8.h., which the State requires be filled at a network Specialty Pharmacy.

g. Mail Order Network:

(1) The Mail Order Pharmacy shall maintain sufficient staff levels and facilities to meet the following requirements:

i. Turnaround time for clean Claims (Claims not requiring intervention): At least 96% must be shipped within two (2) Business Days. This requirement is measured in Business Days from the date the prescription drug Claim is received by the vendor (via paper, phone, fax or Internet) to the date the medication is shipped.

ii. Turnaround time for Claims requiring administrative or clinical intervention: At least 96% must be shipped within four (4) Business Days. This requirement is measured in Business Days from the date the prescription drug Claim is received by the vendor (via paper, phone, fax or Internet) to the date the medication is shipped.

iii. Mail Order dispensing accuracy – The Mail Order Pharmacy shall maintain a dispensing accuracy rate of 99.95% Dispensing Accuracy Rate means the total number of all Mail Order prescriptions dispensed in a quarter minus the number of prescriptions dispensed with an error (incorrect drug, strength, dosage form, patient name, directions, packing nonconformance, or incorrect address resulting in improper delivery), divided by the total number of all Mail Order prescriptions dispensed in that quarter.

(2) The Mail Order Pharmacy shall maintain a current license authorizing the dispensing of controlled substances in Schedules 2, 3, 4 and 5.

(3) The Mail Order Pharmacy is not required to dispense more than a ninety (90) day supply of Covered Drugs, per prescription or refill. This limitation is subject to pharmacist professional judgment, controlled substances restrictions under Tenn. Code Ann. 63-1-164, and manufacturer recommendations. Exceptions apply to medications packaged by the manufacturer in quantities slightly exceeding ninety (90) days if such packaging cannot be reasonably split (e.g., insulin products). In such cases, the Mail Order Pharmacy may dispense using the manufacturer's packaging and charge the Member the applicable ninety (90) day Cost Share. Prescriptions may be refilled only if refills remain, and all dispensing must comply with Tennessee laws and regulations.

(4) The Contractor shall ensure that MAC pricing applies to Generic Drugs at mail, when applicable. A Generic Drug shall never cost more at mail than at a Retail Pharmacy.

(5) The mutually agreed-upon baseline measure (AWP, NADAC, WAC, or other) applied to Mail Order Claims must be based on the actual NDC or NDC-11 of the package size dispensed.

(6) The Mail Order Pharmacy shall notify the Member, the prescriber, and the State if substituting a product will result in higher cost to the Member or the Plan compared to dispensing as written. Substitutions may occur only in cases of widespread drug availability issues, Member safety concerns, drug interaction concerns, or efficacy concerns, and only with prescriber approval when required.

(7) The Mail Order Pharmacy shall notify Members of any prescription delivery delays lasting more than three (3) Business Days. Such notice shall be provided within twenty-four (24) hours of identifying the delay and may be delivered by phone, email, or text.

(8) The Contractor will arrange and pay for a short-term Retail supply of a delayed or incorrectly processed Mail Order prescription caused by your organization. In addition, the Contractor shall not charge Members for expedited delivery of the Mail Order prescription if the prescription delay is caused by your organization.

(9) If a Mail Order package is lost, stolen or not delivered, the Contractor will not charge the Plan or the Member for the Mail Order drug.

(10) The Mail Order Pharmacy shall issue refunds owed to Members rather than maintaining credits on file.

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

(12) The Contractor shall obtain open refill files from the State's current Mail Order contractor. At the end of this contract, the Contractor shall ensure its Mail Order vendor transfers open refill files to the State's new PBM contractor.

(13) The Contractor shall maintain a secure website supporting the Mail Order functions. The website must allow Members to view Pharmacy Claims, request refills and make payments online. The website must be operational no later than thirty (30) days before the go-live date.

h. Specialty Network:

(1) The Specialty Pharmacy network shall serve as the preferred Pharmacy Provider for designated drugs. The Specialty Pharmacy network shall offer reimbursement rates that are, in the aggregate, more favorable than the rates available through the Retail, Mail Order, and 90-Day-At-Retail networks for these designated products. The Specialty Pharmacy network shall maintain the clinical monitoring, Member support, and distribution capabilities unique to Specialty Pharmacy services.

(2) The Contractor, or any other third-party Specialty Pharmacy contracted by the Contractor, may provide Specialty Drugs. The Contractor shall update the list of Specialty Drugs as needed and shall establish pricing for any new Specialty Drugs.

(3) Unless otherwise directed by the State, all drugs included on the Contractor's Specialty Drug list must meet the definition of Specialty Drugs set forth in Contract Section A.2. The Contractor may not reclassify a Specialty Drug as a non-specialty drug, nor reclassify a non-specialty drug as Specialty, without mutual agreement between the Contractor and State and provide supporting justification.

(4) Unless otherwise directed by the State, the Contractor shall limit Specialty Drugs to a maximum thirty (30) day supply per fill, and such drugs shall be dispensed exclusively via Specialty network Pharmacies. To comply with Tenn. Code Ann. § 56-7-2359, the Contractor must solicit Pharmacies located within Tennessee to participate in the Specialty Pharmacy network, even if the Contractor operates its own Specialty Pharmacy. Neither the Contractor nor the Contractor's staff shall attempt to steer Members to a specific Pharmacy within the Specialty Pharmacy network, provided that Members utilize an in-network for their Specialty Drugs.

(5) Contractor acknowledges that the Administrative Fee and any applicable Clinical Fee paid monthly under this Contract constitutes payment for all required services, including all Specialty Drug management functions such as Step Therapy, first fill counseling, product recalls, Member adherence education, PA activities, and standard PBM clinical or nursing-related services.

(6) The Contractor shall ensure that the mutually agreed-upon pricing baseline measure (AWP, NADAC, WAC, or other) applied to Specialty Claims is based on the actual NDC or NDC-11 corresponding to the package size dispensed.

(7) In addition to the Contractor's criteria for Specialty Pharmacy participation, the State imposes the following requirements. The Contractor shall ensure that each Specialty Pharmacy meets the criteria below:

i. State Specialty Network Participation Criteria

a) Storage, Shipping, and Handling: Pharmacies must be able to store, handle, and ship medications in accordance with product labeling.

b) Registration and Licensure: Pharmacy must be properly registered or licensed and in good standing with the Board of Pharmacy in their home state and with the Tennessee Board of Pharmacy if they are located out of state.

c) Member Counseling & Clinical Monitoring: Pharmacy must employ a licensed pharmacist capable of counseling Members on Specialty Drug use, including managing potential side effects, addressing medication adherence, and ensuring appropriate use.

d) Member Notification of Recalls: Pharmacies must identify and notify affected Members in the event of any product recall.

(8) If a Specialty medication package is lost, stolen or not delivered, the Contractor will not charge the Plan or the Member for the Specialty drug.

(9) If a Specialty Pharmacy leaves the Specialty Pharmacy network, the Contractor shall notify affected Members by letter within thirty (30) calendar days. Upon receiving notice that a Specialty Pharmacy is exiting the network, the Contractor shall identify any Members who have used that Pharmacy within the previous ninety (90) calendar days and send those Members a letter that specifies the Pharmacy's termination date and includes a printed list of remaining contracted Specialty Pharmacies. The State reserves the right to review and edit such letters prior to approval and distribution. The Contractor must also notify the State's Director of Pharmacy Services In Writing within ten (10) Business Days each time a Specialty Pharmacy leaves the network.

i. The Contractor shall routinely monitor Member prescription drug utilization to identify potential Pharmacy-shopping or prescriber-shopping behavior involving narcotics and other medications with abuse potential. When the Contractor identifies Member or prescriber patterns that fall outside expected norms, the Contractor shall contact the prescribing Provider(s) to verify the diagnosis and clinical need for such medications. If the Contractor's clinical pharmacist determines that it is appropriate to restrict a Member to a single designated Pharmacy, the Contractor shall notify the State and request authorization to implement a Pharmacy Lock-In for that Member.

j. The Contractor shall enroll Members who meet the Contractor's Lock-In criteria into a Lock-In program that restricts the Member to a single designated Participating Pharmacy and a single prescriber. The Contractor shall submit its Lock-In guidelines to the State for approval during Plan implementation. At least quarterly, the Contractor shall use both automated systems and manual review of prescription drug Claims to identify Members who may be engaging in potential abuse of pain medications or other commonly abused narcotics, or who may be

engaging in possible Pharmacy or prescriber shopping. When such cases are identified, the Contractor shall transmit supporting evidence via secure email to BA and request a review and determination regarding Lock-In placement. If BA determines that a Lock-In is warranted, BA shall notify the Contractor and provide the designated Pharmacy name, address, NABP number, and the date in which the Lock-In shall take effect.

k. The Contractor shall annually provide the State with a network access report such as a Quest Analytics or comparable report demonstrating service and geographic access for the Retail-30 and Retail-90 networks. Each report shall detail network access by urban, suburban, and rural Member classifications to verify compliance with the access standards outlined in this Contract. The State will review the Contractor's Pharmacy network structure and will notify the Contractor In Writing of any deficiencies identified. Within sixty (60) calendar days from the date of such notification, the Contractor shall develop and submit a State-approved corrective action plan to address and remedy the deficiencies.

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

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

n. If one of the top five network Pharmacy chains leaves any of the Contractor's networks or notifies Contractor of plans to leave any of its networks, or network changes impact more than 0.05% of Members, the Contractor shall immediately notify the State as well as draft Member notification letters for mailing to affected Members at the Contractor's cost. Letters should be mailed at least thirty (30) calendar days before the date which the Pharmacy intends to leave the network and should list the three (3) Pharmacies closest to the Member that remain in the applicable network. The State must approve notification letters before they are mailed.

o. Should the number of Retail Pharmacies in your network be reduced by more than three percent (3%) of all Pharmacies in the network (add, drop certain chains, etc.) and/or one of the top five (5) Pharmacy chains by store count before the Effective Date and or any point during the Term, the Contractor shall provide the State with an improved pricing offer for the proposed reduced Retail network at least ninety (90) calendar days prior to the date in which such change takes effect. If the revised pricing that results from a change in the Pharmacy network is not acceptable to the State, the State reserves the right to renegotiate pricing.

A.9. Formulary Management.

a. The Contractor shall design, develop, and implement a Formulary, or multiple Formularies, consistent with the coverage requirements outlined in the Plan Documents. Each Formulary shall include FDA-approved medications that have been reviewed and approved for inclusion by the Contractor's P&T Committee. The Contractor shall serve as the exclusive Formulary administrator for all Formularies associated with the prescription drug benefit. The initial Formulary or Formularies impacting Members on the go-live date shall be fully developed and submitted for state review no later than sixty (60) days prior to go-live.

b. By the go-live date, the Contractor shall assume full responsibility for administering and maintaining the Formulary or Formularies, including all PA criteria and clinical Programs. Throughout the Term, the Contractor shall also assume responsibility for administering and maintaining additional Formularies implemented at the State's request.

c. The Contractor shall permit the addition of new and/or alternative Formularies at the State's request and shall maintain the capability to administer multiple Formularies across different plan designs. The Contractor shall collaborate with the State to update or modify contractual guarantees, as necessary, to accommodate any newly implemented or revised Formularies not anticipated in the initial Program setup. The Contractor shall also allow Formulary customization at the State's request, at no additional cost to the State, including the addition or removal of any products, inclusive of OTC products. The Contractor shall implement customized Formularies within a timeframe proposed by the Contractor and approved by the State In Writing.

d. The Contractor shall monitor Formulary compliance and, upon the State's request, provide quarterly compliance reports to the State. Upon request, the Contractor shall also provide recommendations to improve Formulary compliance.

e. The Contractor shall implement all State-approved or State-requested changes to the Formulary, Step Therapy, PA, and other clinical edit requirement criteria within forty-five (45) Business Days. Additional implementation time may be granted with the State's prior approval In Writing. Required changes include all associated updates to the POS system and any related systems or documentation. The Contractor shall notify Pharmacy Providers and affected Members In Writing at least forty-five (45) days prior to implementing such changes, unless the State requests a shorter notification time. All Pharmacy Provider and Member notifications require the State's prior approval In Writing.

f. The Contractor shall not implement or administer any program that results in the conversion from lower net cost products to higher net cost products or conversion from a lower Member Cost Share to a higher Member Cost Share. Exceptions may be permitted when necessary for Member safety or efficacy, or upon approval by the State and/or prescriber, in response to issues such as widespread marketplace drug availability involving the lower net cost product.

g. Final authority regarding the inclusion or exclusion of any product from the Formulary shall rest solely with the State. For purposes of this contract, the Contractor shall offer and administer a Formulary structure under which all FDA-approved medications are covered, or have an established pathway to coverage, except for those expressly excluded by the State of Tennessee's governing Plan Document(s) or as otherwise directed or approved by the State. No utilization management tools, including but not limited to Step Therapy, Prior Authorization, or quantity limits, may be applied unless the State grants approval for such tools during implementation or at any time during the Term.

h. The Contractor shall regularly review the State's Plan Documents for the State, Local Education, and Local Government Plans to ensure compliance with all medication and supply coverage requirements, including any noted exclusions. The Contractor shall maintain full compliance with these provisions, and with all similar requirements contained in the Plan Documents, throughout the Term.

i. Upon the State's request, the Contractor shall collaborate with State staff to support and facilitate the appropriate use of manufacturer coupons at Pharmacies, in alignment with State policy and Program objectives. The Contractor shall provide the State with any reporting available on Member use and the associated value of manufacturer coupons.

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) promote the prescribing and dispensing of safe, clinically effective, and cost effective drugs within each therapeutic class in a manner that delivers the greatest clinical and financial value to the State; (ii) ensure that higher-cost drugs without significant clinical or therapeutic advantage over alternative within their class are used only when medically necessary; assigned to a higher Formulary tier, or, in certain cases excluded from the Formulary; and (iii) ensure that at least ninety-five percent (95%) of Mail Order prescriptions and at least ninety percent (90%) of Retail prescriptions for Multisource drugs are dispensed using a Generic Drug product.

(2) The Contractor's P&T Committee Formulary review process shall consist of an evidence-based evaluation of clinical guidelines and medical literature to determine which drug classes and agents are appropriate for inclusion on the Formulary. For each drug class selected for inclusion, the Contractor shall identify the agents that are safe, clinically effective, cost-rational, and capable of providing comparable clinical outcomes. The P&T Committee's recommendations shall be based on a comprehensive assessment of clinical effectiveness, safety, and health outcomes, followed by an evaluation of the relative costs of the drugs within each class. Upon the State's request, the Contractor shall provide documentation describing the Formulary review process, including the logic and methodology utilized by the Contractor's P&T Committee.

(3) The Contractor shall identify therapeutic alternatives and cost-saving opportunities for savings and shall report these opportunities to the State on a quarterly basis. The Contractor shall also present recommendations at the annual review meeting regarding any therapeutic categories that, if applicable, should be avoided for inclusion on the Formulary.

(4) The Contractor may modify the drugs included on the Formulary based on factors including, but not limited to, medical appropriateness, manufacturer Rebate arrangements, and patent expirations. The Contractor shall notify the State of any Formulary modifications and shall include a statement explaining the reason for each modification. If a modification affects one of the top twenty (20) drugs by prescription volume among eligible Members, the Contractor shall provide a detailed justification that includes a financial analysis.

(5) Upon the State's review and approval, 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 prescribers (including communications related to Generic Drug substitution programs); and financial incentives for Participating Pharmacies that support program participation.

(6) The Contractor shall design, develop, implement, administer, and maintain applicable quantity limits for designated preferred and non-preferred drugs. These quantity limits shall be based on therapeutic best practices, including current clinical guidelines, and on opportunities to reduce costs through use of the most appropriate dosage forms. The Contractor shall include all applicable quantity limits directly within the Formulary guidebook(s) and shall ensure these limits and related Pharmacy messaging are accurately coded into the POS system.

(7) The Contractor shall ensure that the Formulary guidebook(s) are readily accessible on the Plan Microsite for both prescribers and Members, and that users can easily identify Covered Drugs, their applicable tier placement, and all associated utilization management requirements, including Step Therapy, Prior Authorization, and quantity limits. The Contractor shall also ensure that Specialty drugs and OTC drugs are clearly identified within the guidebook(s). The Contractor shall update the Formulary guidebook(s) on a quarterly basis and shall ensure that the updated guidebook(s) are posted to the Plan Microsite on the same quarterly schedule.

(8) The Contractor shall coordinate its Formulary development process and criteria with its clinical Program requirements, including Prior Authorization, Step Therapy, and other utilization management Programs, to ensure consistency and to minimize disruption for Members and prescribers. The Contractor shall also provide a link to the Contractor's Prior Authorization criteria on the Plan Microsite.

(9) The Contractor shall ensure that the Pharmacy Program and POS system support the dispensing of an emergency supply of medication, including but not limited to early refills, lost prescriptions, vacation supplies, and dose increases, as defined and governed by the applicable Plan Document.

(10) The Contractor shall collaborate with the State to implement utilization edits for medications identified by either the State or the Contractor as wasteful or low value. The Contractor shall notify affected Members In Writing at least sixty (60) days prior to implementing such changes and shall also provide notification to current utilizers as additional drugs are added to the wasteful or low-value Program.

(11) The Contractor shall maintain a Program designed to reduce the utilization of drugs with hyperinflated costs that do not provide meaningful clinical value. The Program's intent is to decrease the use of such drugs and to redirect Members to clinically appropriate, lower-cost alternatives that offer greater therapeutic value. The Contractor shall develop, maintain, administer, and provide to the State, if requested, a list of these medications. The Contractor shall allow the addition of medications to the list at the State's request without being considered customized. The Contractor shall notify the State and affected Members In Writing at least sixty (60) days prior to implementing any changes under this Program and also as additional drugs are added to the Program.

k. The Contractor shall not require the State to participate in any Formulary management program, nor shall the Contractor alter Net Drug Cost PMPM Guarantees or proposed trend guarantees based on the State's decision not to participate in such programs. The State shall retain sole authority to make all final determinations regarding participation in Formulary management programs.

l. The Contractor shall allow Members affected by a State-approved Formulary management program change a minimum of sixty (60) days to comply with the change, unless the State agrees otherwise. The Contractor shall also provide Member exemptions or Continuity of Therapy at the State's request.

m. The Contractor shall notify the State In Writing ninety (90) days in advance of any Formulary change and, if requested, shall provide the State with a State-specific analysis identifying member impact of any proposed Formulary Exclusions on a drug-by-drug basis at the same time.

n. The Contractor shall send Member and prescriber notification letters at least forty-five (45) days in advance of any Formulary update that results in a negative impact to the Member. Such letters shall identify the effective date of the Formulary change, the Member's current medication(s), and the corresponding upcoming Formulary alternatives. The State shall not be billed for these notifications, as they are included in the monthly PMPM Administrative Fee paid to the Contractor.

o. The Contractor shall provide written notice to the State and Members within five (5) Business Days for any Formulary changes due to safety and FDA-driven issues.

