STATE OF MISSISSIPPI

STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE MANAGEMENT BOARD

REQUEST FOR PROPOSAL FOR PHARMACY BENEFIT MANAGER

January 30, 2015

Contact information for this request for proposal:

Pharmacy Benefit Manager RFP
c/o DFA - Office of Insurance
501 North West Street
Suite 901-B Woolfolk Building
Jackson, Mississippi 39201
InsuranceRFP@dfa.ms.gov
601-359-6568 facsimile

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1.1 Overview and Process

The Mississippi State and School Employees Health Insurance Management Board (Board) is seeking a Pharmacy Benefit Manager (PBM) to provide prescription drug benefit management services for the Mississippi State and School Employees' Health Insurance Plan (Plan). The Mississippi Department of Finance and Administration (DFA) provides administrative support to the Board, and is coordinating this Request for Proposal (RFP) with assistance from its consultant PricewaterhouseCoopers LLP (PwC). The Board desires to contract with a qualified, experienced PBM capable of providing prescription drug benefit management services as described in ***Section 3 Scope of Services*** in this RFP.

The effective date of this contract will be January 1, 2016. The term of this contract will be four (4) years with an option to renew for one (1) additional year at the Board's discretion. This contract shall be governed by the applicable provisions of the Mississippi Personal Service Contract Review Board Rules and Regulations, a copy of which is available from the Mississippi State Personnel Board located at 210 East Capitol Street, Suite 800, Jackson, Mississippi, or by accessing their website at www.mspb.ms.gov.

The Board issued this RFP to secure the services of a PBM with the level of experience and expertise necessary to assist the Board in its management of the Plan. The purpose of this RFP is to solicit competitive proposals by defining the Board's needs, providing to potential proposer adequate information to develop proposals, describing the evaluation criteria by which proposals will be scored, and providing proposers with a draft contract.

A copy of this RFP, including any subsequent amendments, along with a copy of all questions from proposers and responses to those questions, will be posted on DFA's website at www.dfa.ms.gov under the heading "Bid and RFP Notices". Before the award of any contract, the proposer will be required to provide sufficient evidence to prove to the Board that it has the necessary capabilities to provide the services specified in this RFP. The proposer may also be required to provide additional client references, as well as related project experience detail in order to satisfy the Board that the proposer is qualified. The Board may make reasonable investigations, as it deems necessary and proper, to determine the ability of the proposer to perform the work, and proposer shall furnish to the Board all information that may be requested for this purpose. The Board reserves the right to reject any proposal if the proposer fails to satisfy the Board that the proposer is properly qualified to carry out the obligations of the contract and to complete the work described in this RFP.

The Plan is a non-ERISA, self-insured health insurance plan currently providing health insurance coverage to approximately 184,000 participants. Eligible participants include active, retired, and COBRA employees (and their enrolled dependents) of the Plan's approximately 330 agencies, universities, community colleges, school districts, and public library systems. Participants are primarily located within

the State of Mississippi with a small number of participants residing in other states. Participants include approximately 115,000 active employees, 700 COBRA participants, 9,400 Non-Medicare retirees, 13,000 Medicare eligible retirees, and 46,000 dependents. It is important to note that Medicare eligible retirees, Medicare eligible surviving spouses and Medical eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits. The details of the current Plan can be found in *Appendix B - 2015 Plan Document*.

The Plan currently offers options of Base Coverage or Select Coverage for active employees, COBRA participants, and non-Medicare eligible retirees. Each coverage type is independent of the other. Under Select Coverage prescriptions are subject to copayments after a $75 pharmacy deductible has been satisfied. The Base Coverage serves as a high deductible health plan in which pharmacy benefits are subject to copayments after the annual $1,800 deductible has been satisfied.

Blue Cross & Blue Shield of Mississippi (BCBSMS) is the current medical Third Party Administrator (TPA) and has served in this capacity since 1998. The TPA collects and provides the PBM with eligibility data and accumulation data such as deductible and out-of-pocket data, etc. BCBSMS is responsible for processing medical claims, and determining medical necessity guidelines for the Plan.

Catamaran is the current PBM and has served in this capacity since 2006. The Plan processed over $200 million in prescription drug charges on approximately 2.4 million claims in 2014. The Plan has a generic utilization rate of approximately 80%. Mail order currently represents less than 2% of claims.

1.2 Purpose and Goals

The purpose of this solicitation is to contract with an organization to provide pharmacy benefit management administration services including network pharmaceutical pricing through financial arrangements with pharmacies. The pharmacy network provided by the PBM must contain a sufficient number of pharmacies to provide to all participants adequate access, in-state as well as out-of-state, as determined cooperatively by the PBM and the Board. The pharmacy network will provide the Plan with a cost-effective network of pharmacies contracted at rates that are commensurate with the size of the Plan and its associated purchasing power. The PBM will provide clinical programs such as prior authorization, step therapy and specialty drug management, and a mail order distribution channel. The Board expects the PBM to be proactive in making recommendations that control costs.

It is the Board's intent to have a fully transparent/pass-through financial pricing arrangement with the PBM. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts & dispensing fees, etc.). The Board must receive the full and complete amount of any discounts and rebates received by the PBM from any and all retail pharmacies, and manufacturer rebates. The PBM will not retain a differential between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM or rebates.

The only compensation the PBM will receive from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal, or agreed upon in writing through subsequent discussion with the Board.

1.3 Instructions to Proposers

All potential proposers are required to indicate their intention to propose and return a signed copy of the Non-Disclosure Agreement (NDA) by 2:00 p.m. Central Standard Time Tuesday, February 17, 2015. Failure to submit an Intent to Propose and signed NDA will disqualify proposer from being considered for these services. An NDA is required in order to receive the claims file for re-pricing, which is required to be submitted with your proposal (see ***Section 6 Claims Re-Pricing*** for details). These documents may be submitted via e-mail to InsuranceRFP@dfa.ms.gov, but an original hardcopy is also required. Your intent to propose should indicate your organization's primary contact, direct telephone number of contact, e-mail address, and facsimile number. The submission of an Intent to Propose does not obligate one to submit a proposal. Questions must be submitted in writing via e-mail or facsimile, and must be received by 2:00 p.m. central standard time February 17, 2015 to receive a response. Proposers are encouraged to submit questions as they arise, and responses will be posted as soon as they are available. Responses to questions will be made available on DFA's website at www.dfa.ms.gov under "Bid and RFP Notices" no later than February 20, 2015. It is the proposer's sole responsibility to monitor the website for responses to questions, and also for any amendments to the RFP.

Proposals must be received in the DFA Office of Insurance in Jackson, Mississippi by 2:00 p.m. Central Standard Time, February 27, 2015. Any proposal received after the deadline will not be considered. Proposals submitted by facsimile or by electronic mail will not be accepted.

1. Number each page of the proposal, and conspicuously mark each page that contains confidential information with the word "CONFIDENTIAL", in the upper-right corner, and use a different color paper from the color used for pages that do not contain confidential information. **Failure to clearly identify trade secrets or confidential commercial or financial information will result in that information being released subject to a public records request.** Please see *Section 1.15 Mississippi Public Records Act/Confidentiality of Proposals*

2. Submit one clearly marked original response with signed proposal cover letter, signed Statutory Requirement disclosure statement, signed Statement of Compliance, and signed Acknowledgement of RFP Amendments (only if amendment is posted). Include four identical copies of the original response in three-ring binders and include one electronic copy of the complete proposal including all sections in Microsoft Word ® format with exhibits in the appropriate Microsoft Office ® format or portable document format (PDF) on flash drive or compact disk.

3. Seal the original proposal and all copies in a package marked, "Proposals – Do Not Open", and attach a label containing the information from the RFP cover page to the package in a clearly visible location to prevent opening by unauthorized individuals.

4. List any item in any section of this RFP or the draft contract (*Appendix A – Draft Pharmacy Benefit Manager Administrative Contract*) with which you do not agree in the Statement of Compliance, which must be signed. (See ***Section 9 Statement of Compliance***) **IMPORTANT NOTE: Clauses in bold type in *Appendix A – Draft Pharmacy Benefit Manager Administrative Contract* are required by Personal Service Contract Review Board (PSCRB) and/or DFA, and are not negotiable.**

5. Label and tab the sections of the proposal as follows:
    A. Introduction
    B. Minimum PBM Requirements Confirmation
    C. Scope of Services Confirmation
    D. Completed Performance Standards Table
    E. RFP Questionnaire with Responses
    F. Financial Proposal
    G. Resumes for Key Staff
    H. Statutory Requirement (This must be signed. See ***Section 8 Statutory Requirement***)
    I. Statement of Compliance (This must be signed. See ***Section 9 Statement of Compliance***)
    J. Acknowledgement of RFP Amendments, if any posted (This must be signed. See *Section 1.10 Acknowledgement of RFP Amendments*)
    K. Any Additional Information Not Specifically Requested
6. Failure to provide all requested information and in the required format may result in disqualification of your proposal.

Proposals must be submitted in writing to the following address:

Pharmacy Benefit Management Services RFP
c/o DFA - Office of Insurance
501 North West Street
Suite 901-B Woolfolk Building
Jackson, Mississippi 39201

In preparing your written response to any RFP question or request for information, you are required to repeat each question or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your organization does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. "Will discuss" and "will consider" are not appropriate answers. All information requested is considered important. If you have additional information you would like to provide, include it as an appendix to your proposal. In addition, each PBM will be required to re-price, based on the proposed financial terms, a claim file for a partial year of actual claims paid in 2014. The Board will use the information contained in your proposal in determining whether you will be selected for contract negotiations. The Board will consider the proposal an integral part of the contract and will expect the proposer to honor all representations made in its proposal. It is the proposer's sole responsibility to submit information relative to the evaluation of its proposal and the Board is under no obligation to solicit such information if it is not included with the proposal. The Board has no obligation to locate or acknowledge any information in the proposal that is not presented under the appropriate outline according to these instructions and in the proper location.

Failure of the proposer to submit such information in a manner so that it is easily located and understood may have an adverse impact on the evaluation of the proposal. All documentation submitted in response

to this RFP and any subsequent requests for information pertaining to this RFP shall become the property of the Board and will not be returned to the proposer.

Original signatures are required on one copy of the proposal cover letter, Statutory Requirement disclosure statement, Statement of Compliance, and Acknowledgement of RFP Amendments (if any is posted). Failure to sign these required documents may result in disqualification of the proposal.

If the Board determines that the proposer has altered any language in the original RFP, the Board may, at its sole discretion, disqualify the proposer from further consideration. The RFP issued by the Board is the official version and will supersede any conflicting RFP language submitted in proposals.

1.4 Important Dates

1/30/2015	RFP Released
2/17/2015	"Intent to Propose", "Questions", and "Non-Disclosure Agreement" Due at the DFA-Office of Insurance
2/20/2015	"Responses to Questions" Released as they are received through this date
2/27/2015	Proposals Due at the DFA-Office of Insurance by 2:00 P.M. CST
3/27/2015	Finalists Selected
Week of 4/6/2015	Presentations by Finalists*
4/22/2015	PBM Selected and Contract Award Notification
7/1/2015	Contract Executed and Implementation Commences
1/1/2016	Service Effective Date

*If deemed necessary by the Board, some proposers may be asked to make presentations in Jackson, Mississippi. You will be given sufficient notification if you are requested to make such a presentation. The Board will not incur any expense for such presentation.

1.5 Duration of Proposal

Within the introduction section of the proposal, you must state that the proposal is valid for a period of at least 180 days subsequent to the date proposals are due. The proposal shall become part of the contract in the event that the contract is awarded to your organization.

1.6 Statutory Requirement

In accordance with Section 25-15-9(1)(a) of the Mississippi Code, each entity that submits a proposal in response to this RFP must provide a **signed** disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or DFA in the development of the State and School Employees' Life and Health Insurance Plan. The statement must include a detailed description of the proposer's participation in the development of the Plan, as well as any resulting compensation received from the Board and/or DFA during the previous fiscal year. If you did not provide such assistance to the Board and/or DFA, you must indicate in your **signed** disclosure statement that this provision does not apply to you. A list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the Mississippi State and School Employees' Life and Health Insurance Plan and a copy of the statutory requirement are contained in ***Section 8 Statutory Requirement*** of this RFP.

1.7 Statement of Compliance Requirement

Please carefully review the information located in ***Section 9 Statement of Compliance*** and include a copy **signed** by an officer, principal, or owner of the organization with your completed proposal. Failure to submit a **signed** *Statement of Compliance* may result in your proposal being eliminated from further consideration.

1.8 Corrections and Clarifications

The Board reserves the right to request clarifications or corrections to proposals. Any proposal received which does not meet the "Instructions to Proposers" in *Section 1.3 Instructions to Proposers,* or the minimum PBM requirements in ***Section 2 Minimum PBM Requirements***, or comply with other proposal requirements of this RFP, including clarification or correction requests, may be considered to be "non-responsive" and may be eliminated from further consideration.

1.9 Right of Negotiation

Discussions and negotiations regarding price and other matters may be conducted with a proposer who submits a proposal determined to have reasonable likelihood of being selected for award, but proposal may be accepted without such discussions. The Board reserves the right to further clarify and/or negotiate with the proposer evaluated best following completion of the evaluation of proposals but prior to contract execution, if deemed necessary by the Board. The Board also reserves the right to move to the next best proposer if negotiations do not lead to an executed contract with the best proposer. The Board reserves the right to further clarify and/or negotiate with the proposer on any matter submitted.

1.10 Acknowledgment of RFP Amendments

Should an amendment to the RFP be issued, it will be posted on DFA's website at www.dfa.ms.gov under "Bid and RFP Notices". Proposers must acknowledge receipt of any amendment to the RFP by signing and returning the amendment form with the proposal, by identifying the amendment number and date in the space provided for this purpose on the amendment form, or by letter. The acknowledgment must be received by DFA by the time and at the place specified for receipt of proposals. It is the proposer's sole responsibility to monitor the website for amendments to the RFP.

1.11 Withdrawal of a Proposal

A proposer may withdraw a submitted proposal by submitting a written notification for its withdrawal to the Board, signed by the proposer, and faxed, e-mailed, or mailed to the Board at the address provided in ***Section 1 Introduction*** of this RFP. The Board shall not accept any amendments, revisions, or alterations to proposals after the due date unless requested by the Board.