A.10. Benefit Coverage/Plan Design.

a. The Contractor shall support and administer any Pharmacy Benefit structure developed by the State or required by law which may include, but is not limited to, the following:

(1) Any current or updated Benefit Plan design (e.g., separate Specialty Drug MOOP);

(2) Different Benefits for different plan options offered to Members or a subset of Members;

(3) Different Member Cost-Share and Benefit limits by dispensing channel;

(4) Minimum/Maximum amounts per prescription;

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

(6) Reduced or alternate Member Cost Share for specific drug classes (e.g., weight loss medications, Specialty Drugs);

(7) Member Cost Share differences based on place of service, Member utilization history, participation in a Program, and the Days' Supply dispensed; and

(8) Integrated medical and pharmacy deductibles and out of pocket maximums on a real time basis

b. At the State's request, the Contractor shall implement value-based payment agreements for medications in which the Provider payments vary based on quality, efficacy, and/or patient outcomes or any combination thereof. The Contractor shall not implement any such value-based payments to Pharmacies or manufacturers without prior approval In Writing from the State. Upon implementation, the Contractor shall provide the State with detailed reporting sufficient to allow effective monitoring of these payments. Such reporting may include, but is not limited to: drug name(s), NDC, and full GPI; manufacturer name; total number of prescriptions filled; total number of Members utilizing each drug; and the projected financial impact and savings to the plan resulting from the Program.

c. Each year, no later than November 1, the Contractor shall provide the State with test result documentation validating the upcoming Plan Year's Benefits configuration within the Contractor's claims adjudication platform. Such documentation shall include Benefit set-up by

drug classification (Generic Drugs, preferred Brand Drugs, non-preferred Brand Drugs, and Specialty Drugs) and by 30-day and 90-day supply, as well as all applicable deductibles and maximum out-of-pocket amounts by coverage level. This process is intended to confirm accurate benefit design implementation for all Plan options.

d. The Contractor shall maintain the thirty (30)-day and ninety (90)-day supply limits as applicable. In circumstances where a Member is traveling for an extended period, the State may, at its sole discretion, authorize a courtesy override. In such cases, the Contractor shall contact the State to obtain approval for any extended-supply or vacation override. When an override is approved, the Contractor shall ensure the Member is charged the appropriate Cost Share for the extended day supply (such as multiple Copayments or Coinsurance amounts). The Contractor shall maintain detailed records of all such overrides within its POS and financial systems for audit purposes.

e. The State may request, and the Contractor shall support, an annual industry and innovation review and planning meeting during the Term of this contract. Such meeting shall be held at either the State's offices or the Contractor's offices, with virtual participation available as needed, and shall include Contractor executives and key leadership with authority and insight into the Contractor's corporate vision and strategic direction. The meeting date, agenda, and attendees shall be jointly developed by, at a minimum, the Program director and the Contractor's account executive.

f. The Contractor shall work with the State to implement any State-requested point solution offerings the Contractor has available and shall ensure all associated costs are billed as Claims. These point solutions shall not negatively impact the Contractor's risk of performance or trend guarantees and shall be excluded from guarantee calculations as necessary.

A.11. Compliance.

a. The Contractor shall ensure that the Plan Benefits and the Contractor's processes, systems and reporting are delivered in compliance with all State and Federal laws, rules and regulations. The Contractor shall be responsible for all related costs for complying with these laws, including, but not limited to, appeals by Pharmacies.

b. The Contractor shall ensure that all Pharmacy Benefits and Programs offered by the State and administered by the Contractor comply with all current and future requirements of the Patient Protection and Affordable Care Act (PPACA). The Contractor shall advise the State on all such Benefits and Programs, including Benefit design, Formulary design and management, Member Cost Share structure, and all levels of appeals.

c. The Contractor shall assist the State, at no additional cost, in complying with all requirements of the Consolidated Appropriations Act of 2021 and Transparency in Coverage regulations, including producing machine-readable files, providing an internet-based self-service tool for Members, maintaining and updating a Provider directory and administering the protections for Members as necessary, and producing all Prescription Drug Data Collection (RxDC) reporting obligations. The Contractor shall provide the State with copies of all data submitted to fulfill the Contractor's portion of the annual RxDC reporting, including, but not limited to, files D3-D8 and the prescription drug components of the narrative response.

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

e. Any fines for noncompliance, whether or not issued to or in the name of the State and/or Contractor, related to services provided by the Contractor under this Contract will be the Contractor's sole responsibility.

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

g. The Contractor shall notify the State of any new federal legislation that will impact the State's pharmacy benefit.

h. The Contractor shall provide support for class action settlements and notify the State of such litigation against the Contractor's organization.

A.12. Clinical Programs.

a. The Contractor shall use prescription drug Claims data to support and enhance Drug Utilization Review (DUR), clinical management initiatives, therapeutic management initiatives, and gaps-in-care analysis, and these activities shall be provided as part of the Clinical Fee at no additional cost to the State.

b. The Contractor shall provide clinical and utilization management programs specific to Specialty Drugs and self-administered injectable medications. The Contractor shall also ensure that a qualified clinician is available to Members through the Specialty Pharmacy network, twenty-four (24) hours per day, seven (7) days per week.

c. The Contractor shall implement a therapeutic substitution and Generic Drug Program designed to inform Providers and Members of clinically appropriate, lower cost alternatives. The Contractor shall provide the State with annual reports on program outcomes and shall furnish additional reports upon the State's request. The Contractor shall obtain the State's prior approval In Writing before initiating any Member-targeted activities.

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

e. The Contractor shall communicate with Members regarding pharmacotherapy alternatives or alternative sites of care when such changes are expected to result in cost savings for both the Member and State, net of Copayments and Coinsurance.

f. The Contractor shall administer a Step Therapy Program that promotes the use of the most cost-effective clinically appropriate therapies. Upon the State's request, the Contractor shall implement additional Step Therapy requirements for specific drugs or classes at no cost to the State. As Formularies are updated, the Contractor shall develop and present proposed Step Therapy criteria for State review, based on therapeutic best practices and designed to encourage use of the most cost-effective options. The Contractor shall reflect applicable Step

Therapy requirements in all Formulary materials and ensure corresponding edits are applied at the point of sale. Prior to approving a Prior Authorization request for a targeted drug, the Contractor shall verify evidence of appropriate prior use of a more cost-effective therapy.

g. Prior Authorization (PA):
   (1) The Contractor shall provide the State, In Writing and at no additional cost, all PA criteria and procedures and decision trees during plan implementation and within two (2) Business Days of any written request from the State throughout the Term.
   (2) The Contractor's POS system shall identify any prescribed drug requiring PA and ensure that the Member obtains the necessary approval before a transaction is authorized and reimbursement is permitted. All PA services shall be provided at no additional cost to the State.
   (3) The Contractor shall, by the go-live date, make available to prescribing Providers a secure online portal for the electronic submission of PA requests. Providing this information solely by telephone or through a customer service record ("CSR") shall not relieve the Contractor of this requirement.
   (4) The Contractor shall ensure that PA staff evaluate ninety-nine percent (99%) of PA requests and notifies the prescribing physician and issues a determination within twenty-four (24) hours, In Writing. The Contractor shall implement an agreed-upon set of edits and PA criteria by 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 quarterly PA performance reports, or as otherwise requested by the State, that include PA statistics such as the number of PAs submitted by drug (at the NDC-11 level), the number approved and denied by drug, the number of denied PAs that proceeded to appeal by drug, the number of non-clinical reviews requested for external review, the cost of alternative medications filled by drug, the number of Members who abandoned therapy after denial without filling an alternative medications (i.e., walkways) and the net savings of each Program by drug, reported in both dollars and on a PMPM basis.
   (6) The State, or its qualified auditor selected at the State's sole discretion, may conduct clinical audits at any time of non-specialty and Specialty Drug Claims approved by the Contractor for filling and payment. Such audits shall verify that the Contractor is adhering to the specific PA criteria for each Program and that all required documentation—such as medical records or chart notes—supports the PA determinations. The Contractor shall apply and follow evidence-based PA criteria when approving non-specialty and Specialty Drug Claims for filling and payment.
   (7) The Contractor shall not issue any PA override that results in a Member being locked into a fixed Copayment or Coinsurance amount indefinitely. All medications shall remain subject to the applicable Copayment or Coinsurance in effect for the relevant Plan Year.

h. The Contractor shall disclose to the State, prior to implementation, any program or service for which the Contractor receives external funding, including the associated funding sources. The State shall have the authority to decline participation in any such external funding program if it determines that the program is not in the best interest of its Members.

i. At the State's request, the Contractor shall implement an opioid management Program that meets or exceeds the current CDC recommendations for opioid prescribing. The Program may include PA processes that allow higher daily Morphine Milligram Equivalents (MME) when approved by the State and appropriately documented by a licensed Provider. All opioid-related

controls, Programs, and management activities shall comply with all applicable Tennessee laws throughout the Term.

j. The Contractor shall provide case management services to Members who obtain Specialty Drugs through the Contractor's Specialty Pharmacy. Such services shall include identifying and outreaching to Members diagnosed with conditions such as cancer, rheumatoid arthritis, Hepatitis C, Multiple Sclerosis, and Hemophilia (these conditions are illustrative and not exhaustive). Registered pharmacists shall collaborate with the Member, the Member's health care Providers, primary caregivers, and the State's contracted medical vendors to coordinate the most appropriate and cost-effective site of care and place-of-fill for Specialty Drugs.

k. The Contractor shall implement a pricing review program to identify and apply the most cost-effective option available for eligible prescription medications at the POS. This pricing review program may include comparing plan-specific pricing to alternative lower-cost pricing sources and applying the lowest available price to the member's claim when allowed under the plan design. The Contractor shall ensure that any price applied through this process is fully integrated into standard Claims adjudication, including correct member cost-share calculations and accumulation toward deductibles and out-of-pocket maximums. All clinical safety checks, utilization management protocols, and Formulary requirements will continue to apply. The Contractor shall provide biannual reporting to the State detailing utilization of the pricing review process, member savings, and operational performance. The State retains audit rights, consistent with the Contract, to review pricing methodologies and Claim outcomes associated with this process.

l. The Contractor shall provide the State with a complete and current list of all clinical programs available through the Contractor. The Contractor shall maintain an inventory reflecting the clinical Programs the State has selected as well as those it has declined. When any change occurs to the Contractor's available clinical Programs—including additions, deletions, or other Program modifications—the Contractor shall notify the State of the opportunity or change within ten (10) Business Days of its availability and shall simultaneously provide an updated clinical Program list and updated State selection inventory. The State retains the sole authority to opt out of any clinical Program and shall make all final determinations regarding Program participation.

m. The Contractor shall proactively provide the complete clinical Program list and the State's selection inventory to the State at least once every six (6) months and within three (3) Business Days of receipt a request from the State In Writing.

n. The Contractor acknowledges and agrees that the State, at its sole discretion, may carve out/engage one or more third-party entities to perform Prior Authorization and utilization management activities for Specialty Drugs and/or non-specialty drugs. The Contractor shall permit such use without objection, fee, or penalty. At no additional cost to the State, the Contractor shall provide all support reasonably required by any such third-party entity to perform its assigned functions. This support includes, but is not limited to: exchanging all necessary Claims, accumulator, and eligibility data; redirecting prescriber, member, drug manufacturer, and/or Pharmacy inquiries related to these services to the appropriate third-party entity; and providing the third party entity with the access necessary to perform its duties, including access to the Contractor's Claims systems and Prior Authorization override systems enabling the third-party entity to: enter Prior Authorization and other Claims related overrides and quantity limits, run test claims, verify member eligibility in real-time, review Claims history in real-time, and confirm State-specific drug coverage status in real time.

A.13. Prospective/Concurrent DUR.

a. The Contractor shall provide a fully automated prospective and concurrent Drug Utilization Review program (DUR Program) that complies with all applicable State and Federal requirements. The DUR Program must meet, at minimum, all federal DUR regulations, the requirements outlined in this section. The DUR Program shall also be sufficiently flexible to incorporate future changes required by the State. The Contractor shall, at least annually during review meetings, recommend new DUR edits designed to improve clinical quality and reduce Pharmacy Program costs.

b. Prior to authorizing Claims and permitting reimbursement, the Contractor's DUR Program 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 incorporate the results of Drug Utilization Review processing directly into the claims adjudication workflow. Claims denied as a result of DUR processing shall include situation specific messaging and error codes sufficient to enable the Pharmacy Provider to take appropriate corrective action. The Contractor may utilize an existing DUR package, provided it complies with all applicable State and Federal requirements. At implementation, the Contractor's DUR Program shall include, at minimum, the DUR features specified below.

(1) Potential Drug Problems Identification - The Contractor's DUR Program shall perform automated DUR functions capable of identifying and reporting potential drug therapy issues to the Pharmacy Provider. At a minimum, the system shall automatically detect and communicate the following:

i. Potential drug overutilization;

ii. Therapeutic duplication when the submitted Claim is associated with other drugs or historical Claims for the Member;

iii. Drug use contraindicated based on the Member's age, gender or presumed diagnosis derived from historical Claims;

iv. Drug-to-drug interactions, including identification of contraindicated by combinations on current or historical Claims for a given Member;

v. The severity level of all drug-to-drug interactions;

vi. Potentially incorrect drug dosages or opportunities to adjust quantity or strength to ensure the most cost-effective therapy;

vii. Potentially inappropriate drug therapy;

viii. Insufficient or excessive medication utilization;

ix. Potential drug abuse or misuse based on the Member's prior utilization of the same or related drugs; and

x. Early refill conditions, including the ability at the drug code level to deny such Claims. The Contractor shall customize refill-too-soon edits as required by the State.

(2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS Pharmacy Claims, the Contractor's DUR Program shall

automatically generate DUR messages in a manner that shall enable a Pharmacy Provider to cancel submission of the Claim or to submit it if it is a message that can be overridden by the Pharmacy. Providers are individually responsible for acting or not acting upon information generated and transmitted through the DUR services, and for performing services in each jurisdiction consistent with the scope of their licenses. The DUR services are necessarily limited by the amount, type and accuracy of Member information made available to the Contractor.

(3) Flexible Parameters for Generation of DUR Messages - The DUR Program 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 DUR Program shall maintain comprehensive Member profiles for use in DUR processing of submitted Claims. These profiles shall be developed using presumed diagnoses derived from Pharmacy Claims and any other relevant data available to the Contractor.

(5) Disease/Drug Therapy Issues Screening - The DUR Program shall be capable of screening drug therapy for potential concerns related to specific drugs associated with high-risk diseases, including but not limited to cardiovascular disease, diabetes, psychiatric conditions, and respiratory disease.

(6) Patient Counseling Support - The DUR Program shall present DUR results to Pharmacy Providers in a format that facilitates appropriate Member counseling and clinical decision-making.

A.14. Retrospective DUR (Retro-DUR Program).

a. The Contractor shall maintain the capability to support a Retro-DUR Program staffed by licensed clinical pharmacists. The Contractor shall develop, maintain and regularly update a set of evidence-based clinical criteria used to identify potential drug therapy issues, including but not limited to polypharmacy, over-utilization, under-utilization, drug-to-drug interactions, therapeutic duplication, incorrect drug dosage or duration of therapy, potential fraud and abuse, and other inappropriate drug therapy concerns, including those related to a Member's age or disease state. For the Retro-DUR Program the Contractor shall:

(1) Provide Provider practice analyses that identify key performance indicators, including but not limited to Generic Drug dispensing rates, controlled substance prescribing rates, and Formulary compliance;
(2) Analyze and trend Providers' prescribing patterns and identify those who practice outside the norms of their peer group;
(3) Identify Members who may be inappropriately utilizing resources, including those exhibiting polypharmacy patterns or obtaining services from multiple Providers;
(4) Identify Members exhibiting excessive use of controlled substances or other medications with a high potential for abuse;
(5) Produce reports that detail Member and prescriber trends and identify potential quality-of-care concerns and potential fraud or abuse; and
(6) Maintain an intervention process and a system for tracking prescriber responses to those interventions.

b. The Contractor shall use evidence-based clinical criteria to conduct quarterly prescriber and Member profile reviews. The Contractor shall determine the number of prescriber and Member profile reviews, with approval In Writing by the State, to be conducted quarterly. The Contractor shall notify the State In Writing of the review focus and the methodology to be employed no fewer than thirty (30) calendar days prior to the start of the initial review.

c. The Contractor shall complete quarterly prescriber and Member profile reviews and shall distribute the resulting findings and recommended interventions by a licensed clinical pharmacist, to prescribers no later than ninety (90) calendar days following the end of each quarter. The Contractor shall implement interventions designed to address issues identified during profile reviews. Interventions may include mailings, telephone outreach, virtual interactions, or face-to-face visits. Additional forms of interaction may be used upon approval by the State. All communications shall include an intervention letter to the prescriber and/or Pharmacy Provider detailing the reason for the letter, the purpose of the intervention and any applicable educational information. Member profile(s) illustrating the identified issue and recommended corrective actions may also be included. The State shall approve all summaries, correspondence, and any other documents produced as a result of the review process prior to their distribution.

d. The Contractor shall have the capability to track all interventions and calculate the cost savings related to the specific interventions.

e. DUR and Retro-DUR Reporting
   (1) The Contractor shall assign a qualified DUR clinical pharmacist designated to the Plan to prepare presentations and participate in meetings with the State to present DUR and Retro-DUR data, findings, utilization trends, and recommendations for improvement. Such presentations shall occur up to four (4) times annually, as requested by the State. For each State-sponsored plan, the Contractor shall provide, at a minimum, reports and information reflecting rolling twelve (12) month trends:
      i. Utilizing Member utilization 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 associated with both Member and Provider profile review and interventions;
      vii. Distribution of clinical alerts as prepared monthly by the Contractor’s clinical management staff; and
      viii. Any additional reports included in the Contractor’s standard DUR reporting package.
   (2) The Contractor shall, upon the State’s request, provide quarterly reports on the outcomes of the Retro-DUR initiatives. The Contractor shall track the impact of DUR initiatives by

comparing specified data elements before and after each intervention. At the State's request, the data elements to be measured may vary based on the study focus and/or type of intervention implemented, and may include, but shall not be limited to:

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

ii. Total number of drugs before and after each intervention;

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

iv. Daily dose of drug in question before and after each intervention;

v. Assessment of relevant interactions before and after each intervention, including drug-to-drug interactions (e.g., number of drugs identified and associated severity levels), pregnancy-related interactions, disease-state interactions, therapeutic duplications, allergy interactions, and age-related medication concerns;

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

vii. Generic Drug medication utilization;

viii. Emergency supply frequency;

ix. Formulary compliance; and

x. Patient adherence, as defined by the medication possession ratio.