1.12 Cost of Proposal Preparation

All costs incurred by the proposer in preparing and delivering its proposal, making presentations, and any subsequent time and travel to meet with the Board regarding its proposal shall be borne at the proposer's expense.

1.13 Proposal Evaluation

All proposals received in response to this RFP by the stated deadline will receive a comprehensive, fair, and impartial evaluation. The evaluation of any proposal may be suspended and/or terminated at the Board's discretion at any point during the evaluation process at which the Board determines that said proposal and/or proposer fails to meet any of the mandatory requirements as stated in this RFP, the proposal is determined to contain fatal deficiencies to the extent that the likelihood of selection for contract negotiations is minimal, or the Board receives reliable information that would make contracting with the proposer impractical or otherwise not in the best interests of the Board and/or the State of Mississippi.

An evaluation committee will evaluate the proposals in the following three-phase process:

Compliance Phase - In this phase of the evaluation process, all proposals received will be reviewed to determine if the following mandatory requirements of this RFP have been satisfied:

1. Intent to Propose and NDA submitted
2. Proposal submission deadline met
3. Required format followed
4. **Signed** original proposal, requested number of copies of proposal, and electronic copy of proposal in Microsoft Office® format on flash drive or compact disk
5. **Signed** Statutory Requirement disclosure statement
6. **Signed** Statement of Compliance with high degree of acceptance of contract terms
7. **Signed** Acknowledgement of RFP Amendment (only if amendment has been posted)
8. Duration of proposal requirement met
9. Minimum PBM requirements met
10. Narrative questionnaire answered
11. Required proposal attachments provided

Failure to comply with these requirements may result in the proposal being eliminated from further consideration. This phase is a pass/fail evaluation. Those PBMs passing the Compliance Phase will be evaluated further. The Board reserves the right to waive minor informalities in a proposal in this phase of the evaluation.

Analysis Phase - In this phase of the evaluation process, the evaluation committee will judge responses received relative to the cost and technical merits of each proposal. Areas are listed in order of their relative importance:

1. Pharmaceutical and Administrative Pricing – The quality and economic value of the financial arrangements including discounts, rebates, dispensing fees, and administrative fees. This will include both the financial terms submitted in ***Section 7 Financial Proposal*** of this RFP as well as the results of the re-priced claims file. ***(Critical)***

2. Clinical Programs, Quality Programs, and System Capability – The quality of the clinical programs offered, including but not limited to Drug Utilization Review (DUR), Prior Authorization, Specialty Drug Management, etc.; information system capabilities including but not limited to, claims processing, automatic edits, physician profiling, the ability to interface with the Board's existing claims administrator, data management PBM, health management PBM, and the flexibility to meet the Board's demonstrated needs; provision of local staff to assist in managing the pharmacy benefit program; demonstrated system of pharmacy audits and other fraud and abuse detection programs. ***(Critical)***

3. Experience with Large Employer Plans and Similar Plan Structures, and Participant Access – Previous experience working with large employer groups and successfully managing drug costs including demonstrated experience in performing the full range of PBM functions including network and claims administration in both a retail and mail order setting; experience in positively impacting physician and participant behavior relating to generic utilization and medication adherence; access to pharmacies for participants locally and nationwide; ability to administer various plan designs including consumer-directed type plan designs. ***(Very Important)***

4. Client and Participant Service, and Reporting – Demonstrated competence in providing quality customer service; ability to provide meaningful reporting on a consistent basis that assists the Board in managing and improving its pharmacy benefit program. ***(Very Important)***

Finalist Phase - In this phase of the evaluation process, references will be contacted and service provision verified. During the reference verification, the evaluation committee will seek to verify demonstration of an acceptable level of performance for programs similar in size and complexity to the Plan. This phase may also include finalist presentations, if deemed necessary by the Board. Finalist presentations will include technical interviews to be conducted in Jackson, Mississippi, to allow finalists the opportunity to showcase their services and their systems. Likewise, Board members, consultants, and staff may use this opportunity to verify information provided by the proposer in the submitted proposal. The Board may also conduct site visits during this phase of the evaluation process, if deemed necessary to develop a comprehensive assessment of proposals.

Subsequent to approval by the Board to enter into contract negotiations with the selected PBM, all proposing PBMs will be notified of the contract award.

1.14 Post-Award Vendor Debriefing

Pursuant to PSCRB Rules and Regulations Sections 7-112 through 7-112.07, the PBM may request a post-award debriefing, in writing, by U. S. mail or electronic submission. The request must be made within three (3) business days of notification of the contract award. A debriefing is a meeting and not a hearing; therefore, legal representation is not required. Should the PBM prefer to have legal representation present, the PBM must notify the DFA and identify the attorney. The DFA shall be allowed to schedule and/or suspend and reschedule the debriefing at a time when a representative of the Office of the Mississippi Attorney General can be present. For additional information regarding the process and procedure for the Post Award Debriefing, please refer to the PSCRB Rules and Regulations that may be found at www.mspb.ms.gov

1.15 Mississippi Public Records Act/Confidentiality of Proposals

Any proposal, including accompanying attachments, will be available for review by State of Mississippi personnel, the Board, members and staff of the Legislature and oversight boards, and the Board's consultants. The proposal is further subject to the "Mississippi Public Records Act of 1983," codified as Section 25-61-1 et seq., Mississippi Code Annotated and exceptions found in Section 79-23-1 of the Mississippi Code Annotated. The Board understands that the proposer may consider some of the information provided in the proposal to be proprietary.

The Board requests that each page of the proposal that proposer considers confidential be on a different color paper than non-confidential pages and be marked in the upper right hand corner with the word "CONFIDENTIAL." Failure to clearly identify trade secrets or confidential commercial or financial information will result in that information being released subject to a public records request.

"Mississippi Public Records Act of 1983," codified as Section 25-61-1 et seq., Mississippi Code Annotated and exceptions found in Section 79-23-1 of the Mississippi Code Annotated provides that proposer can request that prior to the release of any information that proposer will be notified by the Board of the request for the information and given sufficient time to seek protection from the appropriate court. If proposer does not obtain protection from the appropriate court, all information supplied whether marked confidential or not, may be released. The Board will accept no additional restrictions on the release of information contained in a proposal.

1.16 Right to Consider Historical Information

The Board reserves the right to consider historical information regarding the proposer, whether gained from the proposer's proposal, conferences with the proposer, references, or any other source during the evaluation process. This may include, but is not limited to, information from any state or federal regulatory entity.

1.17 Right to Reject, Cancel and/or Issue another RFP

The Board specifically reserves the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or issue another RFP.

Section 2. MINIMUM VENDOR REQUIREMENTS

The following minimum vendor requirements are mandatory. Failure to meet any of these requirements will result in disqualification of the proposal submitted by your organization. This section of your proposal should be located after the introduction and before the confirmation of the scope of services.

Please respond by restating each requirement listed below with documentation that proves specifically how your organization meets that requirement. Please include in your responses the total number of years and types of experience of your organization. If, in the opinion of the evaluation team, you fail to prove that your organization meets any of these minimum requirements, your proposal will be disqualified from further evaluation. You will be notified if your proposal is disqualified, and you will have an opportunity to provide additional information to prove your organization does meet the minimum requirements.

1. The PBM must provide services to at least one million (1,000,000) covered lives in its book of business as of January 1, 2015. Please indicate how you meet this criterion.

2. The PBM must provide services to one employer client with at least one hundred thousand (100,000) covered lives as of January 1, 2015. Please indicate how you meet this criterion, including the employer name, address, contact, title, phone number, fax number, size of group, and number of years the contract has been in place with your organization.

3. The PBM must have at least eight years' experience as of January 1, 2015, in providing the type and scope of services to be procured through this competitive process. Please indicate how you meet this criterion.

4. The PBM must agree to secure an implementation bond or escrow account in the amount of one million dollars ($1,000,000) naming the Board as exclusive beneficiary to guarantee timely and complete establishment of the contract and related services. Such bond or escrow account must be secured within thirty (30) days of the date the contract is executed. Any failure of the PBM to perform timely and complete establishment of such services shall result in damages recoverable by the Board against the PBM's implementation bond or escrow account. Upon the Board's agreement that the PBM has complied with its responsibilities for establishing the pharmacy benefits management program and related administrative services, the implementation bond or escrow account shall be released. This requirement will not apply if the incumbent PBM with services established under the current contract is selected through this procurement process to enter into negotiations for the new contract. Please indicate your agreement to this requirement.

5. Please confirm your agreement to comply with Mississippi Code § 25-15-301(6) as follows:

   "Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the board or participant, or both. Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall allow, upon notice by the board, the board or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the board. The information maintained by any corporation, association, company

or individual, relating to such contracts, shall be available for inspection upon request by the board and such information shall be compiled in a manner that will provide a clear audit trail."

6. All services directly related to the required pharmacy benefits management services must be performed within the United States. Indicate your agreement with this requirement and identify any locations outside the State of Mississippi in which you propose to provide the services described in this RFP.

Section 3. SCOPE OF SERVICES

This section contains information on services and procedures that the PBM must provide or adhere to in servicing the Board's account. The descriptions are not all-inclusive, but are provided to alert you to services or procedures that may require additional planning or programming on your part. A description of the Plan's current prescription drug co-payment program is included in *Appendix B – 2015 Plan Document*.

The following is a list of services the Board expects the successful proposer to provide. Please respond by restating each service listed below, confirm your intention to provide the service, and where appropriate, describe specifically how your organization will provide the service. If your organization is currently unable to provide a listed service, please explain why, and/or how your organization proposes to accomplish the purpose of that service. This section of your proposal should be located after the minimum vendor requirements and before the performance standards.

3.1 Account Service

1. The PBM must assign a dedicated, but not necessarily exclusive, account manager to participate in activities relative to all aspects of the contract between the Board and the PBM, and to meet with the Board on a quarterly basis to review Plan utilization, attend the Board's monthly meetings, and make recommendations regarding services and/or programs on a quarterly basis.

2. The PBM must assign a minimum of one dedicated and exclusive clinical pharmacist to participate in activities relative to all aspects of the contract between the Board and the PBM, and to meet with the Board on a quarterly basis. Duties of the clinical pharmacist will include, but are not limited to, providing advice regarding drugs for which the Plan may require prior authorization for coverage, notification of blockbuster or pipeline drugs, FDA approval of new drugs, and education regarding therapeutic substitutions. The dedicated pharmacist must also reside in the State of Mississippi to participate in employer health/benefit fairs, and visit physician offices and pharmacies to discuss the preferred drug list, use of generics, prescribing and utilization patterns, and educate the provider community on the most up-to-date drug therapies.

3. The PBM must provide consultative services regarding pharmacy benefit design including, but not limited to, formularies, allowable charges, generic drug incentives, implementation of programs which control utilization and optimize health, utilization review services, and evaluation of drug use and cost data.

4. The PBM is responsible for maintaining an adequate customer service staff to respond to inquiries from participants, providers, and the Board regarding the services provided by the PBM through a toll free telephone line. The service shall be available 24 hours, 7 days a week, other than scheduled maintenance times, to participants and providers.

5. The PBM is required to conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM.

6. The PBM is required to participate in activities with the medical claims administrator and/or the Board in responding to participant or provider inquiries or complaints relating to pharmacy benefit services.

7. The PBM is required to participate in a minimum of fifty (50) health/benefit fairs per year to educate participants.

8. The PBM must cooperate with the Board and with all other contractors of the Board with respect to the ongoing coordination and delivery of health care services, and in any transition of responsibilities.

3.2 On-Line Access for Board Staff

The PBM must provide to Board staff read-only access to its claims processing and eligibility system. Access by the Board's staff must include, at a minimum, review of participant claims history and participant eligibility information.

3.3 Pharmacy Network Service

1. The PBM is responsible for the delivery of quality prescription drug services to participants through discount arrangements or other financial contracts with participating pharmacies. The PBM must maintain a pharmacy re-credentialing process at least every two years.

2. The PBM is required to maintain separate credentialing requirements for specialty and compound pharmacies.

3. The PBM is required to provide on-line access to a directory of participating pharmacies, including their names, addresses and telephone numbers. Participating pharmacy information must be regularly maintained and updated.

3.4 Staffing

The PBM will hire and maintain sufficient staff to meet the needs of the Board and the participants.

3.5 Communication Materials/Forms

The PBM, at its own cost, is responsible for designing, printing, and distributing brochures, preferred drug lists, and forms, co-branded, and with the Board's approval, as necessary and required to establish and administer pharmacy services and programs. Communication materials/forms will be mailed to participants, employer units, and the Board. The Board will reimburse the PBM for the actual design costs for any specially customized materials that are requested.

3.6 Identification Cards

The PBM, at its own cost, must provide routine distribution of ID cards, including printing, mailing, and postage. The PBM, at its own cost, will provide ID cards directly to the participant's home address for (1) the initial enrollment of the Plan, (2) future new enrollees, (3) participants who change coverage category (e.g. single to family), and (4) replacement of lost cards. Participants with

single coverage should receive one (1) ID card; participants with dependent coverage should receive two (2) ID cards. The information to be printed on each ID card will include, at a minimum, the participant's name and identification number, Plan name, the PBM name and toll free customer service telephone number.

3.7 Data Transfers and File Maintenance Requirements

1. The selected PBM will receive updated eligibility information from the Board's medical claims administrator. It is the PBM's responsibility to coordinate the data transfer with the Board's medical claims administrator to ensure an efficient and accurate process. The PBM is also responsible for the electronic transfer of prescription drug claim information to the Board's medical claims administrator for purposes of coinsurance maximum, out-of-pocket limit, and deductible accumulation.

2. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's health management PBM, and for accepting the electronic transfer of information from the Board's health management PBM relative to enrollment in the Plan's tobacco cessation program or other programs that may require special pharmacy benefits. The Board currently contracts with ActiveHealth Management, Inc. for health management services.

3. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's decision support services PBM. The Board currently contracts with Truven Health Analytics Inc. for decision support services.

4. The PBM may be responsible for the electronic transfer of prescription drug claim information to the Board's healthcare transparency PBM. At the time of this writing, a PBM has been selected to provide these services, but no contract is place.