A.15. Financials.

a. The Contractor shall adhere to the Net Drug Cost PMPM Guarantees and trend guarantees, and any associated requirements for each listed in Contract Section C.3. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, premiums, or revenue from the State of Tennessee.

b. All claims, other than Gene and Cell Therapy claims, shall be included in the Net Drug Cost PMPM guarantees and trend guarantees.

c. The Contractor shall be contractually prohibited from making Spread or a profit on the Retail, Mail Order, or Specialty Discounts.

d. The Contractor shall charge no more than the amount as determined by Pass-Through Transparent Pricing paid to the Pharmacy for each drug plus a Dispensing Fee, if applicable.

e. Baseline Pricing Measure:
(1) The Contractor shall guarantee the mutually agreed upon baseline pricing measure (i.e., AWP, NADAC, WAC, or other) used to price Claims will be the one associated with the actual NDC or NDC-11 for the product on the date dispensed and the actual package size from which the product was dispensed at a Participating Pharmacy, Mail Order Pharmacy, or Specialty Pharmacy. The Contractor shall communicate any exceptions to this rule (e.g., including, but not limited to Compound Drugs) to the State In Writing, and such exceptions are subject to approval by the State.

(2) The Contractor shall not charge the State a higher AWP price for any repackaged products assigned a new NDC number by a repackager, a manufacturer, or at Mail Order,

than the original manufacturer/labeler AWP price for the same product (drug name, form, and strength).

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

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

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

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

(5) The Contractor shall apply a MAC List to Generic Drug medications dispensed through Mail Order Pharmacies and at Retail-90 network Pharmacies. The MAC List applied in these channels shall be equivalent to or lower than the MAC List prices applied to Retail-30 Claims. The Contractor shall ensure that the effective MAC Discounts are more aggressive/better than the effective non-MAC AWP-based Discounts. The Contractor shall use a single, uniform MAC List across all network Pharmacy types, including Retail-30, Retail-90, Specialty and Mail Order Pharmacies. Upon the State's request, the Contractor shall provide the most current MAC List in spreadsheet format. The Contractor shall employ its most aggressive MAC pricing, defined at its highest Discount levels, and such pricing must include at least 95% of all Generic Drugs. The MAC pricing schedule for Mail Order and Retail-90, including Specialty Drugs dispensed in these channels, shall reflect pricing that is the same as or more favorable (e.g., lower per-unit cost) than the pricing applied at Retail-30 for every MAC drug. The Contractor's MAC pricing schedule for Mail Order and Retail-90 shall also include a comparable list of low-cost Generic Drugs consistent with Retail generic fixed-price programs. The Contractor shall ensure that a

Member transitioning from the Retail channel to the Mail Order channel shall not incur a higher cost unless the increase is attributable to a manufacturer price increase or the Member's prior cost being based on the Retail Pharmacy's U&C charge. The Contractor shall add newly available Generic Drugs to the MAC List no later than twenty-one (21) calendar days following their market availability.

(6) 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 lowers the price for the State or the State agrees that the change is acceptable.

(7) The Contractor shall apply 'lowest-of-pricing' logic at Retail, Mail Order, 90-Day-At-Retail, and Specialty Pharmacies, which means that the Plan and Members will pay the lesser of (i) Member or Plan Cost Share or (ii) Ingredient Cost as defined in this Contract. In no event will the Member or Plan Cost Share be greater than the contracted cost. The Contractor shall not bill the State for any Zero Balance Due Claims.

(8) The Contractor shall not charge a minimum Member or Plan Cost Share for any Mail Order, Retail-30, 90-Day-At-Retail, or Specialty Pharmacy Claims.

f. Prescriptions dispensed from Mail Order Pharmacies shall be priced according to the baseline pricing measure, per the terms of Section A.15, regardless of the day-supply dispensed.

A.16. Pharmacy Manufacturer Payments.

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

b. The Contractor, or any other entity that negotiates and collects Manufacturer Payments allocable to the State, shall pass the full value of all Rebates properly allocated to the State via check or ACH. All payments shall also be accompanied by a spreadsheet allocating the amount by each of the six (6) state funds: Fund 55000 (State Actives), Fund 56000 (Local Education Actives), Fund 58000 (Local Government Actives), Fund 51010 (State Retirees), Fund 52000 (Local Education Retirees), and Fund 53000 (Local Government Retirees). For Rebate payments, the amount shall be further broken down by the calendar quarter(s) for which the check amount(s) are attributable at the NDC-11 level. 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 shall 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. If such changes result in a material impact to the Contractor's ability to meet the Net Drug Cost PMPM Guarantee, Contractor shall notify the State within thirty (30) calendar days of the State's requested change. Any changes the State then decides to pursue may result in a Contract amendment.

d. The Contractor shall pass one hundred percent (100%) of Manufacturer Payments to the State.

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

f. For Specialty Drugs, Rebates and Manufacturer Payments shall be based on 30-day supply Adjusted Claim count.

g. If the State chooses to implement POS Rebates for any or all Plan options, the Contractor shall administer Rebates at the POS at the NDC-11 level.

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 shall approve In Writing before those changes are implemented. The Contractor shall agree to an annual market check, if requested by the State, to compare the aggregate value of all financial terms of the Contract. There shall not be a minimum threshold of savings as a result of the market check for the Contractor to offer better pricing to the State. If the market check indicates that at least one comparator group has more favorable pricing terms than the State in aggregate, the parties shall negotiate to reach mutual agreement on revised pricing terms and other applicable pricing provisions. The Contractor shall implement mutually agreed upon improved pricing for the State by, at a minimum, the identified difference in value effective January 1 of the next Plan Year and shall remain in effect for the remainder of the Term or until subsequent market check changes are adopted. If the market check indicates no pricing adjustments are needed, the Contract pricing shall continue until a new market check warrants a change. The market check shall focus on comparable arrangements in the marketplace for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. The State's Benefits consultant and actuarial consulting firm shall determine similar employer groups for size and benefit structure to serve as comparison(s). The Contractor shall cooperate with the State's contracted Benefits and actuarial consulting firm in completing the market check.

b. Contractor agrees that no contractual term or individual financial component of the Contract will negatively impact the State as a result of the market check.

c. Contractor shall provide comments on the market check report within ten (10) Business Days of receipt.

d. Contractor shall accept, execute, and return any amendment prepared by the State to bring the terms of this Contract within market and incorporate market check adjustments approved by the State. Contractor shall execute and return such amendment within ten (10) Business Days of receipt, or within such other timeframe specified by the State.

A.18. Information Systems.

a. The Contractor's systems shall have the capability of adapting to any future changes necessary as a result of modifications to the design of the Plan or this Contract and its requirements, including but not limited to, data collection, records and reporting based upon unique identifiers to track services and expenditures across population types/demographic groups and geographic regions. The systems shall be scalable and flexible so they can be adapted as needed within negotiated timeframes and in response to changes in Contract requirements and/or increases in enrollment estimates. The Contractor's system architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:

(1) Changes in payment methodology;
(2) Additions and deletions of in-scope services;
(3) Changes in program management rules (e.g., eligibility for certain services); and
(4) Standardized contact, event and/or service codes.

b. The Contractor shall ensure that its electronic data processing (EDP) and electronic data interchange (EDI) environments (both hardware and software), data security, and internal controls meet all applicable federal and state standards, including HIPAA and the HITECH Act. Said standards shall include, but not be limited to, the requirements specified under each of the following HIPAA subsections:

(1) Electronic Transactions and Code Sets;
(2) Privacy;
(3) Security;
(4) National Provider Identifier;
(5) National Employer Identifier;
(6) National Individual Identifier;
(7) Claims attachments;
(8) National Health Plan Identifier; and
(9) Enforcement.

c. All Contractor systems shall maintain linkages and subscriber-to-Dependent (e.g., spouse-to-spouse and parent-to-child) relationships between initial and related subsequent interactions/transactions, events and/or activities. Additionally, when the Contractor houses indexed images of documents used by Members and subcontractors to transact with the Contractor, the Contractor shall ensure that these documents maintain logical relationships to certain key data, such as Member identification and subcontractor identification numbers. The Contractor shall also ensure that records associated with a common event, transaction or customer service issue have a common index that facilitates search, retrieval, and analysis of related activities (e.g., interactions with a particular Member about the same issue).

d. Upon the State's request and timeline, the Contractor shall be able to generate a listing of all Members (including each Member's Edison identification number) that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular Members or groups therein. The Contractor shall also be able to generate a sample of said document.

e. Retention and Accessibility of Information

(1) The Contractor shall maintain a comprehensive information retention plan that is in compliance with federal and state requirements and provide that plan to the State upon request.

(2) The Contractor shall maintain information online for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

(3) The Contractor shall provide forty-eight (48) hour turnaround or better on requests for access to information that is up to three (3) years old, and seventy-two (72) hour turnaround or better on requests for access to information that is between four (4) and five (5) years old. Such requests for information shall be made by the State or its authorized designee.

(4) If an audit or administrative investigation, and/or civil or criminal prosecution is in progress or otherwise unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

f. Information Ownership. All information, including data, documents and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. All contract-related information retained by the Contractor, including but not limited to, communications and files related to Members, shall be made available to the State upon request. The Contractor is expressly prohibited from sharing or publishing State information and reports or releasing such information to external entities, affiliates, parent company, or subsidiaries without the prior consent of the State In Writing.

(1) Upon termination of this Contract and request by the State, the Contractor shall provide to the State or its designated agent, all pertinent data identified by the State to support a transition of the Plan from the Contractor. The information shall be furnished in a format and medium that is compatible with the data processing system maintained by the State or its designated agent. Additionally, the Contractor shall provide all information necessary to properly interpret the data supplied. To ensure the continuous operation of the Plan and upon thirty (30) days' notice, this information shall be provided to the State or its designated agent.

g. System Availability

(1) The Contractor shall ensure that critical Member, provider and other web-accessible and/or telephone-based functionality and information, including the website described in Contract Section A.24., are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability as agreed to by the State and the Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement. Any scheduled maintenance shall occur between the hours of 12:00 a.m. and 5:00 a.m. Central Time and shall be scheduled in advance with notification on the Member Website. The Contractor shall make efforts to minimize any downtime between 5:00 a.m. and 12:00 a.m. Central Time.

(2) The Contractor shall ensure that the systems within its span of control that support its data exchanges with the State and the State's contractors are available and operational according to the specifications and schedule associated with each exchange.

h. Prior to implementing any major change, modifications to or replacement of the Contractor's core information systems functionality and/or associated operating environment, the Contractor shall notify the State In Writing of the change, modification, or replacement within a reasonable amount of time (commensurate with the nature and effect of the change or modification) if the change, modification, or replacement: (a) would affect the Contractor's ability to perform one or more of its obligations under this Contract; (b) would be visible to State system users and Members; (c) might have the effect of putting the Contractor in noncompliance with the provisions or substantive intent of this Contract; and/or (d) would

materially reduce the coverage amounts payable or services provided to the average Member. If directed by the State, the Contractor shall discuss the proposed change, modification, or replacement with the State prior to implementing the same. Subsequent to this discussion, the State may require the Contractor to demonstrate the readiness of the impacted systems prior to the date of the actual change, modification, or replacement.

i. System and Information Security and Access Management Requirements

(1) The Contractor's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

i. Restrict access to information on a "minimum necessary" basis (e.g., users permitted inquiry privileges only and not permitted to modify information);
ii. Restrict access to specific system functions and information via role-based access controls, including inquiry-only capabilities and the ability to create, change or delete certain data. Global access to all functions shall be restricted to specified staff jointly agreed to by the State and the Contractor. Contractors will use role-based access controls that restrict system access to authorized users based on their predefined job roles;
iii. Restrict unsuccessful attempts to access system functions to five (5), with system functions that automatically prevent further access attempts and record these occurrences; and
iv. Ensure that authentication credentials are not passed in clear text or otherwise displayed or presented.

(2) The Contractor shall make system information available to duly authorized representatives of the State and other federal and state agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

(3) The Contractor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the Contractor and the State.

(4) Audit trails shall be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

i. Contain a unique log-on or terminal ID, the date, and time of any "create", "modify" and/or "delete" action and, if applicable, the identification number of the system job that effected the action(s);
ii. Have the date and identification "stamp" displayed on any online inquiry;
iii. Trace data from the final place of recording back to its source data file and/or document;
iv. Be supported by listings, transaction reports, update reports, transaction logs, and/or error logs; and
v. Facilitate batch audits as well as individual record audits.

(5) The Contractor's systems shall have inherent functionality that prevents the alteration of finalized records.

(6) The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities upon request. The physical security provisions shall be in effect throughout the Term.

(7) The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

(8) The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

(9) The Contractor shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Contractor's span of control.

(10) The Contractor shall conduct a security risk assessment at least annually and communicate the results to the State in compliance with Contract Attachment E. The first report shall be provided by the date specified in Contract Section A.35 and annually thereafter. The risk assessment shall also be made available to appropriate federal and state agencies. At a minimum, the assessment shall contain the following: identification of loss risk events/vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 – 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); and requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR§164.308(a)(6)).

(11) To maintain the privacy of PHI, the Contractor shall provide the State a method of securing e-mail for daily communications between the State and the Contractor. The Contractor shall set up Transport Layer Security (TLS) with the State. This protection shall be enabled by the Effective Date of the Contract and shall remain in effect throughout the Term of the Contract unless otherwise directed by the State.

(12) The Contractor shall provide designated State employees with access and update authority to the Contractor's enrollment and/or client system by the date specified in Contract Section A.35. Additional users may be added at any time at the State's request In Writing. The contractor shall provide appropriate training and system documentation to State employees as requested by the State.

A.19. Data Integration and Technical Requirements.

a. The Contractor shall establish and maintain an electronic data interface with Edison by the date specified in Contract Section A.35 for the purpose of retrieving and 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. Second level authentication is accomplished using the State's standard software product, which supports PKI. The Contractor shall design a solution and submit to the State In Writing how its design meets the requirements of this Contract using industry standard software that can transmit files in a secure fashion. The initial implementation phase of this solution and the final production solution will differ in the method of authentication. All the solution's files shall be encrypted during transmission, and the method of transmission will also be encrypted. Decryption of the files that are downloaded from this solution will not be decrypted until they are securely stored

within the Contractor's environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State uses public key encryption with advanced encryption standard to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the State shall notify the Contractor and the Contractor shall comply. The Contractor shall establish and maintain the security of all confidential state data according to all applicable State and Federal standards within thirty (30) days of the State's use of the new or additional encryption standard or tool.

b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not perform changes to enrollment data without the State's approval In Writing. This prohibition shall include, but not necessarily be limited to initiation, termination, and/or changes of coverage.

c. By the date specified in Contract Section A.35, the Contractor shall complete testing of the transmission, receipt, and loading of the test enrollment file from the State.

d. By the date specified in Contract Section A.35, the Contractor shall load, test, verify and make available online for use the State's enrollment information. The Contractor shall certify, In Writing, to the State that the Contractor understands and can fully accept and utilize the enrollment files as provided by the State, in the format provided by the State, with no modifications.

e. The Contractor shall maintain, in its systems, enrollment records of all individuals covered by the Plan. The Contractor shall confirm eligibility of each Member based on enrollment information provided by the State, which applies to the period during which charges were incurred.

    (1) Daily Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall retrieve, unless otherwise directed by the State, via secure medium, daily enrollment files from the State in the State's Edison 834 file format, which may be revised. Files will include full population records for all Members and will be in the format of ANSI ASC X12N, Benefit Enrollment and Maintenance 834 (5010), version 005010X220A1, with several fields customized by the State. Change files will not be sent. The Contractor shall make all manual changes requested by the State, and the State will not reissue another enrollment file. The Contractor shall contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily enrollment file is loaded.

    (2) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) Business Day of receipt of the daily file and one hundred percent (100%) shall be posted within two (2) Business Days of receipt of the daily file. Results will be calculated for a quarterly score as shown in Contract Attachment D.

    (3) The Contractor shall submit to the State a daily enrollment file error report in a format agreed upon by the State, within one (1) Business Day of processing the daily file, which shall contain:
        - only errors that require State correction; and
        - an indication of the correction required to resolve the error (refer to Contract Attachment C.)

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

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

f. Decision Support System:

(1) Contractor shall provide the State's DSS contractor with all of the State's Claims data, data layouts, and data dictionaries in the formats, layouts and specifications mutually agreed upon, including but not limited to NDC, GPI, and GCN for all prescription drug Claims.

(2) Contractor shall submit complete and accurate data to the State's DSS contractor no later than fifteen (15) days following the end of each calendar month. Complete and accurate data is defined to be data that:

i. Contains records for all finalized Claims activity within the specified time periods;
ii. Has the same format and content as the agreed-upon record layout and data dictionary;
iii. Does not have unreported changes in either format or content; and
iv. Is submitted in a single record format.

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

(4) If this Contract is terminated, Contractor shall continue to provide Claims data to the State's DSS contractor until all Claims incurred prior to the Contract termination date have been processed.

(5) Contractor shall provide data without any restrictions on its use. Contractor acknowledges and agrees that the Claims data transmitted pursuant to this Contract is owned by the State and that Contractor has no claim, rights, or title to the same.

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

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

(8) The Contractor's Claims data provided to the State's DSS contractor shall meet the quality standards detailed in Contract Attachment D, SLA Scorecard as determined by the State's DSS contractor. The Contractor shall not withhold any processed claims data from the file submission. Measured by the State on a quarterly basis, the Contractor's data submission to the DSS contractor, as reported by the DSS contractor to the State, compared to the Contractor's data sent to the State on the required quarterly report shall meet the following measures:

i. Date of birth: Data missing for ≤ 3% of Claims;
ii. Pharmacy Provider ID missing: Data missing for ≤ 1.5% of Claims; and
iii. NDC or NDC 11 missing: Data missing for ≤ 1.5% of Claims.

(9) All Claims data shared with the DSS contractor shall include all payment sources and amounts such that the total Claim nets out to zero (0) after the Member Cost Share and Plan Cost Share. This shall include any third-party payments, and any adjustments to the Contractor's file to include all relevant fields shall be at the Contractor's expense.

(10) The Contractor shall submit Rebate data to the State's DSS contractor at the NDC-11 level for individual Claims data.

g. 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 identified through enrollment discrepancy resolution in a timeframe required by the State.

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

i. The Contractor shall not hold the State financially responsible for any IT service fees tied to the build of new connections, maintenance or adjustment of existing connections needed to administer data feeds.

j. At the State's request, the Contractor shall load all current PAs and overrides (Mail Order, Specialty and Retail) that exist for current Members from all existing PBMs no later than sixty (60) calendar days prior to the go-live date.

k. At the State's request, the Contractor shall accept at least two (2) years of historical data from the State's previous PBM contractor. This includes, but is not limited to, Pharmacy Claims history, Provider data, recipient data, preferred drug list, PAs, refills, lock-in and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's Mail Order and Specialty Pharmacy. The Contractor shall also share at least two (2) years of historical data with the State's new PBM at least 60 calendar days prior to the Term of this Contract and provide lag files, if needed, following the Term of this Contract.

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

m. The Contractor shall transfer to the State, sixty (60) days prior to the expiration of this Contract or within sixty (60) days' 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. General Communications.

a. The Contractor shall develop and provide a written marketing and communications plan by the date specified in Contract Section A.35. In addition, the Contractor shall update this marketing and communications plan on an annual basis as specified in Contract Attachment C, #17 by the date specified by the State or as needed by the State to reflect any changes for the current Plan Year in marketing strategy and updated methods, tools or technology and/or address emerging needs to engage with Members. Contractor's marketing and communications plan shall reflect a thoughtful, proactive approach to drive engagement and utilization of applicable services and Programs. Contractor is encouraged to relay what resources they have that will support marketing and communications. All marketing and communication plan updates shall be approved In Writing by the State.

(1) Contractor shall collaborate with other contractors, if applicable, to generally promote Program initiatives.
(2) Contractor shall provide an annual analytics report as specified in Contract Attachment C, #15 of marketing and communications efforts and results that should include direct mail, email, website and/or other communications statistics. Contractor shall use the Contractor's template with prior approval In Writing by the State. Analytics should include metrics on both activities conducted and results achieved to drive engagement with and utilization of applicable Partners for Health services and Programs for Members, and enrolled spouses and Dependents if applicable and data is available.
(3) Contractor agrees that all materials distributed and prepared or produced by the Contractor shall be accurate in all material respects.

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

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

(1) Written information;

(2) Audio/video and webinar presentations;

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

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

marketing efforts covered shall require prior notification In Writing by the State. The Contractor shall attend specific events at the request of the State;

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

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

f. Contractor shall comply with the Federal Register Nondiscrimination in Health Programs and Activities (81 FR 31375, 45 CFR 92), or to the extent applicable to the Plan.

A.21. Member Communication/Materials.

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

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

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

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

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

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

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

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

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

c. The State has and retains the ability to edit and customize all communication pieces distributed by the Contractor, including the right to require that the State branding “Partners for Health” logo be included on any Member letters, correspondence or other materials. The Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements. Exceptions may be granted by the State, In Writing, when the materials or digital communications are for a Contractor’s greater book of business and the State is opting into a communications campaign not otherwise required by this Contract.

d. The Contractor shall work in conjunction with the State’s staff to ensure continuity of branding across all Plan materials, mailings, emails, website, apps, social media and any other communications information, tools, methods and resources. This branding shall include, but is not limited to, use of the Partners for Health logo, color scheme and applicable taglines. All uses of these branding elements shall be approved In Writing by the State.

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

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

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

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

i. The Contractor shall ensure that the up-to-date versions of all printed Member marketing and communication materials can be downloaded from the Plan Microsite or accessible via a mobile device or other method. The Contractor shall provide the State an electronic copy of all marketing and communication materials at the State’s request for posting on the State’s website.

j. On an annual basis, at least two (2) months prior to the State’s annual enrollment period, the Contractor shall provide the State, in electronic format, any enrollment material requested by the State that may be helpful to potential Members. Items may include, but not be limited to, a toll-free Member services number, website address, website logon information, a confidentiality statement, procedures for accessing services, informational fliers, and other pertinent updates, changes and/or materials.

A.22. Communications Mailing.

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

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

c. If a mistake is the result of the Contractor's error and is not corrected prior to printing or distribution, the Contractor shall pay the postage, printing and production costs for these communications. The Contractor shall produce and distribute corrected versions of individual materials at the State's discretion within ten (10) Business Days.

d. If Member materials containing a State generated error were approved by the State In Writing and the error was detected after the materials were mailed, the State shall reimburse the Contractor the production and postage cost of mailing a corrected version pursuant to Contract Section C.3.

e. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit Plan changes or other communications, outside of annual enrollment or not otherwise required by this Contract, shall be treated as pass-through costs. Such costs shall be billed to the State and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor with all charges being allocated to the number of Member letters by fund (state actives, state retirees, local education actives, local education retirees, local government actives, local government retirees). The State shall pay the postage, printing, and production costs of such mailings to comply with Contract Section C.3.

f. The Contractor shall not pass on postage or mailing fees for the Mail Order Pharmacy or preferred Specialty Pharmacy to the State during the Term.

A.23. Member Identification (ID) Cards and Welcome Packets.

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

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

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

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

d. Ninety-eight percent (98%) of ongoing welcome packets and ID cards, as measured quarterly, shall be produced and mailed to new subscribers within four (4) Business Days of receipt of complete and accurate enrollment information. The mailing of ongoing welcome packets and ID cards shall be reported by the Contractor, and quarterly results shall be calculated for a quarterly score as shown in Contract Attachment D. The score shall be

calculated by dividing the number of welcome packets mailed on time by the total number of welcome packets that were required to be mailed during the quarter.

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

f. For Contractor errors or Contractor-initiated changes, Contractor shall reproduce Member ID cards at no additional cost to the State (including priority shipping).

A.24. Plan Microsite, Member Website, and Mobile Application.

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

b. The Contractor shall include, at a minimum, the following functionality, information, and/or links to information on the Plan Microsite:
   (1) the capability to host streamed content (audio and video) from external vendors, including video and multimedia tools, as determined by the State to be useful and applicable to Members;
   (2) Contractor customer service phone number and hours;
   (3) links to register and sign into the Member Website;
   (4) a search tool to check drug cost for each available plan type;
   (5) a search tool containing all network Participating Pharmacies, including Pharmacy name, address, city, state, zip code, and phone number, for the following:
      i. Retail-30 network;
      ii. Retail-90 network;
      iii. Specialty network; and
      iv. Vaccine network.
   (6) A designated section for "important documents" that includes, at a minimum, the Member handbook, Formulary guidebooks, Prior Authorization criteria, CDHP preventive drug list, PPACA preventive drug list, and smoking cessation document;
   (7) Links to other State contractors' websites if requested by the State; and
   (8) Other information as requested by the State.

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

d. The Contractor shall submit the text and screenshots of the Plan Microsite to the State for review and approval by the date specified in Section A.35.

e. The Contractor shall grant the State access to the customized developed Plan Microsite for review and approval no later than the date specified in Contract Section A.35.

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

g. The Contractor shall obtain and cover the cost of the domain name for the Contractor's Plan Microsite. The Plan Microsite URL must approved by the State In Writing prior to Contractor's purchase of the URL.

h. Contractor shall ensure that all information and materials available on the Plan Microsite meet any state or federal regulatory requirements.

i. The Plan Microsite shall be fully operational on or before the date specified in Contract Section A.35.

j. Contractor shall have a mobile application available for Member use and a Member Website accessible via a Member log-in portal on the Plan Microsite. Contractor shall maintain the mobile application and Member Website which shall be available twenty-four (24) hours a day, three hundred sixty-five (365) days a year except for maintenance windows

k. The Member Website and mobile application shall, at a minimum, contain the following functionality and information:
    (1) Member-specific Benefits, including Member and Plan Cost Share;
    (2) Member Claims history;
    (3) an intuitive user interface, including other resources such as online secure messaging or live chat capabilities to answer questions from Members;
    (4) access to check Benefits status (accumulators, etc.);
    (5) Mail Order refill/order tracking;
    (6) a search tool containing all network Participating Pharmacies, including Pharmacy name, address, city, state, zip code, and phone number, for the following:
        i. Retail-30 network;
        ii. Retail-90 network;
        iii. Specialty network; and
        iv. Vaccine network.
    (7) Formulary information;
    (8) a search tool to check drug cost for each available plan type;
    (9) access to temporary and digital Member ID cards;
    (10) any applicable Member forms (e.g., appeal forms, direct Member reimbursement, etc.);
    (11) ability to track the status of Prior Authorizations;
    (12) requests for explanation of Benefits; and
    (13) other information as requested by the State.

l. The Contractor shall update web-based versions of all materials as Plan changes are made within fifteen (15) Business Days and correct errors within three (3) Business Days.

m. The mobile application and Member Website shall be fully operational on or before the date specified in Contract Section A.35.

n. Unless otherwise approved by the State, the Contractor shall update content and/or documents posted to the Plan Microsite and Member Website within five (5) Business Days of the State's prior approval of changes to said content and/or documents.

o. The Contractor's mobile application shall adhere to all security measures as it relates to Member data. The Contractor shall provide a one hundred percent (100%) secure web-based application that requires only a web-browser and an internet connection.

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

q. The Plan Microsite, Member Website, and mobile application displaying content made available pursuant to this Contract shall include all functionality necessary to materially comply with: (i) the Web Content Accessibility Guidelines (WCAG) 2.1, Level A and AA Success Criteria; and (ii) all accessibility laws applicable to state and local government web and mobile application content, including but not limited to the Americans with Disabilities Act and applicable federal regulations, and Tennessee state laws relevant to accessibility.

r. Contractor shall not post any content made available pursuant to this Contract on its Plan Microsite, Member Website, or mobile application that is not in full compliance with all accessibility laws applicable to state and local government web and mobile application content, including but not limited to the Americans with Disabilities Act and applicable federal regulations, and Tennessee state laws relevant to accessibility.

s. Contractor shall review content posted on web or mobile sites required by this Contract for compliance with accessibility laws applicable to state and local government web and mobile content, including the Americans with Disabilities Act and applicable regulations, and Contractor shall indemnify and hold the State harmless for any fines, penalties, or damages resulting from Contractor's failure to comply.

t. Within forty-five (45) days of the Contract Effective Date, the Contractor shall provide the State with a copy of all Contractor and subcontractor online terms and conditions, online service agreements, privacy policies, notices of privacy policy, or other documents required to be accepted by Members of the State of TN health plans when they access online accounts, services, or Programs being delivered by the Contractor or subcontractors pursuant to this Contract.

   Contractor and its subcontractors shall not require members of the State of TN health plans to agree to online Terms of Use, Privacy Policies, Notices of Privacy Policies, or other similar documents that contain provisions which conflict with the terms of this Contract or Business Associate Agreement (BAA) between the State of TN and Contractor, or with the terms of this Contract or BAA between Contractor and its subcontractors in order to access services provided pursuant to this Contract. Any terms contained in such online documents which violate this prohibition shall be deemed void and not applicable to or binding upon the Members.

   The Contractor shall be responsible for ensuring compliance with this provision and noncompliance with this provision by the Contractor or its subcontractor is a material breach of this Contract for which the Contractor shall be directly responsible.

   Under no circumstances will disputes between the Contractor or its subcontractors and a member of the State of TN health plan arising from services provided pursuant to this

Contract be governed by law other than Tennessee law and applicable federal law or adjudicated in forums other than those in the State of Tennessee with subject matter jurisdiction over the dispute.

A.25. Reporting and Systems Access.

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

b. The Contractor shall provide access to an online reporting system (e.g., eligibility system and Claims history system) to BA staff no later than one (1) month prior to the system go-live date. Additional users must be added at any time at the State's request, with no limit to the number of users, and at no additional cost. The State shall 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 online reporting system on all Contractor systems and tools no later than one (1) month prior to the go-live date. This training shall be conducted either virtually or on-site at the BA office. The State shall provide laptop computers and internet access, and the Contractor shall provide the training materials, system, and trainer/teacher/coach shall be provided. The Contractor shall ensure that the teacher is fully trained on all the various system-generated reports, ad-hoc reports, and can fully explain and walk State staff through them in a clear, articulate manner. At the State's request, the Contractor shall provide system access to the State's Benefits consultants/actuaries at no additional cost.

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

d. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of the State's 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. The Contractor shall deliver up to ten (10) reports annually deemed as urgent by the State within twenty-four (24) hours upon the State's request and at no additional cost to the State.

e. The Contractor, as requested by the State, shall generate a bi-weekly file of Members with a first fill during the previous month for any antidepressant, anti-anxiety, sleep aid, or any other medication group requested by the State. Contractor shall share via secure server or email this list of Members and Edison ID numbers with the State's EAP/BHO contractor.

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

g. 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-11 level. The Contractor shall provide an annual reconciliation report demonstrating true-up to one hundred percent (100%) no later than one hundred fifty (150) days following the end of each calendar year. See Contract Attachment C.

h. Contractor shall ensure that its reporting system available to State staff allows for pulling Claims data by, at a minimum, various dates, groups, plan types, Member ID (Edison ID) and can be broken down by product name, Pharmacy name, address, city and state, the NDC of the product, Rebates at NDC-11, and GPIs 2 through 14 (code and description) that applies to the product, as well as provide the Pharmacy-submitted drug cost, net plan paid amount, and any Member Cost Share (Copayment/Coinsurance).

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

j. The Contractor shall show Dispensing Fees and Ingredient Costs separately for each Claim for reporting purposes. Dispensing Fees shall not be included within Ingredient Cost calculations. The Contractor shall provide a document demonstrating how Dispensing Fees are assigned to a drug at the State's request.

A.26. 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 meet or exceed the KPIs throughout the Term. The Contractor and State shall review quarterly and annually the Contractor's success in achieving its performance objectives for the prior quarter and prior year in which services were delivered. Such performance shall be measured to comply with the KPIs and desired outcomes outlined in the SLA Scorecard (Contract Attachment D).

c. The quarterly SLA Scorecard for the previous calendar quarter shall be provided to the State in Excel format within sixty (60) days of the end of each calendar quarter. The annual SLA Scorecard for the previous calendar year shall be provided to the State in Excel format with the 4th quarter SLA Scorecard.

A.27. Administrative Services.

a. The Contractor, upon request by the State, shall review and comment on benefit provisions in the Plan. When so requested, the Contractor shall comment regarding:
   (1) industry practices; and/or
   (2) the general financial impact to premium rates plus Plan and Member costs if future changes were made to the Benefits of the Plan.

b. The Contractor shall provide assistance and information (not legal advice) to the State regarding applicable existing and proposed Federal and State laws, court holdings and regulations affecting the Plan, and other Plan related matters as needed.

c. The Contractor shall provide assistance with questions and issues raised by the State, individual employees/retirees, former and current Members and others identified by the State.

d. The Contractor shall respond to all inquiries In Writing from the State within two (2) Business Days after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State within one (1) Business Day as to when the response can be furnished to the State. For matters designated as urgent by the State, the Contractor shall provide a response to the State on the same Business Day. During non-business hours, the Contractor shall provide a response to urgent matters to the State on the next Business Day. Staff members, from the applicable business unit, with final decision-making authority shall provide responses. Said responses may be communicated through the account manager.

e. The Contractor shall answer, In Writing, within five (5) Business Days, all written inquiries from Members concerning Benefits available through the Plan, its clarifications and revisions, and other relevant information.

f. The Contractor shall perform, following review and approval by the State, a Member satisfaction survey no less than annually. The survey instrument shall be developed by the Contractor and approved by the State In Writing. The survey shall be conducted at a time mutually agreed upon by the State, and the Contractor shall guarantee a statistically valid response rate consistent with the sample size. The Contractor shall obtain an overall Member satisfaction rating equal to or greater than eighty-five percent (85%) in the first year and ninety percent (90%) in all subsequent year(s) throughout the Term. The Contractor shall report the results annually to the State which will be calculated for an annual score as shown in Contract Attachment D. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified by the survey.

g. The Contractor shall not modify the services or Benefits provided to Members during the Term without the prior consent of the State In Writing.

h. The Contractor shall refer all media and legislative inquiries concerning the Plan to BA, which will have the sole and exclusive responsibility to respond to all such inquiries. However, the Contractor shall respond directly to audit requests from the Comptroller or from divisions within the Department of Finance & Administration, and to subpoenas. The Contractor shall copy BA on all correspondence in response to any audit or subpoena.

i. 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.

j. The Contractor shall ensure that the U. S. Postal Service or other mailing service does not return any undeliverable mail to the State.

k. The Contractor shall accept and process Claims filed directly by Members and Providers. The Contractor shall be responsible for processing all Claims with an incurred date of January 1, 2028 (go live date) through the Term, excluding the six-month runout period. There shall be no additional administrative cost to the State during the Claims payment run-out period.

l. Fraud and Abuse

(1) The Contractor shall implement and actively engage in procedures to prevent and detect fraud or abuse by Providers, Pharmacies, or Members. At least two (2) months prior to go-live, the Contractor shall submit a description of its fraud and abuse detection and prevention procedures to the State. The Contractor shall notify the State, In Writing, within thirty (30) days of any changes to its fraud and abuse procedures.

(2) The Contractor's procedures for preventing and detecting fraud and abuse shall include, at a minimum, the use of data analytics, rules-based edits, pattern recognition, and/or other pre- and post-payment activities to identify, prevent and detect Claims that are abnormal, implausible, and/or high-risk; and identify complex and/or concealed billing and utilization patterns.