3.8 Claims Processing Services

1. The PBM's claims processing services must include, at a minimum, verification of eligibility, review of claims in accordance with the Plan benefits, receipt, processing, adjustment, and authorization of claim payments, provision of claim forms, and provision of explanation of benefit (EOB) forms for paper claims.

2. The PBM must maintain, at a minimum, the following information for all claims: participant name, participant identification number, patient name or other specific identifier, claim number, pharmacy number, pharmacy name, service date, mail/retail indicator, formulary flag, specialty indicator, ingredient cost, dispensing fee, sales tax amount, plan paid amount, co-payment amount, NDC, drug name.

3. The PBM must be able to accommodate multiple plan designs such as the Plan's current Base Coverage and Select Coverage as described in *Appendix B – 2015 Plan Document*, and must be able to process claims with a deductible that is integrated with the medical plan deductible (i.e. Base Coverage).

3.9 Federal Reporting

The PBM is responsible for the distribution of 1099 forms for providers to the extent required by Federal law. As required by Federal law, the PBM, after discussions and negotiations with the Board, will prepare and file reports required by the Federal Government.

3.10 Coordination of Benefits

The PBM is responsible for providing coordination of benefits (COB) services. The medical claims administrator provides information regarding a participant's COB status to the PBM. The PBM must reject primary payment for participants for whom the Plan is secondary and must provide for secondary payment of prescription drug claims, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims, are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable co-payment for that prescription drug. Any additional cost for this service must be included in the financial proposal.

3.11 Quality Control

The PBM is responsible for quality control processes to regularly evaluate the performance and accuracy of the claims processing systems and the claims processing staff. Findings of quality control evaluations will be provided to the Board.

3.12 Appeal Resolution

The PBM is responsible for administering an appeal process for claims partially or fully denied for payment upon the request of a participant or provider in accordance with guidelines outlined in the Plan Document.

3.13 Prior Authorization Program

The PBM must provide prior authorization services to promote cost management while ensuring that participants can access needed prescription drugs. The prior authorization program must use evidence-based guidelines and the latest clinical literature and outcomes data, as well as FDA guidelines. The PBM will advise DFA regarding those drugs for which the Plan may benefit by requiring prior authorization for coverage. The PBM's staff, under the supervision of clinical pharmacists, will review participant prescriptions for those drugs requiring prior authorization and/or medical necessity review in accordance with criteria, definitions and procedures developed by the PBM.

3.14 Management Reporting

The PBM must provide management reports with content and in a format approved by the Board. These reports will be provided, at the Board's request, in a hard copy and/or electronic format. The PBM must provide assigned Board staff access to web-based reporting tools for management and other reports. The PBM is also expected to have the capability of providing ad hoc reports at the Board's request.

3.15 Drug Utilization Review (DUR)

The PBM is required to provide a concurrent, prospective and retrospective DUR system to assist pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems at the time the prescription is dispensed to the participant. The DUR program must provide an evaluation of drug therapy before each prescription is filled by means of an online, real-time, electronic point-of-sale claims management system. Evaluation must include, at a minimum, monitoring for therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, and screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, physician profiling, and clinical abuse/misuse and, as necessary, introduce remedial strategies in order to improve the quality of care of the participant.

3.16 Step Therapy

The PBM is required to provide a step therapy program designed to optimize rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history.

3.17 Dosage Optimization

The PBM is required to provide a dose optimization program designed to slow the rising cost of prescription drugs and help increase patient compliance with drug therapies. As part of the dose optimization program, the PBM must work with the participant, the health-care provider and pharmacist to replace multiple doses of lower strength medications with a single dose of higher-strength medications where appropriate.

3.18 Medication Adherence Program

The PBM is required to provide a comprehensive pharmacy care program to improve medication adherence for participants with chronic conditions. As part of the medication adherence program, the PBM will provide telephonic coaching that will involve calls to participants from a health educator who is specially trained in the chronic condition. The calls will involve coaching participants on behavioral reinforcement strategies that will help them to continue taking their medications on schedule; calls will also include specially tailored education for the chronic condition. Doctors will receive written educational information on the rates of medication adherence, implications of non-adherence, and methods for improving adherence. Doctors will also receive alerts on participants who are not filling their medication prescriptions.

3.19 Quantity Limits

The PBM is required to provide a limitation program for drugs which are indicated only for a specific therapeutic period or are limited to certain amounts. If, based on on-line adjudication, the quantity of a covered drug is not approved by the PBM, the prescribing physician must be allowed to contact the PBM for prior approval of additional quantities based on documentation of medical necessity.

3.20 Early Refill

The PBM is required to process requests from participants, pharmacists, and providers for early refills or advance supplies of a medication due to vacations, dosage changes, or for lost or destroyed medication.

3.21 Website

1. The PBM will develop and maintain a searchable public website that contains at a minimum:
   A. A current provider directory
   B. Ability to conduct a zip-code based pharmacy proximity search
   C. Claim forms for both primary and secondary coverage
   D. On-line mail order refill capabilities
   E. Mail order forms
   F. Formulary or preferred drug list
   G. Alternative drug price check functionality
   H. Research drug interactions, side effects, and risks of drugs
   I. Determine the availability of generic substitutions
   J. Health/wellness information
2. The website must be accessible to participants and providers with no access restriction or registration requirement except for those functions which allow for review of a participant's prescription claim history, or that include other forms of personal health information.

3.22 Field and Desk Audits

Pharmacy field and desk audit services must be included in the administrative fee, and the PBM must provide an annual report of audit activities and findings. Any errors will be addressed and corrected in a timely manner by the PBM. Any amounts recovered due to a field or desk audit will be 100% refunded to the Board.

3.23 Specialty Medication and Supplies

The PBM is required to provide prescription fulfillment and distribution of specialty medications and supplies, pharmaceutical care management services, customer service, utilization and clinical management, integrated reporting, and claims processing. The specialty medication program must include, at a minimum, patient profiling focusing on the appropriateness of specialty medication therapy and care, and the prevention of drug interactions. The program must also include patient education materials, patient monitoring, adherence programs, and compliance programs. Programs such as drug utilization review, drug limitation (step therapy, quantity and supply limits) and prior authorization services must be extended to the specialty medication program. Channel distribution (retail, specialty mail pharmacy) must be optimized for plan and participant savings. The specialty drug program must comply with the State's "any willing provider" statutory requirements (Section

83.9.6 subs 3(b)). Note: An exclusive central fill distribution channel is not acceptable.

Specialty medications must be deliverable to the participant's residence or the participant's physician's office. The PBM must provide to participants a toll free telephone access to a registered nurse, pharmacist, or patient care coordinator (as appropriate) twenty-four (24) hours per day, seven (7) days per week.

3.24 Mail Order Services

1. The PBM must make available a mail order prescription drug program to process and dispense covered prescription drugs. Programs such as drug utilization review, drug limitation, and prior authorization services must be extended to mail order services and must be consistent with the retail channel.

2. The PBM's mail order service must provide to participants toll free telephone access to a pharmacist and customer service representative twenty-four (24) hours per day, seven (7) days per week.

3. Discounts provided on mail order claims should meet or exceed those of retail.

3.25 Annual Explanation of Benefits

As an optional service, the PBM must be capable of providing an annual on-line explanation of benefits (EOB) to each participant utilizing the prescription drug program. The purpose of the annual EOB is not only to provide the participant with a complete list of prescription drugs processed through the prescription drug program, but to educate the participant regarding potential savings based on therapeutic and generic substitutions, dosage optimization, etc. At a minimum, the explanation of benefits should include:

1. Name and Address of PBM

2. Toll Free Number for PBM

3. Participant's Name and Address

4. Participant's Identification Number

5. Patient's Name

6. Provider Name

7. Claim Date of Service

8. Type of Service

9. Total Charges

10. Discount Amount

11. Allowed Amount

12. Excluded Charges

13. Amount Applied to Deductible

14. Co-Payment or Coinsurance Amount

15. Total Patient Responsibility

16. Total Payment Made and To Whom

3.26 Rebates

Rebates are defined as any amounts received directly or indirectly by the PBM, regardless of the title or description, whether by cash, credit or other in kind methodologies arrived from or attributable in any way to the Plan's utilization. The Board shall be entitled to receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates received by the PBM attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. Any such intermediary shall pay to the PBM all amounts it receives through its own intermediary or pharmaceutical manufacturer agreements that are directly attributable to prescription drug claims paid by the Board. The intermediary will pay the PBM 100% of the rebates it receives, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). With regard to rebates received by the PBM from any intermediary, the Board shall have audit rights to ensure compliance by the PBM and its intermediary with transparency and rebate submission requirements. The PBM will ensure that, to the extent that the Plan's prescription drug purchases are included, any agreement the PBM now has, or subsequently enters into with an intermediary for rebate collection, contain sufficient language to provide the Board free and direct audit access to the financial records, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the Transparency requirement is being met by the PBM and the intermediary. Any fees or cost associated with rebates administration should be included in the PBM's bundled administration fee.

3.27 Transparency

1. The Board is seeking a transparent financial pricing arrangement from the PBM. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts & dispensing fees, etc.). The Board must receive the full and complete amount of any discounts received by the PBM from any and all retail pharmacies. The PBM will not retain a differential (i.e. spread) between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM.

2. The Board will not apply the above standard to mail order or specialty pharmaceutical transactions when owned by the PBM. For these mail order or specialty pharmaceuticals, the Board will accept the best possible discount arrangements from the PBM as it relates to a

discount from AWP. Rebates generated through mail order or specialty pharmaceuticals will be subject to the transparency requirement described below.

3. The Board must receive all rebates received by the PBM attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers. A "rebate" will include any amounts received directly or indirectly by the PBM, regardless of title or description, whether by cash, credit or other in kind methodologies attributable to the Board's utilization.

4. The only compensation the PBM will receive from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal or agreed upon in writing through subsequent discussion with the Board.

3.28 Full Disclosure and Independent Review

The Board must have access to all of the PBM's financial records including the Maximum Allowable Cost (MAC) list used to adjudicate the Board's claims, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the transparency requirement is being met by the PBM during the period covered by the contractual term. Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

1. Any amount paid for the Plan by the PBM to retail pharmacies under contract with the PBM's retail network is subject to audit even though the PBM may deem said contracts proprietary and confidential;

2. Fees, which include administrative fees, paid to the PBM by pharmaceutical manufacturers are subject to review for audit purposes;

3. Any amount paid for the Plan by the PBM to a mail order or specialty pharmacy, when not owned by the PBM, will be subject to audit, whether or not the contract is considered proprietary and confidential by the PBM;

4. Discounts negotiated directly by the PBM with manufacturers shall be subject to audit; and

5. Aggregate rebate collecting, reporting, and contractual arrangements.

The Board, at its discretion, may use the services of an independent reviewer to perform reviews/audits of the PBM's records on behalf of the Board. The Board and its independent reviewer will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board has the right to review/audit records for the entire term of the agreement without limitation up to two times per calendar year. Any claims information, documents, etc. which the PBM may deem as containing "trade secrets" will not preclude an examination of such items through the audit process. The PBM will provide the Board assistance in the audit reviews by providing access to records, copies of claims data, access to reasonable support staff, etc. at no cost to the Board. The PBM will cooperate with the independent reviewer and agree to respond to any inquiries by the independent reviewer within 45 days. The PBM will not restrict the size of the claims sample reviewed by the independent reviewer which may include a review of

100% of all claims for the period under review. The Board will bear the cost of any fees charged by its independent reviewer.

3.29 Market Checks

The Board may perform, or have performed on its behalf, following the eighteenth (18th) month of the effective date services being provided and annually thereafter, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions.

If the Board or its designee provides the PBM with a written report conducted by a third party audit firm that takes into account, in the aggregate, the general plan design, formulary, clinical and trend programs utilized by the Board, participating network, utilization, and demographics for generally comparable plans that indicate a 1% or greater savings, the PBM will have the opportunity to respond, within thirty (30) days of receipt of the third party auditor market assessment, with a proposed amendment to the contract for new pricing terms that are mutually agreed upon and implemented no later than sixty (60) days after the third party audit firm report is completed and provided to the PBM. If the parties cannot come to agreement on the new terms, the Board reserves the right to terminate the contract with 120 days advance notice without penalty.

Section 4. PERFORMANCE STANDARDS

Your organization must agree to abide by the performance standards specified below. The Board reserves the right to reduce or waive any fees at risk if, in the Board's sole discretion, failure to meet a performance standard was due to extraordinary circumstances.

Please respond by completing the "Fees at risk" column of the following table. This section of your proposal should be located after the scope of services and before the responses to the questionnaire.

Performance Standard Topic	**Description of Standard**	**Standard**	**Fees at risk ($ or % of admin fee).**
Pharmacy Network Access	95% of all participants within 5 miles of 1 participating pharmacy	95%+	
Network Pharmacy POS Compliance	99% of time internal on-line system available Measurement Period: Quarterly	99%+	
Retail Paper Claims Processing Time	95% of prescriptions reimbursed or responded to within 15 business days of receipt Measurement Period: Quarterly	95%+	
Retail Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct co-payment, or correct deductible). Retail claims adjudication accuracy is the total number of retail claims paid correctly divided by the total number of retail claims paid. Measurement Period: Quarterly	99.5%+	
Mail Order Claims Processing Time	95% of prescriptions requiring NO intervention to be shipped within 2 business days (as measured from date order received at the PBM to date order shipped) 95% of prescriptions requiring administrative or clinical intervention to be shipped within 5 business days (as measured from date order received at the PBM to date order shipped) Measurement Period: Quarterly	95%+ within 2 business days 95%+ within 5 business days	
Mail Order Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct co-payment, or correct deductible). Mail order claims adjudication accuracy is the total number of mail order claims paid correctly divided by the total number of mail order claims paid. Measurement Period: Quarterly	99.5%+	