(3) The Contractor's procedures to prevent and detect fraud and abuse shall include post-payment Claims reviews and reconciliations designed to identify and remedy system or other errors permitting the payment of fraudulent Claims as soon as possible but no less than monthly.

(4) The Contractor shall review all Pharmacies that submitted a Compound Drug Claim quarterly to be measured against peer groups to control for fraud, waste and abuse.

(5) In the event that the Contractor's fraud and abuse detection and prevention procedures detect evidence that an unusual or potentially fraudulent transaction has occurred, the Contractor shall immediately submit joint notifications to Benefits Administration and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the notification and provide further instructions to the Contractor within a reasonable time.

(6) The Contractor shall provide a written narrative or report to the State on a quarterly basis regarding the effectiveness of the Contractor's fraud and abuse program. Reporting shall include, at a minimum, key metrics for program activities; benchmarking against prior periods; and recommendations for strengthening the program.

(7) The Contractor's implementation and active engagement in effective fraud detection and prevention processes is considered a material provision of this Contract. The Contractor's failure to comply with the provisions of this Section, or any other action or omission by the Contractor that permits or results in fraudulent payments by the Plan, shall constitute a breach of Contract.

(8) The Contractor shall indemnify and reimburse the State in full for all amounts paid as a result of the Contractor's failure to comply with the terms of this Section or that otherwise should reasonably have been prevented by the Contractor's fraud detection and prevention procedures. The Contractor's obligation to indemnify the State for such amounts is not contingent upon the Contractor's ability to collect the funds from the perpetrator of the fraud or other third party. The Contractor further agrees it shall be liable for the reasonable cost of attorneys' fees, court costs, expert witness fees, and other litigation expenses for the State to enforce the terms of this provision.

A.28. 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 shall be conducted on the Mail Order and Specialty Pharmacies.

b. The Contractor shall contact Pharmacies with aberrant Claims or trends to gain an acceptable explanation for the finding or to submit a corrected Claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State upon the State's request. Each

quarter or upon the State's request, the Contractor shall summarize findings from the reports and share with the State to address Program revisions and remit payment to the State for any Claims recovered from Pharmacies that were paid in error. Each payment shall be made for the gross amount (not net of other Claims payment activity) by check or ACH, and the Contractor shall provide substantiating documentation in an Excel format at the fund level (State Actives, State Retirees, Local Education Actives, Local Education Retirees, Local Government Actives, and Local Government Retirees).

c. The State may request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery and elimination of the aberrant practice. The Contractor shall have qualified staff available to conduct field audits or have an agreement with a contractor acceptable to the State within ninety (90) days of the go-live date.

d. The Contractor shall share one hundred percent (100%) of all audit recoveries (Retail, Mail Order, and Specialty) with the State on a quarterly basis within thirty (30) calendar days from the close of the quarter.

A.29. Audit Authority.

a. Upon thirty (30) days written notice and the execution of any applicable third-party confidentiality agreement(s), if any, reasonably required by the Contractor, the State and/or its authorized representative shall have the right to examine and audit Contractor services and pricing to ensure compliance with all applicable requirements. The scope of said audits shall be defined by the State. For this Section, the term, "Contractor," shall include its parent organization, Affiliates, subsidiaries, and subcontractors, who provide services under this Contract. The requirements set forth in this Section are separate and distinct from the audit requirements set forth in D.11 and D.37.

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

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

d. In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period in accordance with the timeframe for audits listed in Contract Section D.11. Previous audits of a set of Claims, Providers, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year and any charges or fees in any form for any audits that the State chooses to exercise.

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

f. The Contractor shall, at its own cost, provide the State and/or its authorized representative with prompt and complete access to any data, data extracts, documents, access to systems, and other information necessary to ensure Contractor compliance with all requirements of this Contract. This includes, but is not limited to, one hundred percent (100%) of pharmacy Claims data, with all NCPDP fields from the most current version and release.

g. The Contractor shall provide reasonable cooperation with requests for information, which includes, but is not limited to, the timing of the audit, deliverables, data/information requests, and the Contractor's response time to the State's questions during and after the process. The Contractor shall provide written responses to all findings received during the audit process to assist in clarification and suggested resolutions. For any audits being conducted, the following requirements apply:

   (1) The Contractor shall provide a response to all "initial findings" within thirty (30) calendar days.

   (2) The Contractor shall acknowledge receipt of follow-up questions to Contractor responses within forty-eight (48) hours of receipt and provide a formal response with answers within five (5) Business Days.

   (3) If the audit identifies confirmed errors, the Contractor shall provide service warranty reports to the auditor for every confirmed error within thirty (30) calendar days of audit closure.

   (4) The Contractor shall review the service warranty with the auditor and the State for final approval. The service warranty shall be reversible and shall not introduce a new methodology to offset amounts due to the State.

   (5) The Contractor shall not hold the State liable for underpayments made as a result of the Contractor's error and discovered through the audit.

   (6) The Contractor shall provide a formal audit response within thirty (30) days of the audit conclusion, or at a later date if mutually determined with the State to be more reasonable based on the number and type of findings.

h. The State shall not be responsible for any time or costs incurred by the Contractor in association with an audit, including but not limited to, providing data, reports, documentation, systems access, or space.

i. If the outcome of the audit results in an amount due to the State, the Contractor shall pay the amount due within (30) thirty days of final audit report notification from the State. Any amount due the State which is not paid within thirty (30) days of the final audit report will be deducted from the total amount of fees due to the Contractor pursuant to C.3 until the full amount due is paid. If the Contractor disagrees with a finding resulting in a payment to the State, the State

will review the Contractor's comments, but if the State retains the original audit findings, the Contractor shall be responsible for any payment to the State.

j. Upon request by the State In Writing, the Contractor shall fund the following audits which shall be conducted by a qualified organization or representative chosen by the State and the scope of the audit shall be defined by the State:
    (1) Pre-and/or post implementation audits to include, at a minimum, whether the Contractor's adjudication system is configured according to the State's benefit design; and
    (2) Any follow-up audits if significant deficiencies, as determined by the State, are noted. Additionally, the Contractor shall participate in the following audits upon request by the State In Writing:
    (3) Operational audits focusing on, at a minimum, Claims administration, Rebates, Manufacturer Payments, contracts, Guarantees, and other audits as outlined in this Section.

k. The Contractor shall perform all tasks necessary to complete the pre-implementation audit and correct any deficiencies prior to the effective date of any benefit changes being implemented.

l. The Contractor shall submit to the State by the date specified in Contract Section A.35. a summary of its methodology for conducting internal Claims and operational audits, including audits to determine Claims Payment Accuracy and Claims Processing Accuracy. The Contractor shall notify the State In Writing at least thirty (30) calendar days in advance of any significant changes to its methodology.

m. The quarterly internal audit for Claims Payment Accuracy and Claims Processing Accuracy shall be performed by the Contractor on a statistically determined random sample using a ninety-five percent (95%) confidence interval with a margin of error of five percent (5%).

n. The Contractor shall comply with Tenn. Code Ann. § 4-3-1021 by providing prompt, reasonable assistance, including (a) submitting initial audit documentation within thirty (30) Business Days of request and (b) responding to audit findings within thirty (30) Business Days unless otherwise agreed, in coordination with the State and the State's authorized representative, to support completion of required audits and reports in accordance with applicable requirements.

    (1) The State and/or the State's authorized representative 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 with, at a minimum, all NCPDP fields from the most current version and release; Retail Pharmacy contracts; pharmaceutical manufacturer contracts; GPO, Mail Order and Specialty Pharmacy contracts to the extent they exist with other contractor(s); utilization management reviews; clinical Program outcomes; appeals; and any additional information needed to complete the audits.

o. 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 necessary to perform an accurate and complete audit of Rebates received by the State. To the extent that the Contractor contracts with a separate GPO in connection with Rebates or Manufacturer Payments for the State, the State may (a) directly confirm the existence of contract(s) between the Contractor and such third-party GPO (i.e., view the Contract introduction, recitals, and signature block) and (b) audit all aspects of such Contract with the establishment of applicable

third-party confidentiality agreement(s), if any, as reasonably required by the GPO. Upon request by the State or the State's authorized representative, the Contractor shall provide full disclosure of Rebates and Manufacturer Payments received by the Contractor, its Affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line-item detail by the NDC or NDC-11 level and line-item detail by pharmaceutical manufacturer showing Actual Acquisition 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, 2028 until the termination of Benefits shall be included in any kind of Pharmacy audit, regardless of tier level (Generic Drug, preferred brand, 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.

p. The State or State's authorized representative will audit the Manufacturer Payments that are accrued and paid to the State. These payments shall be one hundred percent (100%) auditable to the NDC or NDC-11 level.

q. The Contractor and any PBM Affiliates and GPOs shall disclose to the State's authorized representative any and all Manufacturer Payments, including but not limited to, Manufacturer Administrative Fees or other reimbursements received in connection with any Rebates, Discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug Manufacturer Payments, which include volume of pharmaceutical use by, or on behalf of, the State. In addition, the Contractor shall, upon request by the State, disclose all fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

r. The State, and any division therein, including State employees from the Comptroller's audit staff, may request a full Claims extract for their audit purposes at any time. The Contractor shall work with the State to supply a full Claims extract for each Claim processed under this Contract that includes, but is not limited to, such variables as date filled; Pharmacy name, address, and phone number; drug name and NDC-11 level; quantity dispensed; gross cost; Plan cost; Member cost; prescriber name and NPI; and date adjudicated (paid date or the date that the actual Pharmacy was paid).

s. All PBM-negotiated Retail Pharmacy contracts and Rebate contracts are fully disclosed to, and auditable by, the State or its authorized representative.

t. The Contractor shall review each and every Compound Drug claim greater than $200 and complete an audit of the recipe when claims appear aberrant.

u. Every payment by the State to the Contractor, whether representing fees, Claims or otherwise, is subject to audit and reconciliation, and no such payment made by the State would constitute a waiver of its right to audit or reconciliation.

v. The State shall have the right to audit the Contractor's books and records related to the Net Drug Cost PMPM Guarantee and the classification and billing of Gene and Cell Therapy Drugs, subject to mutually agreed confidentiality and data security requirements.

w. The State retains the right to audit such information as reasonably required to determine that the Contractor is complying with the Actual Acquisition Cost pricing model, which includes but is not limited to: one hundred percent (100%) of pharmacy claims data, with all NCPDP fields from the most current version and release; data management; Retail Pharmacy contracts with the Contractor; pharmaceutical manufacturer and wholesaler agreements; Mail Order and

Specialty Pharmacy acquisition contracts; Specialty Service Fee agreements; approved and denied utilization management reviews; clinical Program outcomes; appeals; and information related to verifying compliance with the Actual Acquisition Cost pricing model.

A.30. 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 the Plan's 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 Drug 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.

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's Pharmacy Program. The Contractor shall prepare and maintain a document suitable for printing or posting to the Contractor-managed Plan Microsite. The Contractor shall obtain prior approval In Writing from the State for all materials.

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

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

A.31. 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 shall include, at the third level, an independent review organization as required by the PPACA. The Contractor shall comply with the appeals provisions set forth in the State's Plan Documents. Certain Pharmacy issues are not appealable including, but not limited to, Member Cost Share amounts, Formulary decisions, and network coverage.

b. At least thirty (30) days prior to the go-live date, the Contractor shall provide 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. Unless otherwise directed by the State, the Contractor shall meet PA submission requirements set forth in the Prior Authorization Fairness Act (Public Chapter 395 of 2023) or any subsequent applicable law governing PA submission requirements and shall decide Pre-Service Appeals within fifteen (15) calendar days and Post-Service Appeals within thirty (30) calendar days. Ninety-nine percent (99%) of Pre-Service Appeals shall be decided within fifteen (15) calendar days from receipt of appeal and ninety-nine percent (99%) of Post-Service Appeals within thirty (30) calendar days from receipt of appeal. The Contractor shall offer an expedited appeals process. If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed medications, then a request for an expedited consideration may be submitted by the Member, their duly authorized representative or treating physician. The Contractor shall respond to ninety-eight percent (98%) of expedited (urgent) appeals within seventy-two (72) hours of receipt of the appeal. An appeal may come in the form of a PA request from the prescriber, in which case the Contractor shall render an approval and PA number and length of time the authorization is approved or a denial on the PA request. All costs and charges associated with appeals at all levels shall be included in the monthly Administrative Fees that the State will self-bill and pay to the Contractor each month. The State shall not be invoiced for any appeals-related charges.

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

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

A.32. Customer Services.

a. The Contractor shall operate and maintain a dedicated toll-free customer service phone line manned by qualified Benefits specialists for Members and Pharmacy Provider inquiries twenty-four (24) hours a day, seven (7) days a week. Contractor personnel shall be trained to answer questions regarding all aspects of the State's Pharmacy Benefit, including Plan design, Participating Pharmacies, clinical Programs, clinical management Programs, Mail Order Pharmacy, and the Specialty network. The Contractor's toll-free customer service line/call center 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 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 premium payment issues, and the Contractor's customer service center representatives should only refer these issues back to Benefits Administration.

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

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

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

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

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

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

i. Call center metrics:

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

   (2) All inbound calls to the Contractor's call center and/or toll-free customer service lines shall be answered with a daily Average Speed of Answer of twenty (20) seconds or less, including calls routed to an interactive voice response ("IVR").

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

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

   (5) The Contractor shall provide customer service/call center statistics showing the daily average for Members to the State on a quarterly basis.

j. 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, or 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.

k. 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).

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

m. 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.

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

o. 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.

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

q. The call management system shall enable the logging of all calls, including:

(1) The caller's identifying information (e.g., employee ID);

(2) The call date and time;

(3) The reason for the call);

(4) The call center representative/operator who 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).

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

s. The Contractor shall provide Members and Pharmacy Providers with an option on the toll-free telephone number to immediately consult with a licensed pharmacist between the hours of 7am – 7pm Central Standard Time Monday through Friday. Outside of the hours of 7am – 7pm Central Standard Time Monday through Friday, Members and Pharmacy Providers will have an option to receive a call back from a pharmacist within one (1) hour. This help desk shall be available twenty-four (24) hours a day, seven (7) 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.

t. 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.

u. 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.

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

w. The Contractor shall notify the State of any customer service disruptions lasting more than an hour.

A.33. Warranty.

a. 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.34. Inspection and Acceptance.

a. 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.

A.35. Due Dates for Project Deliverables.

Unless otherwise specified In Writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Plan Implementation			
1.	Pharmacy benefit go-live (the go-live date)	A.4.a	January 1, 2028
2.	Kick-off meeting for all key Contractor staff	A.4.d	Within thirty (30) days after Contract Effective Date
3.	Implementation plan and timetable	A.4.e	Within thirty (30) days after Contract Effective Date
4.	State readiness review	A.4.f	November 1, 2027 (on or before)
Staffing			
5.	Account Team Satisfaction	A.5.h	Within fifteen (15) days of receiving the State's satisfaction survey results with a corrective action plan as necessary to remedy any identified deficiencies
Claims Payment and Reconciliation			
6.	Report demonstrating its level of Pass-Through Transparent Pricing	A.7.c	Quarterly after go-live date
Pharmacy Network			
7.	Network lists available on Plan Microsite	A.8.c	During implementation by September 1, 2027, then updated quarterly
8.	Mail Order website operational	A.8.g.(13)	By December 1, 2027, and maintained thereafter
9.	Network Access report	A.8.k	Annually
10.	Quarterly network changes report	A.8.l	Within five (5) Business Days of the end of each quarter following go-live date
Formulary Management			
11.	Initial Formulary development	A.9.a	November 1, 2027 (on or before)
12.	Administer and maintain the Formulary or Formularies	A.9.b	By go-live date
13.	Formulary compliance report	A.9.d	Quarterly after go-live date if requested by the State
14.	Formulary guidebook(s)	A.9.j.(7)	By go-live date and beginning of every quarter thereafter
15.	Formulary changes	A.9.m	Ninety (90) days in advance of any Formulary changes
Benefit Coverage/Plan Design			
16.	Benefits set-up test results	A.10.c	Annually, no later than November 1

Compliance			
17.	Gag Clause Prohibition Compliance Attestation	A.11.d	Annually by the federal deadline
Clinical Programs			
18.	Therapeutic substitution and Generic Drug dispensing program reporting	A.12.d	Annually if requested by the State
19.	Disclosure of PA criteria and procedures	A.12.h.(1)	By December 1, 2027, and within two (2) Business Days of any written request from the State thereafter
20.	PA Performance reporting	A.12.h.(5)	Quarterly after go-live date, or as requested by the State
21.	Report detailing utilization of pricing review program, member savings, and operational performance/Complete clinical program list and the State's selection inventory	A.12.l / A.12.n	Every six (6) months and within three (3) Business Days of receipt of written request from the State
Retrospective DUR (Retro-DUR)			
22.	Profile review focus and methodology	A.14.b	Thirty (30) days prior to initial review start date
23.	DUR and Retro-DUR presentations	A.14.e.(1)	Up to four (4) times annually, as requested by the State
24.	Retro-DUR Outcomes	A.14.e.(2)	Quarterly after go-live date as requested by the State
Information System			
25.	Security risk assessment	A.18.i.(10)	November 1, 2027, and annually thereafter
26.	Enrollment and/or client system access	A.18.i.(12)	November 1, 2027
Data Integration and Technical Requirements			
27.	Establish and maintain an electronic data interface	A.19.a	November 1, 2027 (on or before)
28.	Complete all testing of enrollment file	A.19.c	November 1, 2027 (on or before)
29.	Load, test, verify and make available online for use the State's enrollment information	A.19.d	November 1, 2027 (on or before)
30.	Retrieve daily enrollment update	A.19.e.(1)	Daily after go-live date
31.	State enrollment data match	A.19.e.(5)	Not to exceed two (2) times annually, as requested by the State
32.	Claims data transmission to DSS contractor	A.19.f.(2)	Fifteen (15) calendar days following the end of each calendar month