Performance Standard Topic	Description of Standard	Standard	Fees at risk ($ or % of admin fee).
Rebate Remittance Time	100% of all rebate dollars received by the PBM remitted to the Board within 60 days after the last calendar day of the quarter in which such rebates were received. Measurement Period: Quarterly	100% of all rebate dollars within 60 calendar days after the last calendar day of the quarter in which such rebates were received	
Customer Service	90% of calls answered by a live customer service representative within 30 seconds during open hours <5% of calls abandoned 100% of written inquiries responded to within 10 business days Measurement Period: Quarterly	90%+ <5% 100%	
Account Service	Subjective satisfaction of Board with the contractual and administrative relationship based on mutually agreed satisfaction survey. Measurement Period: Annually	Satisfied	$40,000 at risk
ID Card Distribution	95% of ID cards mailed within 15 days of receipt of eligibility data (for monthly changes) or request for replacement card Average time to mail ID cards for ongoing eligibility (from the clean eligibility information provided) is ≤ 5 business days Measurement Period: Quarterly	95%+ ≤ 5 business days	
Reporting Requirements	Quarterly reports provided to Board ≤ 30 calendar days after the end of the quarter Measurement Period: Quarterly	No more than 30 calendar days after the end of the quarter	

Section 5. QUESTIONNAIRE

5.1 General

1. State the full name of your organization and describe its structure, including your main and branch offices, and the average number of employees for 2014. Provide the address of the main office, and if different, the address of the office that will provide the proposed services for the Board. Please provide your organizational structure. Indicate whether your organization operates as a corporation, partnership, or individual. If it is incorporated, include the state in which it is incorporated. List the name and occupation of those individuals serving on your organization's Board of Directors.

2. List the name of any entity or person owning 10% or more of your organization. Indicate if any of the above are pharmaceutical manufacturers and their percent of ownership.

3. Please describe any restructuring, mergers, and/or downsizing that occurred within your organization over the past 24 months.

4. Please describe any anticipated major changes to your organizational structure, ownership, etc. in the next 12-24 months.

5. Is your organization licensed or authorized to provide the proposed services in the State of Mississippi?

6. Provide the name, title, address, e-mail address, telephone number and facsimile number of the contact person for this RFP.

7. Describe the qualifications and experience of key staff who will be responsible for providing the proposed services to the Board. Include copies of their resumes as an appendix to your proposal.

8. State if the proposed account manager, any officers or principals and/or their immediate families are, or have been within the preceding 12 months, employees of the State of Mississippi.

9. Please provide a brief description of any outside PBMs or subcontractors that will be involved in providing key services detailed throughout your proposal. Please include the term of your current contract with each PBM or subcontractor. Describe the nature of the relationship with the subcontractor, including any ownership interest.

10. List your organization's accreditation or service/quality ratings, including year obtained and certification duration if applicable.

11. Mississippi law requires that the PBM shall cooperate with all other contractors of the Board in the ongoing coordination of health plan services and in any transition of responsibility. Confirm that you will comply with this requirement.

12. Confirm that your organization is not presently debarred, suspended, proposed for debarment,

declared ineligible or voluntarily excluded from covered transaction by any federal department or agency, or by any political subdivision or agency of the State of Mississippi.

13. Has your organization ever been involved in a lawsuit involving any area covered by this RFP? If yes, provide details including dates and outcomes.

14. During the past five years, has your organization, related entities, principals or officers ever been a party in any material criminal litigation, whether directly related to this RFP or not? If so, provide details including dates and outcomes.

15. Has your organization been cited or threatened with citation within the last three years by federal or state regulators for violations of any federal, state, or local law or federal, state or local regulation? If the answer is yes, please describe the circumstances in detail.

16. Has your organization had any HIPAA breaches or incidents examined for potential HIPAA breach within the last three years? If the answer is yes, please describe the circumstances in detail.

5.2 Network Operations

Participant Access

Note: *Responses to the questions below should reflect only those pharmacies currently under contract with your network and not include projections for future growth or expansion. If more than one network is proposed, address each question separately relative to each network. Refer to* Appendix F - Top 50 Pharmacies Utilized by Participants *for a listing of the top 50 pharmacies utilized by participants.*

17. Do you have an operating network of pharmacies in Mississippi? When was it established? How many pharmacies are currently under contract in Mississippi? If you are proposing multiple networks, provide information for each separately.

18. Please provide an electronic copy of your directory of participating pharmacies in the State of Mississippi for each network proposed.

19. Do your networks typically use chain or independent pharmacies or both? Provide a listing of chains included and excluded from your proposed network for the Board. List the percentage of chain pharmacies in your network and a percentage of total pharmacies in network.

20. Do you charge any fees to pharmacies for participation in your network? If yes, please describe the nature of the fees and provide the amount of the fee charged.

21. Do you charge pharmacies transaction fees, directly or indirectly (e.g., "click" or "switch" fees) for submitting claims to your organization? If so, please describe all such fees, including any differences between paid and rejected claim submissions, and the fees you receive from retail pharmacies for this arrangement.

22. How would your network provide PBM services to out-of-state retirees and other out-of-area plan participants?

23. Do you offer more than one pharmacy network? If so, briefly compare and contrast the networks offered as they relate to number of pharmacies, excluded chains, discounts and fees.

24. Based on the census information contained in *Appendix D – Census Information*, prepare a Geo-Access® or similar report indicating provider access based on one (1) pharmacy within 15 miles, 10 miles and 5 miles for the entire Plan population for the network you are proposing for the Board.

25. Based on the census information contained in *Appendix D – Census Information*, please summarize your provider access for pharmacies currently under contract for the network you are proposing for the Board, in aggregate, for the State of Mississippi based on one (1) pharmacy within 15 miles, 10 miles and 5 miles.

26. Provider Access – 1 pharmacy

State of Mississippi	15 Miles	10 Miles	5 Miles
Aggregate Access	_____%	_____%	_____%

Quality Control

27. What are the criteria for acceptance of a pharmacy into your network?

28. How often do you re-credential pharmacies in your network? Describe the credentialing and re-credentialing process.

29. How often do you physically visit your network pharmacies? Which elements of performance are audited?

30. Describe your pharmacy network auditing programs and services, clearly indicating how frequently the program is run and the process to investigate any findings that are deemed potentially fraudulent. Also describe all programs (and interventions) available for retail, specialty, and long term care pharmacy networks to:

    A. Identify potential abuse patterns by participants

    B. Identify over-prescribing by doctors

    C. Identify potential fraud by dispensers and/or participants

31. Describe ongoing assessments used to monitor quality and performance of pharmacies in the network.

32. Do you agree to accept responsibility for collecting overpayments from the retail pharmacy if the pharmacy charges more than the contracted price for any and all prescription drug claims, and reimbursing the Board for any overpayments?

33. Do your network contracts include any incentives for retail pharmacies regarding the dispensing of generics or preferred products?

Mail Order Operations

34. Does your organization provide a mail order program? If so, please describe.

35. List all of your mail order and specialty facilities (include pharmacy name, location, length of operation, average fill accuracy for 2013 & 2014, facility prescription capacity and current volume).

36. Do you own mail order facilities or contract with another PBM? If contracted, how long has this relationship been in place?

37. Describe by what methods your mail order pharmacy is able to accept prescriptions (e.g. mail, fax, phone, email, e-prescribing, etc.).

38. What delivery service does your mail order use to deliver prescriptions? Do you offer alternative delivery options (e.g. priority overnight, etc.)? If so, what is the cost of these services?

39. Describe your process for transitioning a client from an existing mail order facility to your facility.

40. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does the PBM handle prescriptions returned by the participants?