33.	Claims data transmission to third parties	A.19.h	Daily, unless otherwise directed by the State
34.	Load PAs, overrides, and open refills	A.19.j	November 1, 2027 (on or before)
35.	Claims data transmission to State	A.19.m	Within sixty (60) days of notice of Contract termination
General Communications			
36.	Written marketing and communications plan	A.20.a	By November for implementation and by January 31 annually thereafter
Member Communication/Materials			
37.	Annual Enrollment information	A.21.j	Two (2) months prior to annual enrollment
Member ID Cards and Welcome Packets			
38.	Initial ID cards and welcome packets	A.23.c	Fourteen (14) Business Days prior to go-live
39.	Ongoing ID cards and welcome packets	A.23.d	Within four (4) Business Days of receipt of the enrollment file
Plan Microsite, Member Website, and Mobile Application			
40.	Plan Microsite go-live	A.24.a	September 1, 2027, and September 1 of each year thereafter
41.	Submit Plan Microsite text and screenshots and website login credentials	A.24.d	August 2, 2027, and August 15 every year thereafter
42.	Access to Plan Microsite (for review and approval)	A.24.e	August 2, 2027, and August 15 every year thereafter
43.	Plan Microsite fully operational	A.24.i	On or before September 1
44.	Member Website and mobile application fully operational	A.24.j	December 15, 2027
45.	Member Website updates	A.24.m / A.24.n	New Plan Year information one (1) month prior to the new Plan Year / Updates within five (5) Business Days, unless otherwise approved by the State
Reporting and Systems Access			
46.	Reporting and eligibility system access	A.25.b	December 1, 2027
47.	State staff systems training	A.25.b	December 1, 2027
48.	Compliance report	A.25.f	Sixty (60) days following the end of each quarter after go-live

49.	Rebate payments report and annual reconciliation	A.25.g	Sixty (60) days following the end of each quarter after go-live and annually no later than one hundred fifty (150) days after the end of each calendar year
50.	Open service issues	A.25.i	Monthly after go-live, if requested by the State
SLA Scorecard and Performance			
51.	SLA Scorecard	A.26.c	Previous calendar quarter shall be provided to the State in Excel format within sixty (60) days of the end of each calendar quarter. The annual SLA Scorecard shall be provided with the 4th quarter.
Administrative Services			
52.	Member satisfaction survey	A.27.f	Annually (mutually agreed upon)
53.	Description of its fraud and abuse procedures	A.27.l.(1)	At least two (2) months prior to go-live.
54.	Fraud and abuse program effectiveness	A.27.l.(6)	Quarterly after go-live
Pharmacy Audits			
55.	Network Pharmacy audits	A.28.a	Annually, 5%
56.	Develop a trend or log	A.28.b	Quarterly, or upon the State's request
57.	Field audit staff	A.28.c	Within ninety (90) days of go-live
58.	Audit Recoveries	A.28.d	Quarterly basis within thirty (30) calendar days from the close of the quarter
Audit Authority			
59.	Summary of methodology for conducting internal Claims and operational audits	A.29.l	During implementation by September 1, 2027, then at the State's request
Provider Education			
60.	Develop and implement educational Programs	A.30.a	At the State's request
Appeals			
61.	Contractor grievance procedures	A.31.b	December 1, 2027
Customer Services			
62.	Toll-free customer service line	A.32.a	Two (2) weeks prior to the go-live date
63.	Customer service/call center statistics	A.32.i.(5)	Quarterly after go-live date

Payment Methodology			
64.	PMPM Reconciliation	C.3.c	One hundred fifty (150) days after the end of each twelve (12) month Plan Year
Information Technology Security Requirements (State Data, Audit, and Other Requirements).			
65.	SOC2 Type II report	D.37.a.(4)	Within thirty (30) days of the Contract Effective Date and annually thereafter (in addition to periodic requests for bridge reports from State Audit)
66.	Business continuity/Disaster Recovery results	D.37.c.(4)	December 1, 2027, and annually thereafter

B. TERM OF CONTRACT:

B.1. This Contract shall be effective April 1, 2027 ("Effective Date") and extend for a period of fifty-one (51) months after the Effective Date ("Term"). This provides nine (9) months of implementation, thirty-six (36) months of service delivery, and six (6) months for claims runout. The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

B.2. Renewal Options. This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to one (1) renewal option under the same terms and conditions for a period not to exceed twenty-four (24) months, not including the six-month runout period, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of seventy-five (75) months.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

PLACEHOLDER FOR COMPLETED COST PROPOSAL TABLE FROM BEST EVALUATED RESPONDENT

The State shall compensate the Contractor monthly for all services outlined in this Contract, at the rates indicated above, based upon the number of Members certified by the State to the Contractor. The Contractor shall be paid based on enrollment counts calculated by the State's Edison system.

(1) The State shall fund the Contractor monthly for the Administrative Fee and Clinical Fee based on the State's record of enrolled Members as of the first day of the month.

(2) The Net Drug Cost PMPM Guarantees are NOT contingent upon the State maintaining a minimum number of Members.

(3) The Contractor shall provide a Net Drug Cost PMPM Guarantee inclusive of both Plan Paid and Member Cost Share. For avoidance of doubt, the Net Drug Cost PMPM Guarantee amount should not be reduced by Member Cost Share and/or any Manufacturer Payments that could be attributed to Member Cost Share.

Net Drug Cost PMPM Guarantee shall include all prescription drug Claims, other than Gene and Cell Therapy Claims, and shall be calculated as:

(Ingredient Costs plus Dispensing Fees plus Sales Tax less Manufacturer Payments) divided by the total number of months each Member is eligible based on the Member enrollment files provided by the State each month for payment.

(4) The Net Drug Cost PMPM Guarantees shall be:

i. Year 1 of the Contract will be guaranteed based on the Contractor's Net Drug Cost PMPM Guarantee in the C.3.b. cost table.

ii. Year 2 of the Contract will be the lesser of:

a) the Contractor's quoted Year 2 Net Drug Cost PMPM Guarantee in the C.3.b cost table; or

b) the Year 1 Actual Net Drug Cost PMPM plus the Contractor's Year 2 trend guarantee in the C.3.b cost table.

iii. Year 3 of the Contract will be the lesser of:

a) the Contractor's Year 3 Net Drug Cost PMPM Guarantee in the C.3.b cost table; or

b) the Year 2 Actual Net Drug Cost PMPM plus the Contractor's Year 3 trend guarantee in the C.3.b cost table.

If the Contract is renewed for an additional two years, per Contract Section B.2:

iv. Year 4 will be guaranteed based on the Contractor's updated Net Drug Cost PMPM Guarantee and shall not be greater than an agreed upon industry benchmark trend.

v. Year 5 will be the lesser of:

a) the Contractor's updated Year 5 Net Drug Cost PMPM Guarantee; or

b) the Year 4 Actual Net Drug Cost PMPM plus the Contractor's updated Year 5 trend guarantee.

(6) Savings achieved on the State's behalf that result in the Actual Net Drug Cost PMPM to be less than the Net Drug Cost PMPM Guarantee are retained by the State, and no payment shall be owed by either party. Thus, the Net Drug Cost PMPM Guarantee represents the maximum the State will pay for drug costs. The

proposed Administrative and Clinical Fees will be the maximum paid for all other contracted services.

(7) The Contractor shall NOT require the State to make any Plan design changes or implement any programs to receive or maintain Net Drug Cost PMPM Guarantees, including, but not limited to, Pharmacy Discount Card programs.

c. PMPM Reconciliation

(1) Contractor shall reconcile the Actual Net Drug Cost PMPM to the Net Drug Cost PMPM Guarantee one hundred fifty (150) days after the end of each twelve (12) month Plan Year.
(2) Contractor shall calculate the Actual Net Drug Cost PMPM using the Manufacturer Payments collected for Claims adjudicated during the applicable Plan Year.
(3) Actual Net Drug Cost PMPM shall be calculated as: (Ingredient Cost plus Dispensing Fees plus Sales Tax less Manufacturer Payments) divided by total months each member was eligible, based on the Member enrollment files provided by the State each month for payment.
(4) Contractor shall include all Claims in the calculation of the Actual Net Drug Cost PMPM Guarantee, other than Gene and Cell Therapy Claims. There should be no other Claims excluded from the Actual Net Drug Cost PMPM Guarantee.
(5) Should Actual Net Drug Cost PMPM be greater than the Net Drug Cost PMPM Guarantee, Contractor shall, within thirty (30) days after PMPM Reconciliation, pay the State the net shortfall on a dollar-for-dollar basis up to the maximum payout, if applicable.
(6) Should Actual Net Drug Cost PMPM be less than the Net Drug Cost PMPM Guarantee, the State shall retain all value/savings. There will not be shared savings when Actual Net Drug Cost PMPM is less than the Net Drug Cost PMPM Guarantee.
(7) Contractor shall pay the State all Manufacturer Payments collected by Contractor for Claims adjudicated during the applicable Plan Year. One hundred percent (100%) of any Manufacturer Payments received by Contractor after the PMPM Reconciliation of a Plan Year shall be passed through to the State.

d. Claims Payments. The State shall fund the Contractor for the total issue amount of the Claims payments, net of cancellations, voids or other payment credit adjustments. Unless otherwise mutually agreed In Writing by the parties, the Contractor shall notify the State of the funding amount required, and the State will fund the Contractor weekly, provided that the Contractor's payment process includes timely settlement of ACH transactions. As the parties shall mutually agree In Writing, the transfer of said funding to the Contractor for Claims payments shall be affected weekly by ACH debit from the Contractor to a designated State bank account.

(1) 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.
(2) The State reserves the right to review documentation either before or after the transfer of funding for Claims payments and, as the State may deem appropriate, to adjust the funding amount to be transferred or withhold the amount of any overpaid funding from another funding transfer.
(3) The Contractor acknowledges that funding for Claims payments shall be adjusted in full consideration of the Contract Scope of Service requirement that the Contractor shall identify and pursue Claims that may be subject to COB and recovery of overpayments.

e. 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 Claim payment request and the State overpays the Claim, then the State may withhold the overpaid monies from Administrative Fees.

f. Claims processed at Participating Pharmacies with an annual prescription volume at a level that, if the pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the pharmacy for the enhanced amount of professional Dispensing Fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual (per Tennessee PC 1070) shall have a professional Dispensing Fee at a rate that is not less than the amount paid by the TennCare program to a Pharmacy, if the Pharmacy's annual prescription volume is at a level that, if the Pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the Pharmacy for the enhanced amount of professional Dispensing Fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual (per Tennessee PC 1070).

g. Manufacturer Payments:

(1) Quarterly, within ninety (90) calendar days after the end of each calendar quarter in a Plan Year, the Contractor shall pay the State no less than one hundred percent (100%) of the Manufacturer Payments attributable to the State’s utilization of Covered Drugs.

(2) The Contractor shall pay out to the State all Manufacturer Payments earned by the State regardless of the termination of this Contract with final reconciliation and payment made to the State one hundred eighty (180) calendar days post-termination.

(3) The Contractor agrees that any and all amounts owed to the State, including Rebates, Manufacturer Payments, guarantee shortfalls, and recoveries identified during Claims audits, will be paid by the appropriate due date. Any unpaid amount after the stated due date will bear interest at the greater of the secured overnight financing rate plus one (1%) percent per month or the highest interest rate allowed by law.

(4) Any Rebates and Manufacturer Payments received from Manufacturers after the reconciliation will not be applied to the next reconciliation. For avoidance of doubt, one hundred percent (100%) of any Manufacturer Payments received by the Contractor after the PMPM Reconciliation of a Plan Year shall be passed through to the State.

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

h. The Contractor understands and agrees that this Contract is deemed a one hundred percent (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 Participating Pharmacies.

i. The Contractor shall guarantee that the financial terms presented are State-specific.

j. The Contractor shall guarantee that the Dispensing Fee per Paid Claim is based on Paid Claims only, not Claims that are reversed or rejected.

k. The Contractor shall guarantee that U&C priced Claims will not be assessed a Dispensing Fee.

l. The Contractor shall reimburse, when necessary and appropriate, monies to Members when an overpayment has occurred by the Member.

m. 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.

n. For mailings in addition to those identified in this Contract, the State shall reimburse the Contractor for the following selected actual costs in the performance of this Contract upon Contractor providing documentation of actual costs incurred.

(1) Postage. The State shall reimburse the Contractor for the actual cost of postage for additional mailings or materials produced as directed and authorized by the State.

(2) Printing/Production. The State shall reimburse the Contractor an amount equal to the actual cost of document printing/production of additional mailings or materials produced as directed and authorized by the State.

Notwithstanding the foregoing, the State retains the option to authorize the Contractor to deliver a product to be printed. The State also retains the option to 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.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.5. 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 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) calendar days of the quarterly SLA scorecard assessment.

C.6. Purchase Order in lieu of Invoice. The State will generate a purchase order and initiate monthly payment of the purchase order for the administration fees, based upon the State's record of enrolled Members as of the first day of the month, utilizing the rates listed in C.3. above.

C.7. Reconciliation of Payment. The Contractor shall reconcile, within ten (10) Business Days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

C.8. Payment of Purchase Order. A payment by the State shall not prejudice the State's right to object to or question any payment, purchase order, 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 reflected on the purchase order.

C.9. Payment Reductions. The payment to the Contractor shall be subject to reduction for amounts included in any purchase order or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.10. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3. above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Heather Pease, Director of Procurement and Contracts
Tennessee Dept. of Finance and Administration - Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave.
Nashville, TN 37243
heather.pease@tn.gov

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) Invoice number (assigned by the Contractor);
(2) Invoice date;
(3) Contract number (assigned by the State);
(4) Customer account name: Department of Finance & Administration, Division of Benefits Administration;
(5) Customer account number (assigned by the Contractor to the above-referenced Customer);
(6) Contractor name;
(7) Contractor Tennessee Edison registration ID number;
(8) Contractor contact for invoice questions (name, phone, or email);
(9) Contractor remittance address;
(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;
(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;
(12) Applicable payment methodology (as stipulated in Section C.3) of each good or service invoiced;
(13) Amount due for each compensable unit of good or service; and
(14) Total amount due for the invoice period.

b. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Section A and in accordance with payment terms and conditions set forth in Section C;
(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;
(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and
(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Section C.10.

C.11. 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.12. 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.13. 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.14. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other Contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

C.15. Compensation Disclosure. All sources of indirect or transactional payment or compensation to the Contractor and any and all PBM Affiliates, including GPOs, as a result of or in connection with the State's business, must be disclosed to the State In Writing. The Contractor, and any and all PBM Affiliates, including GPOs, shall submit an annual disclosure detail statement of all such sources of revenue within sixty (60) calendar days prior to the end of the year for the subsequent calendar year. The annual disclosure detail statement shall be updated and submitted to the State within sixty (60) calendar days of any changes throughout the year.

C.16. The State shall not be obligated to pay the Contractor any amounts other than those expressly set forth in Section C.3 of this Contract. No additional fees, charges, or costs, whether direct, indirect, incidental, or otherwise, shall be payable by the State.

D. MANDATORY TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first-class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient

confirmation. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Heather Pease, Director of Procurement and Contracts
Tennessee Dept. of Finance and Administration - Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave.
Nashville, TN 37243
heather.pease@tn.gov
Telephone # 615-253-1652
FAX # 615-253-8556

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered effective upon receipt or recipient confirmation as may be required.

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate or suspend this Contract upon written notice to the Contractor. The State's exercise of its right to terminate or suspend 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 or suspends 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 or suspension date but shall not be entitled to compensation for any services performed subsequent to termination date or during a period of suspension. Should the State exercise its right to terminate or suspend 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 by submitting to the State a completed Attestation (accessible through the Edison Supplier Portal) and included at Attachment A, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to State officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from subcontractors shall be maintained by the Contractor and made available to State officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one Party are not employees or agents of the other Party.

D.16. Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless from any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other

attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. The Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to one times the total Paid Claims, as defined in Contract Section A.2., that have processed throughout the one year of Contract performance immediately preceding the breach. If the breach occurs in the first year of the contract, the calculation will be based on processed claims from the beginning of Contract performance until the date of the breach, prorated to equal one year PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys' fees, court costs, expert witness fees, and other litigation expenses for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA Compliance. As applicable, the State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules and will comply with all applicable requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a

government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

e. The Contractor shall not sell 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 Member or Plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. Subject to the Limitation of Contractor's Liability, the Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's noncompliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments, including the cost of credit protection. At the request of the State, the Contractor shall offer credit protection for those times in which a Member's PHI is accidentally or inappropriately disclosed.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees for the affected obligations until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25. State and Federal Compliance. The Contractor shall comply with all State and Federal laws and regulations applicable to Contractor in the Contractor's performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict or choice of law rules. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101-408.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, including all the terms and conditions of the Parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the Parties, whether written or oral.

D.28. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;
b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes
    1. Contract Attachment A Attestation;
    2. Contract Attachment B Liquidated Damages
    3. Contract Attachment C Reporting Requirements; and
    4. Contract Attachment D Service Level Agreement Scorecard.

c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
d. the State solicitation, as may be amended, requesting responses in competition for this Contract;
e. any technical specifications provided to proposers during the procurement process to award this Contract; and
f. the Contractor's response seeking this Contract.

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101, *et seq*., addressing contracting with persons as defined at Tenn. Code Ann. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self-insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO")

"Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) Business Days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The Parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead, Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

    1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

    2) The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

b. Workers' Compensation and Employer Liability Insurance

1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

    i. Workers' compensation and employer liability insurance in the amounts required by appropriate state statutes.

    If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

    i. The Contractor employs fewer than five (5) employees;

    ii. The Contractor is a sole proprietor;

    iii. The Contractor is in the construction business or trades with no employees;

    iv. The Contractor is in the coal mining industry with no employees;

    v. The Contractor is a state or local government; or

    vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Professional Liability Insurance

    i. 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:

        1. 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;

        2. 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

        3. 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.

    ii. 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

    iii. 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. Cyber Liability Insurance

    1) The Contractor shall maintain cyber liability insurance in an amount not less than three million dollars ($3,000,000) per occurrence or claim and five million dollars ($5,000,000) annual aggregate. Such insurance shall be sufficiently broad to respond to the Contractor's duties and obligations under this Contract, and shall include coverage for all acts, claims, errors, omissions, negligence, infringement

of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than three million dollars ($3,000,000) 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.

e. Crime Insurance

1) The Contractor shall maintain crime insurance, which shall be written on a "loss sustained form" or "loss discovered form" providing coverage for third party fidelity, including cyber theft and extortion. The policy must allow for reporting of circumstances or incidents that may give rise to future claims, include an extended reporting period of no less than two (2) years with respect to events which occurred but were not reported during the term of the policy, and not contain a condition requiring an arrest or conviction.

Any crime insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and one million dollars ($1,000,000) in the aggregate. Any crime insurance policy shall contain a Social Engineering Fraud Endorsement with a limit of not less than two hundred and fifty thousand dollars ($250,000). This insurance may be written on a claims-made basis, but in the event that coverage is cancelled or non-renewed, the Contractor shall purchase an extended reporting or "tail coverage" of at least two (2) years after the Term.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's subcontractors and that are subject to tax.

D.34. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with the requirements of this Contract and applicable State and Federal law. All material, information, and data regardless of form, medium or method of communication, that the Contractor will have access to, acquire, or is provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as "Confidential Information." The State grants the Contractor a limited license to use the Confidential Information but only to perform its obligations under the Contract. 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 under state or federal law or otherwise authorized in writing by the State. Contractor shall take all necessary steps to safeguard the confidentiality of such Confidential Information in conformance with the requirements of this Contract and with applicable State and Federal law.

As long as the Contractor maintains State Confidential Information, the obligations set forth in this Section shall survive the termination of this Contract.

D.35. Boycott of Israel. The Contractor certifies that it is not currently engaged in, and covenants that it will not, for the duration of the Contract, engage in a Boycott of Israel, as that term is defined in Tenn. Code Ann. § 12-4-119.

D.36. Prohibited Contract Terms. The prohibited Contract terms and conditions enumerated in Tenn. Code Ann. § 12-3-515, shall be a material provision of this Contract. The Contractor acknowledges, understands, and agrees that the inclusion of a term or condition prohibited by Tenn. Code Ann. § 12-3-515, shall be null and void and the Contract shall be enforceable as if the Contract did not contain such term or condition.

D.37. Information Technology Security Requirements (State Data, Audit, and Other Requirements).

a. "State Data" is any and all data that can be accessed, processed, generated, including derivative works, stored, or hosted by the Contractor in performance of this Contract." The Contractor shall protect State Data as follows:

(1) The Contractor shall ensure that all State Data is housed in the continental United States, inclusive of backup data. All State Data must remain in the United States, regardless of whether the data is processed, stored, in-transit, or at rest. Access to State Data shall be limited to US-based (onshore) resources only.

All system and application administration must be performed in the continental United States. Configuration or development of software and code is permitted outside of the United States. However, software applications designed, developed, manufactured, or supplied by persons owned or controlled by, or subject to the jurisdiction or direction of, a foreign adversary, which the U.S. Secretary of Commerce acting pursuant to 15 C.F.R. § 7 has defined to include the People's Republic of China, among others, are prohibited. Any testing of code outside of the United States must use fake data. A copy of production data may not be transmitted or used outside the United States.

(2) The Contractor shall encrypt State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 **or** 140-3 (or current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Contractor shall provide installation and maintenance support at no cost to the State.

(3) The Contractor shall maintain, obtain, or undergo the following third-party information security certification(s) or examination(s) for both the Contractor and the Contractor's processing environment containing State Data. The Contractor shall ensure that each certification or examination remains current and valid throughout the term of the Contract.

i. SOC 2 Type II Examination - The Contractor and Contractor's processing environment containing State Data shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants (AICPA) for a System and Organization Controls for service organizations (SOC) Type II examination that includes the Security, Availability, and Confidentiality Trust Services Criteria.

ii. HITRUST Certification – The Contractor and Contractor's processing environment containing State Data shall maintain a current HITRUST risk-based two (2) year(r2) validated assessment issued under the HITRUST Common Security Framework and performed by an authorized HITRUST External Assessor Organization

(4) Upon request by the State or the Comptroller of the Treasury, and within thirty (30) days of completion or receipt of any certification or examination required under Contract Section D.37.a(3) the Contractor shall provide the State or the Comptroller of the Treasury with the following documentation and deliverables. The Contractor shall ensure that all documentation remains current, complete, and accurate throughout the term of the Contract.

i. SOC 2 Type II Examination
   1) The SOC 2 Type II examination report in its entirety;
   2) A corrective action plan describing each identified deficiency, planned remediation steps, and anticipated completion dates; and
   3) If any SOC examination report for the Contractor or any Subcontractor supporting this Contract includes a modified opinion, meaning the opinion is qualified, adverse, or disclaimed, the Contractor shall notify the State of the modified opinion within thirty (30) days of receipt and provide the Contractor's plan of corrective action.

ii. HITRUST Certification
   1) The current HITRUST assessment report in its entirety;
   2) The HITRUST Certification Letter for the current [r2] Validated Assessment, issued by HITRUST Alliance after validation by an Authorized HITRUST External Assessor Organization, the letter must show assessment type, scope, and certification dates; and
   3) A corrective action plan describing each identified deficiency, planned remediation steps, and anticipated completion dates.

Upon request by the State or the Comptroller of the Treasury, the Contractor shall also provide current Subcontractor certifications, reports, and related deliverables pertaining to services provided under this Contract within thirty (30) days. If any certification, authorization, examination, or assessment required under this Contract for any Subcontractor supporting this Contract lapses, expires, is suspended, or is revoked, the Contractor shall notify the State in writing within five (5) Business Days of learning of the status change and provide: (i) the effective date and reason; (ii) the services and State Data affected; and (iii) the Contractor's corrective action plan and interim risk mitigations.

No additional funding shall be allocated for these examinations as they are included in the Maximum Liability of this Contract.

(5) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment per the NIST 800-115 definition. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment. The Contractor shall provide a letter of attestation on its processing environment that penetration tests and vulnerability assessments has been performed on an annual basis and taken corrective action to evaluate

and address any findings.

In the event of an unauthorized disclosure or unauthorized access to State Data, the State Strategic Technology Solutions (STS) Security Incident Response Team (SIRT) must be notified and engaged by calling the State Customer Care Center (CCC) at 615-741-1001. Any such event must be reported by the Contractor within twenty-four (24) hours after the unauthorized disclosure has come to the attention of the Contractor.

(6) If a breach has been confirmed a fully unmodified third-party forensics report must be supplied to the State and through the STS SIRT. This report must include indicators of compromise (IOCs) as well as plans of action for remediation and restoration. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures.

(7) Upon State request, the Contractor shall provide a copy of all State Data it holds. The Contractor shall provide such data on media and in a format determined by the State

(8) Upon termination of this Contract and in consultation with the State, the Contractor shall destroy, and ensure all subcontractors shall destroy, all State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) Business Days after destruction.

b. Minimum Requirements

(1) The Contractor shall implement and maintain privacy and security controls that follow the guidelines set forth in NIST 800-53, "Security and Privacy Controls for Federal Information Systems and Organizations," as amended from time to time. The Contractor shall meet annually, or as otherwise agreed, with the State to review the implementation of this Section. Upon request from the State or the Comptroller of the Treasury, the Contractor must provide the State or the Comptroller of the Treasury with a System Security Plan that describes how the Contractor implemented privacy and security controls within NIST 800-53.

(2) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(3) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are always fully compatible with current versions of the Operating System and Application to ensure that security vulnerabilities are not introduced.

(4) In the event of drive/media failure, if the drive/media is replaced, it remains with the State and it is the State's responsibility to destroy the drive/media, or the Contractor shall provide written confirmation of the sanitization/destruction of data according to NIST 800-88.

c. Business Continuity Requirements.

The Contractor shall maintain sets of documents, instructions, and procedures that enable the Contractor to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance to key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

(1) Disaster Recovery Capabilities

Disaster Recovery Capabilities refer to the actions the Contractor takes to meet the Recovery Point Objective (RPO) and Recovery Time Objective (RTO) defined below. Disaster Recovery Capabilities shall comply with NIST SP 800-53 Rev. 5, Contingency Planning (CP) controls, (moderate baseline controls) including CP-1 through CP-10, as applicable, and shall ensure continuity of operations for critical systems and services.

i. Recovery Point Objective (RPO)

The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: one (1) hour.

ii. Recovery Time Objective (RTO)

The RTO is defined as the targeted duration of time and service level within which a business process must be restored after a disruption in order to avoid unacceptable consequences: seventy-two (72) Hours.

(2) Disaster Recovery Plan

The Contractor and Subcontractor(s) shall maintain a documented Disaster Recovery Plan aligned with NIST SP 800-53 CP controls (e.g., CP-2: Contingency Plan, CP-4: Contingency Plan Testing, CP-6: Alternate Storage Site). The plan shall include, at minimum:

i. Identification and prioritization of critical systems, applications, and dependencies

ii. Backup and restoration procedures

iii. Roles, responsibilities, and communication protocols

iv. Periodic review and maintenance procedures

The Contractor shall provide a summary of the Disaster Recovery Plan to the State upon request.

(3) Disaster Recovery Testing

The Contractor and Subcontractor(s) shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A Disaster Recovery Test shall verify the effectiveness of restoration procedures executed after a critical IT failure or disruption. Success shall be defined as demonstrating the ability to meet the State's RPO and RTO objectives.

(4) Reporting

The Contractor shall provide written confirmation to the State after each Disaster Recovery Test, including documentation of the actual RPO and RTO results achieved during the test and verification that these values meet the requirements specified in section D.37.c(1)

d. Comptroller Audit Requirements.

Upon reasonable notice and at any reasonable time, the Contractor agrees to allow the Comptroller of the Treasury, or the Comptroller's duly appointed representatives, to perform information technology control audits of the Contractor's information technology hosting and processing environment used by the Contractor to provide services under this Contract. The

audit may evaluate whether the Contractor has implemented appropriate privacy and security controls consistent with NIST Special Publication 800-53, including controls generally classified as general controls and application controls. The audit may also assess whether those controls are designed and operating effectively and whether the Contractor is complying with applicable policies, laws, and regulations.

For purposes of this section:

General Controls are policies, procedures, and technical mechanisms that support the overall operation and integrity of information systems and applications, including areas such as access security, change management, system development, backup and recovery, and system maintenance.

Application Controls are the automated or manual controls built into specific applications to ensure the completeness, accuracy, authorization, and validity of data and transactions processed by those applications.

The audit may include, but is not limited to:

1) Review and evaluation of independent assurance deliverables required under Contract Section D to determine whether the Contractor or Subcontractor's control environment and related safeguards are designed and operating effectively;

2) Review of documentation describing the Contractor's information technology control environment, policies, and procedures;

3) Interviews with technical and management personnel responsible for implementing, monitoring, and maintaining information technology controls;

4) Inspection of technical, administrative, or physical controls implemented to protect State Data and support service delivery under this Contract;

5) Review of relevant transaction logs, audit trails, vulnerability scans, or other supporting evidence necessary to verify compliance with applicable control requirements; and

6) Performance of other audit procedures deemed necessary by the Comptroller of the Treasury to verify compliance with applicable federal or state laws, regulations, or policies, or to assess the adequacy and effectiveness of the Contractor's control environment.

The Contractor shall ensure that its Subcontractors cooperate and provide reasonable access to information or personnel necessary for the audit to the extent such information pertains to the services provided under this Contract.

The Contractor must have a process for correcting control deficiencies that were identified in the Comptroller of the Treasury's information technology audit. For any audit issues identified, the Contractor shall submit a corrective action plan to the Comptroller of the Treasury which addresses the actions taken, or to be taken, and the anticipated completion date in response to each of the audit issues and related recommendations of the Comptroller of the Treasury. The corrective action plan shall be provided to the Comptroller of the Treasury upon request from the Comptroller of the Treasury and within thirty (30) days from the issuance of the audit report or communication of the audit issues and recommendations. Upon request from the Comptroller of the Treasury, the Contractor shall provide documentation and evidence that the audit issues were corrected.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

D.38. State Sponsored Insurance Plan Enrollment. The Contractor warrants that it will not enroll or permit its employees, officials, or employees of subcontractors to enroll or participate in a state sponsored health insurance plan through their employment, official, or contractual relationship with Contractor unless Contractor first demonstrates to the satisfaction of the Department of Finance and Administration that it and any subcontract entity satisfies the definition of a governmental or quasigovernmental entity as defined by federal law applicable to ERISA.

D.39. Foreign Adversary Company Attestation. The Contractor attests that they are not a "Foreign adversary company" within the meaning of Pub. Ch. 768 (2026) and that the Contractor is not knowingly selling an information and communications technology final product or service within the meaning of Pub. Ch. 768 (2026).

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. Additional lines, items, or options. At its sole discretion, the State may make written requests to the Contractor to add lines, items, or options that are needed and within the Scope but were not included in the original Contract. Such lines, items, or options will be added to the Contract through a Memorandum of Understanding ("MOU"), not an amendment.

a. After the Contractor receives a written request to add lines, items, or options, the Contractor shall have ten (10) business days to respond with a written proposal. The Contractor's written proposal shall include:
    (1) The effect, if any, of adding the lines, items, or options on the other goods or services required under the Contract;
    (2) Any pricing related to the new lines, items, or options;
    (3) The expected effective date for the availability of the new lines, items, or options; and
    (4) Any additional information requested by the State.
b. The State may negotiate the terms of the Contractor's proposal by requesting revisions to the proposal.
c. To indicate acceptance of a proposal, the State will sign it. The signed proposal shall constitute a MOU between the Parties, and the lines, items, or options shall be incorporated into the Contract as if set forth verbatim.
d. Only after a MOU has been executed shall the Contractor perform or deliver the new lines, items, or options.

E.3. 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.4. Artificial Intelligence (AI) Use and Compliance Requirements. The Contractor agrees that any product, service, or solution incorporating Artificial Intelligence (AI), including Generative AI

(GenAI), procured under this Contract shall comply fully with the State of Tennessee's Enterprise Artificial Intelligence Policy (Policy 200-POL-007), available at: tn.gov/content/dam/tn/finance/artificial-intelligence/200-POL-007 Enterprise Artificial Intelligence Policy.pdf

The Contractor further agrees to the following:

a. Data Privacy and Security

Contractor shall not use, access, store, transmit, or process any State Data—including but not limited to confidential, privileged, personally identifiable information (PII), protected health information (PHI), Payment Card Industry (PCI) data, criminal justice information (CJIS), federal tax information (FTI), Centers for Medicare & Medicaid Services (CMS) data, Social Security Administration (SSA) data, Family Education Rights & Privacy Act (FERPA) data, or internal communications—through any AI tools or platforms unless:

(1) The AI tool is explicitly approved in writing by the State.

(2) The tool is operated within a secure State-controlled or approved environment.

b. Prohibition on Model Training

Contractor shall not use State Data to train, fine-tune, or otherwise improve AI models, unless expressly authorized in writing by the State and in accordance with Policy No. 200-OL-007.

c. Transparency and Accountability

Contractor shall clearly disclose when AI tools are used in providing services or generating content on behalf of the State. Contractor is responsible or the accuracy, reliability, and appropriateness of all AI-generated outputs.

d. Use of Approved Tools Only

Only State-approved AI platforms, systems, or services may be used in the performance of this contract. Use of public, consumer, or non-State-managed AI platforms (e.g., ChatGPT, Google Gemini, etc.) with State Data is strictly prohibited unless authorized in writing.

e. Ongoing Compliance and Risk Mitigation

Contractor shall ensure continued compliance with evolving State and Federal regulations related to AI. The State reserves the right to audit or review AI usage under this Contract at any time.

f. Indemnification

Contractor shall further indemnify and hold harmless the State in accordance with the Hold Harmless section of this Contract for any unauthorized disclosure, misuse, or compromise of State Data resulting from AI-related processing that violates this Contract or State policy.

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. Liquidated Damages. If the Contractor fails to fully meet any of the performance guarantees

outlined in Contract Attachment B to the satisfaction of the State ("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.7. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify or ensure that Contractor is in full compliance with its obligations under this Contract in relation to PII. 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.

E.8. 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.

E.9. Americans with Disabilities Act. The Contractor must comply with the Americans with Disabilities Act (ADA) of 1990, as amended, including implementing regulations codified at 28 CFR Part 35 "Nondiscrimination on the Basis of Disability in State and Local Government Services" and at 28 CFR Part 36 "Nondiscrimination on the Basis of Disability in Public Accommodations and

Commercial Facilities," and any other laws or regulations governing the provision of services to persons with a disability, as applicable. For more information, please visit the ADA website: http://www.ada.gov.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE	**DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE AGENCY NAME:

NAME & TITLE	**DATE**

ATTACHMENT A

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

CONTRACT ATTACHMENT B

Liquidated Damages

To effectively manage contractual performance, the State has established Liquidated Damages associated with certain Contractor's obligations under the Contract. The Contractor is expected to meet certain performance guarantees according to the timeline and specifications outlined in this Contract Attachment. If these guarantees are not fully met to the satisfaction of the State, the State is entitled to impose liquidated damage assessments as stated in this Contract Attachment.

The parties agree that the amounts of the Liquidated Damages in this Contract Attachment reflect 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 under this Section does not automatically extinguish Contractor's liability for failure to satisfy a performance guarantee, shall not be construed as the State's exclusive remedy against Contractor, and shall not limit the State's right to pursue any other remedies available under the Contract or applicable law.

Assessment of Liquidated Damages does not relieve the Contractor of its obligation to deliver all Contracted services or otherwise perform its contractual obligations.

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's receipt of the Invoice containing an assessment of Liquidated Damages. If payment is not received by the due date, the Liquidated Damages amount may be withheld from future payments owed to the Contractor in connection with this Contract or any contract that the Contractor has with the State without further notice.

1. Program go-live	
Guarantee	The Pharmacy Benefits and Program(s) shall take effect and be fully operational on the go-live date specified in Contract Section A.35.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond the go-live date that the Pharmacy Benefits and Programs are not operational as described in Contract section A.4.a.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay, the State is unable to provide Pharmacy Benefits coverage to Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, Member disruption, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled after the go-live has been achieved, as determined by the State.
2. Implementation	
Guarantee	The Contractor shall deliver an implementation plan and comply with all tasks, deliverables, and milestones included in the implementation plan, as required in Contract Section A.4.e, necessary to install the Program by the go-live date.
Assessments	a. Five hundred dollars ($500) per Business Day for delivery of the plan beyond the implementation plan delivery date in Contract Section A.35.

	b. One thousand dollars ($1,000) per Business Day for tasks, deliverables, or milestones in the implementation plan that are not met by the agreed upon timelines.
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	a. Assessed, reported, and reconciled after receipt of the plan. b. Assessed, reported, and reconciled following the completion of the tasks, deliverables, or milestone.
3. Operational Readiness	
Guarantee	Prior to the go-live date, the Contractor shall resolve noncompliance with Contract terms identified by the State during its operational readiness review including all milestones required in Contract Section A.4.f.
Assessment	Ten thousand dollars ($10,000) for each Business Day after go-live that a finding is not resolved, as determined by the State.
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, reported and reconciled after the State verifies that all findings of non-compliance have been resolved.
4. Plan Design	
Guarantee	Plan design, per written communications with Benefits Administration, (including covered services, excluded services, Member Cost Share, Formulary updates, Ingredient Cost pricing, etc.) will be implemented correctly.
Assessment	Twenty-five thousand dollars ($25,000) per each incorrect plan design setup.
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	Original plan design, effective 1/1/28, assessed, reported and reconciled after the go-live date. Subsequent plan design(s), assessed, reported and reconciled after the effective date of the plan design setup and assessed quarterly.
5. Enrollment File Set-Up	
Guarantee	As required in Contract Section A.19.d, enrollment information must be loaded, tested, verified and available online for use by the date specified in Contract Section A.35.

Assessment	Ten thousand dollars ($10,000) for each Business Day beyond the date specified in Contract Section A.35.
Justification	Enrollment file set-up is a critical step in providing Member 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 following the State's confirmation that the enrollment file setup is complete.
6. Network Access	
Guarantee	As required in Contract Section A.8.e, the Contractor shall maintain a network of Retail-30 Pharmacy Providers that meet the following access standards using a Quest Analytics or comparable 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	One hundred thousand dollars ($100,000) per year until all the access standards listed above are met.
Justification	The Contract requires minimum access standards and without those, Members do not have access to Pharmacies within the access standards and therefore the potential to go without prescription medication and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported and reconciled annually using the Quest Analytics or comparable report provided by the Contractor.
7. URAC Accreditation	
Guarantee	As required in Contract Section A.3.d, the Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.

Assessment	Twenty thousand dollars ($20,000) annually if the accreditation is not met and 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.
8. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	To comply with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per violation until resolved. This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours 3. Program Director associated with this Contract time and work estimated at fifteen (15) hours 4. Executive Director's time and work estimated at one (1) hour 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours.
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.
Measurement	Assessed, reported, and paid after each occurrence.
9. Privacy and Security of Protected Health Information Impacting 500 or more Members	

Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours 4. Executive Director's time and work estimated at eighteen (18) hours 5. Department attorney time including legal review estimated at thirty (30) hours 6. Service Center staff time and work answering Member questions/concerns estimated at one hundred (100) hours 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally required media release to media outlets across the State.
Measurement	Assessed, reported, and paid after each occurrence.

Contract Attachment C

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format approved by the State, and shall be of the type and at the frequency indicated below, or as otherwise directed by the State. The State reserves the right to modify reporting requirements as deemed necessary to monitor Contract implementation. The State will provide the Contractor with at least sixty (60) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

1. Monthly reports shall be submitted by the 15th of the following month
2. Quarterly reports shall be submitted by the 20th of the following month; and
3. Annual reports shall be submitted within ninety (90) days after the end of the calendar year.

Note: Any report due on a State Holiday or weekend will then be due on the following Business Day.

Reports shall include, at a minimum (not an all-inclusive list; refer to Contract for all specifics):

1. **Business Continuity/Disaster Recovery results,** December 1, 2027, and annually thereafter.
2. **Network Access Report,** submitted annually.
3. **Quarterly Network Changes Report,** submitted within five (5) Business Days of the end of each calendar quarter after go-live date.
4. **Formulary Compliance Report,** submitted quarterly after go-live date.
5. **Therapeutic substitution and Generic Drug dispensing Program report,** submitted annually.
6. **PA reporting,** submitted quarterly after go-live date.
7. **Rebate reporting,** submitted no later than sixty (60) days following the end of each quarter after go-live.
8. **Rebate Annual Reconciliation,** submitted no later than one hundred fifty (150) days after the end of the calendar year for the previous calendar year.
9. **Financial Reporting,** submitted no later than one hundred fifty (150) days after the end of each twelve (12) month Plan Year. The Contractor shall reconcile the Actual Net Drug Cost PMPM to the Net Drug Cost PMPM Guarantee as described in PMPM Reconciliation C.3.c.
10. **Operational/Performance Reporting,** submitted monthly within fifteen (15) days of the end of the previous month.
11. **Compliance Report (aka report card),** submitted no later than sixty (60) days following the end of each calendar quarter showing for the previous quarter the Contractor's outcome for each of the measurements in the Contract Attachment B and Contract Attachment D of this Contract, as well as any payment amount due for that quarter (if applicable).
12. **Rebate Payments report,** submitted no later than sixty (60) days following the end of each calendar quarter after go-live and annually no later than one hundred fifty (150) days after the end of each calendar year.
13. **SOC2 Type II report,** submitted within thirty (30) days of the Contract Effective Date, annually thereafter, and in addition to periodic bridge reports as requested by the State in compliance with Contract Section D.37.a(4).
14. **Out-of-Network Accumulator Claims report,** if requested by the State, submitted quarterly for the previous calendar quarter to the State's TPAs. At a minimum, the data fields to include are: Member account ID (Edison ID), Member name, Member date of birth, Member address, Member city, Member state, Member zip code, Claim fill date, GPI 4 class code, brand/generic indicator, prescriber NPI, prescriber full name, prescriber address, prescriber city, prescriber state, prescriber zip code, Pharmacy NCPDP ID, Pharmacy name, Pharmacy address, Pharmacy city, Pharmacy state, Pharmacy zip code, prescription Claim number, total dispensed quantity, total Days' Supply, total Ingredient Cost paid, total Dispensing Fee, total Sales Tax, total member cost amount, total net cost, total prescriptions, and total deductible applied amount. See A.19.h.

15. **Marketing and communications analytics report**, provided annually in compliance with A.20.a(2)
16. **Customer service/call center statistics**, provided quarterly in compliance with A.32.i(5).
17. **Enrollment file error report,** submitted daily within one Business Day of processing the daily file.
18. **Claims Payment Accuracy and Claims Processing Accuracy,** actual results for the requirements in sections A.6 and A.7 reported quarterly. Quarterly results will be calculated for a quarterly score as shown in Contract Attachment D.
19. **Fraud and abuse**, quarterly in compliance with A.27.l(6).
20. **Other Reports,** as specified in this Contract and using templates prior approved In Writing by the State.

Service Level Agreement Scorecard

The SLA Scorecard and associated KPIs below are used to measure the Contractor's performance against the desired outcomes. KPIs shall be evaluated, scored, and reconciled via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard for each KPI at the frequency listed (e.g., quarterly, annually, per occurrence) documenting the Contractor's outcome for each KPI during that time period. The State and Contractor will agree upon the required reporting format during implementation. Based on the scores, the State will determine, and may assess, any At-Risk Performance Payments. Amounts due will be a percentage of fees earned during the time period the KPI was measured (see Tables A and B below) and/or the per occurrence amount listed in Table C.

It is agreed by the State and the Contractor that any At-Risk Performance Payment assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
1.	POS System Availability	POS system, used by contracted Pharmacies to process Pharmacy Claims, as required in Contract Section A.6.m shall be accessible and operational ninety-nine-point nine percent (99.9%) of the time.	99.90%	99.90% or greater	9	
				97.98-99.89%	6	
				97.0-97.97%	3	
				Less than 97%	0	
2.	POS System Processing	As required in Contract Section A.6.d, the Contractor shall process ninety-nine-point five percent (99.5%) of POS Claims on a daily basis within five (5) seconds.	99.5%	99.5% or greater	5	
				98.0-99.4%	3	
				97.0-97.9%	1	
				Less than 97%	0	
3.	Claims Processing Accuracy	Claims Processing Accuracy, as required in Contract Section A.6.k, shall be greater than or equal to ninety-nine-point nine percent (99.9%) at Retail, and greater than or equal to ninety-nine-point ninety-nine percent (99.99%) at Mail Order and Specialty.	Retail 99.9%	99.9% or greater	6	
				97.0-99.8%	4	
				95.0-96.9%	2	
				Less than 95%	0	
			Mail Order 99.99%	99.99% or greater	6	
				97.0-99.98%	4	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
				95.0-96.99%	2	
				Less than 95%	0	
			Specialty 99.99%	99.99% or greater	6	
				97.0-99.98%	4	
				95.0-96.99%	2	
				Less than 95%	0	
4.	Claims Payment Accuracy	Claims payment accuracy, as required in Contract Section A.7.g, shall be ninety-nine-point nine percent (99.9%) or higher.	99.9%	99.9% or greater	6	
				97.0-99.8%	4	
				95.0-96.9%	2	
				Less than 95%	0	
5.	Generic Drug Substitution - Mail Order	As required in Contract Section A.9.j.(1), ninety-five percent (95%) or more of Mail Order prescriptions for Multisource drugs shall be dispensed with a Generic Drug product.	95%	95% or greater	6	
				93.0-94.9%	4	
				91.0-92.9%	2	
				Less than 91%	0	
6.	Generic Drug Substitution - Retail	As required in Contract Section A.9.j.(1), ninety percent (90%) or more of Retail prescriptions for Multisource drugs shall be dispensed with a Generic Drug product.	90%	90% or greater	8	
				88.0-89.9%	4	
				86.0-87.9%	2	
				Less than 86%	0	
7.	PA Evaluation	As required in Contract Section A.12.h.(4), the Contractor's PA staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.	99%	99% or greater	6	
				97.0-98.9%	4	
				95.0-96.9%	2	
				Less than 95%	0	
8.	Enrollment posting	Post ninety-eight percent (98%) of electronically transmitted enrollment	98%	98% or greater	8	
				97% - 97.9%	6	
				96% - 96.9%	4	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
		updates within one (1) Business Day as required in Contract Section A.19.e(2).		Less than 96%	0	
9.	Eligibility Discrepancies	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within two (2) Business Days of identification, as required in Contract Section A.19.e(4).	100%	100%	3	
				98.0-99.9%	2	
				96.0-97.9%	1	
				Less than 96%	0	
10.	Pre-Service Appeals	Ninety-nine percent (99%) of Pre-Service Appeals shall be decided within fifteen (15) calendar days from receipt of appeal, as required in Contract Section A.31.c.	99%	99% or greater	4	
				95.0-98.9%	3	
				91.0-94.9%	2	
				Less than 91%	0	
11.	Post-Service Appeals	Ninety-nine percent (99%) of Post-Service Appeals within thirty (30) days from receipt of appeal, as required in Contract Section A.31.c.	99%	99% or greater	4	
				95.0-98.9%	3	
				91.0-94.9%	2	
				Less than 91%	0	
12.	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.32.a. Excluded from this are contracted-planned down times or Force Majeure Events as listed in Contract Section D.24.	100%	100%	8	
				98.0-99.9%	6	
				96.0-97.9%	4	
				Less than 96%	0	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
13.	Average Speed of Answer	All inbound calls to the Contractor's call center and/or toll-free customer service lines shall be answered with a daily average speed of answer of twenty (20) seconds or less, including calls routed to an IVR, as required in Contract Section A.32.i.(2).	20 seconds	20 Seconds or less	8	
				21-30 seconds	6	
				31-40 seconds	4	
				Greater than 40 seconds	0	
14.	Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-eight percent (98%) of ongoing welcome packets and ID cards shall be produced and mailed within four (4) Business Days of receipt of complete and accurate eligibility information, as required in Contract Section A.23.d.	98%	98% or greater	6	
				96.0-97.9%	4	
				91.0-95.9%	2	
				Less than 91%	0	
15.	Plan Microsite	Provide a Plan Microsite that can sustain ninety-nine-point nine percent (99.9 %) continuous uptime as required in Contract Section A.24.f.	99.9%	99.9% or more	8	
				98.0-99.8%	4	
				96.0-97.9%	2	
				Less than 96%	0	
16.	Member Website	Maintain a Member Website that is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year except for maintenance windows as required in Contract Section A.24.j.	24 hours, 365 days	100%	8	
				98.0-99.9%	6	
				96.0-97.9%	2	
				Less than 96%	0	
17.	Claims Data Submission	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	Data shared with DSS contractor within fifteen (15) days of the end of each month	<= 10 days: 100%	8	
				11 days: 99%	4	
				12 days: 98%	2	
				>12 days: 97%	0	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
		by the State, as required in Contract Section A.19.f.				
18.	Data Transmission to Third Party Contractors	Unless otherwise directed by the State, the Contractor shall provide daily accumulator data feeds to the State's third-party contractors listed in Contract Section A.19.h. until all Claims incurred during the Term have been paid.	Data accumulator feeds to be shared each day with the State's TPAs	Daily: 100%	8	
				98%-99.9% of daily files shared timely	4	
				96%-97.9% of daily files shared timely	2	
				Less than 96% of daily files shared timely	0	
19.	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.(8). Date of birth: Data missing for ≤ 3% of Claims Pharmacy Provider ID missing: Data missing for ≤ 1.5% of Claims NDC or NDC 11 missing: Data missing for ≤ 1.5% of Claims	3 measures met	3 measures met	4	
				2 measures met	3	
				1 measure met	1	
				0 measures met	0	
20.	Quarterly Reporting	The Contractor shall distribute to the State all reports required in the Contract within the time frame and in the format specified in the Contract.	90%	90-100%	10	
				80-89.9%	8	
				70-79.9%	6	
				60-69.9%	4	
				Less than 60%	0	
Total Quarterly Points Available						145
Total Quarterly Points Achieved						# TBD
Quarterly Score (Total Quarterly Points Achieved / Total Quarterly Points Available)						% TBD

TABLE A - Quarterly					
KPI	**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
At-Risk Performance Payment Due • Quarterly Score determines at risk performance payment % (See At Risk Performance Payment % table below) • Payment due = reporting quarter's total fees * corresponding at risk performance payment % based on the Quarterly Score					$TBD

TABLE B – Annually						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Annual Score**
21.	Annual Reporting	The Contractor shall distribute to the State all reports required in the Contract within the time frame and in the format specified in the Contract as required in Contract Attachment C.	90-100%	90-100%	10	
				80-89.9%	8	
				70-79.9%	6	
				60-69.9%	4	
				Less than 60%	0	
22.	Member Satisfaction Survey	The level of overall Member satisfaction, as measured annually through the Member satisfaction survey, shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the Contract term as required in Contract Section A.27.f.	85% year 1 of contract	85% or greater	10	
				83-84.9%	8	
				81-82.9%	6	
				79-80.9%	4	
				Less than 79%	0	
			90% in years 2-4 of contract	90% or greater	10	
				88-89.9%	8	
				86-87.9%	6	
				84-85.9%	4	
				Less than 84%	0	
Total Annual Points Available						20
Total Annual Points Achieved						# TBD
Annual Score (Total Annual Points Achieved / Total Annual Points Available)						% TBD
At-Risk Performance Payment Due • Annual score determines at risk performance payment % (See At Risk Performance Payment % table below)						$TBD

• Payment due = (total annual fees * corresponding at risk performance payment % based on the Annual Score) * 20%	

Score	At Risk Performance Payment % for Tables A and B
>=96	0% of previous quarter Administrative and Clinical Fees
91 – 95.9	.25% of previous quarter Administrative and Clinical Fees
86 – 90.9	.50% of previous quarter Administrative and Clinical Fees
81 – 85.9	.75% of previous quarter Administrative and Clinical Fees
76 – 8.9	1% of previous quarter Administrative and Clinical Fees
71 – 75.9	1.5% of previous quarter Administrative and Clinical Fees
66 – 70.9	2% of previous quarter Administrative and Clinical Fees
61 – 65.9	3% of previous quarter Administrative and Clinical Fees
<61	4% of previous quarter Administrative and Clinical Fees

TABLE C – Per Occurrence				
KPI		**Description**	**Performance Requirement**	**At Risk Performance Payment**
23.	**Unauthorized Usage of Information**	Unless prior approved In Writing by the State, and in compliance with State and Federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.	If Contractor uses data without prior approval	$50,000
24.	**Key Staff Vacancies**	As required in Contract Section A.5.k, if any Key Staff become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.	Vacancy filled within sixty (60) days	$1,000 for each Business Day exceeding the 60-day requirement until resolved.
25	**Member Communications**	The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). as required in Contract Section A.21.b.	100%	$1,000 per incident

CONTRACT ATTACHMENT E

HIPAA BUSINESS ASSOCIATE AGREEMENT COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between The State of Tennessee, Finance and Administration, Division of Benefits Administration (hereinafter "Covered Entity") and _ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge that they are subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name: _____ **Execution Date:** _____

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.

1. 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 two Business Days) report, to Business Associate, immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the breach.

2.7. As required by the Breach Notification Rule, Business Associate shall, 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 30 Business Days from Covered Entity notice to make an amendment.

2.10. Business Associate shall make its internal practices, books, and records including policies and procedures and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.11. Business Associate shall document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.

2.12. Business Associate shall provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 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 two Business Days) 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 promptly 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
Attn: Heather Pease
Director of Procurement and Contracts
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 253-1652
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. HITECH Act Compliance. The Parties acknowledge that the HITECH Act includes significant changes to the Privacy Rule and the Security Rule. The privacy subtitle of the HITECH Act sets forth provisions that significantly change the requirements for business associates and the agreements between business associates and covered entities under HIPAA and these changes may be further clarified in forthcoming regulations and guidance. Each Party agrees to comply with the applicable provisions of the HITECH Act and any HHS regulations issued with respect to the HITECH Act. The Parties also agree to negotiate in good faith to modify this BAA as reasonably necessary to comply with the HITECH Act and its regulations as they become effective but, in the event that the Parties are unable to reach agreement on such a modification, either Party will have the right to terminate this BAA upon 30- days' prior written notice to the other Party.

8.4. Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.5. 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.

8.6. 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

BUSINESS ASSOCIATE:

With a copy to:
ATTN: Heather Pease
Director of Procurements and Contracts
At the address listed above
Phone: (615) 253-1652
Facsimile: (615) 253-8556
E-Mail: heather.pease@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 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.

8.7. 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

8.8. 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.

8.9. 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.

8.10. 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.

8.11. Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page

one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

CONTRACTOR NAME **Date:**

James E. Bryson, Commissioner of Finance & Administration **Date:**