41. Describe your process for notifying participants of the expiration date of their current script, next refill date, number of remaining refills, prescriptions not on formulary, generic substitution availability, etc.

42. Describe any programs for participant outreach to encourage switching of maintenance drug prescriptions to mail order from retail, or for optimization of savings for both the plan and participant.

43. Do you apply MAC pricing for mail order drugs? If so, is it the same as retail?

44. Describe your mail order "auto fill" program, if one is available. Describe the day supply refill metric to manage the "auto-fill" program and controls in place to avoid wastage or stockpiling?

45. Describe the type and frequency of reports routinely provided to your clients relative to your mail order pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.

Specialty Operations

46. Does your organization provide a specialty pharmacy program?

47. How do you define a specialty drug?

48. List all of your specialty facilities (include pharmacy name, location, length of operation, average fill accuracy for 2013 & 2014, facility prescription capacity and current volume).

49. Do you own the specialty pharmacy or contract with another PBM? If contracted, how long has this relationship been in place? Identify the location(s) of the specialty pharmacy facility (if specialty drugs are dispensed from separate facilities) that will primarily service the Board.

50. What delivery service does your specialty program use to deliver prescriptions? Do you offer an alternative delivery options (e.g. priority overnight, etc.)? If so, what is the cost of these services?

51. Describe your process for transitioning a client from an existing specialty pharmacy to your facility.

52. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does the PBM handle prescriptions returned by the participant?

53. Describe your process for notifying participants of expiration date of their current script, next refill date, number of remaining refills, prescriptions not on formulary, generic substitution availability, etc.?

54. Describe any programs for participant outreach to encourage switching specialty medications for optimization of savings for both the plan and participant.

55. Do you apply MAC pricing for any specialty drugs?

56. Describe your "auto fill" program, if one is available. Describe the day supply refill metric to manage the "auto-fill" program and controls in place to avoid wastage or stockpiling?

57. Does the specialty pharmacy contact the participant prior to shipping each prescription to ensure medication is still required?

58. Describe the shipping process and quality controls utilized by the specialty pharmacy to assure stability of temperature sensitive medications.

59. Can specialty be shipped directly to the doctor's office for administration?

60. Describe any initiatives your organization has that are designed to assist plan sponsors in lowering the cost of specialty drugs dispensed or administered in the doctor's office and reimbursed through the medical plan?

61. Describe your ability to monitor and align specialty utilization between the medical and pharmacy channels, including assessing, monitoring, and optimizing participant cost sharing and clinical rule parity.

62. What chronic diseases are managed through your specialty pharmacy program?

63. Describe your specialty pharmacy program including the frequency of contact, telephonic and other, with patients and physicians, the qualifications of staff, etc.

64. Describe how your specialty pharmacy program manages the appropriate dispensing of medications to minimize the waste of prescription drugs. Does your specialty pharmacy have any cycle management programs for potentially toxic medications, that would include aspects such as enhanced communication, adverse drug event monitoring, therapy response monitoring, participant's adequate supply monitoring, new start partial fill (to increase adherence and potential cost savings), adherence monitoring, and physician outreach to corroborate doses taken, dosage changes, side effects experienced, and pharmacist recommended interventions.

65. Describe the type and frequency of reports routinely provided to your clients relative to your specialty pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.

66. Describe your strategy for controlling the increasing cost of the specialty medications.

Compounding Operations

67. Does your organization provide a compounding pharmacy program? How do you define compounding medications?

68. List all of your compounding pharmacies (include pharmacy name, location, length of operation, average fill accuracy for 2013 & 2014, facility prescription capacity and current volume). Do you own compounding pharmacy facilities or contract with another PBM? If contracted, how long has this relationship been in place?

69. Describe any initiatives your organization has that are designed to assist plan sponsors in lowering the cost of compounding medications?

70. Describe the type and frequency of reports routinely provided to your clients relative to your compounding pharmacy program.

5.3 Plan Design and Formulary Management

71. Please describe your formulary development process. Is your formulary approved by a committee? If so, provide the committee profile including the profession of each participant.

72. How often is your formulary updated? Would you be willing to establish a formulary specific to the Board's program? Please provide your recommended formulary in an electronic format as an appendix to your proposal.

73. Do you have a "preferred list" in addition to your full formulary? If so, provide this information. Describe the process and criteria used for selecting "preferred" drugs. Provide your recommended preferred drug list in an electronic format as an appendix to your proposal. Each drug listed should also contain the appropriate 11-digit NDC code.

74. To what extent do you use evidence-based effectiveness studies in the development of your preferred drug list(s)? What are the sources of research used?

75. Do you have any programs designed to increase generic utilization? If yes, please describe.

76. Will you agree to grant the Board prior notice for the addition or deletion of drugs from the Board's prescription drug formulary or preferred drug list?

77. Can you administer a plan design where the participant is reimbursed 100% for the lowest cost drug in a therapeutic class and then must self-pay the variance between the lowest cost drug and all other drugs in the therapeutic class?

78. Can you administer a plan design where the participant's cost for a multi-source brand drug is the generic co-pay plus the difference in cost between the generic and brand drug?

5.4 Client/Participant Services

79. Describe your customer service structure for clients and participants for all programs (i.e., mail order, specialty drugs, and prior authorization). Include organization, hours and days of operation, staffing, and training.

80. Would you be willing to assign a dedicated, but not necessarily exclusive, customer service representative team to the Board's account? If not, how many additional clients would the customer service representative routinely handle? What is the average size (in covered lives) of the accounts?

81. Confirm that participants have access to a toll-free number for claim/participant services inquiries. Provide the hours the toll-free number is staffed. How will after-hours calls be handled? Confirm that your proposal provides a fee quotation for supplying this service.

82. The Board requires that you assign a dedicated, but not necessarily exclusive, account manager to meet with the Board on a quarterly basis to review Plan utilization, attend the Board's monthly meetings, make recommendations regarding services and/or programs on a quarterly basis, to discuss performance, address administration issues and review reports. Please confirm that you agree to this.

83. Confirm you are willing to assign one (1) dedicated and exclusive pharmacist residing in the State of Mississippi to visit physician offices and pharmacies and participate in health/benefit fairs?

84. What services are available to accommodate special populations, including non-English speaking, hearing and vision impaired, and the elderly?

85. Does your organization conduct satisfaction surveys of participants? How often? Would you be willing to customize this survey for the Board? Please provide a sample of the most recent survey and the results. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee.

86. Does your organization provide communication/patient education materials to participants? How often? Would you be willing to customize these materials for the Board? Please provide a sample of the most recent communications release. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee, including the cost of mailing any communication materials to participant home locations.

87. Confirm that you are willing to develop and maintain a website as described in the ***Section 3 Scope of Services***. Please provide a web address to view as an example of the website you propose for the Board. The Board does not require that you develop a website for exclusive use by the Board.

88. Please refer to ***Section 3 Scope of Services*** for the Board's website requirements. Describe your web-based program available to participants. Does the program allow participants to check to status of a claim, view and print submitted claim activity, confirm the price of medications, review therapeutic alternatives, check the preferred/non-preferred, generic status of a medication, etc.?

89. Describe any online tools available for comparing drug pricing between pharmacies.

90. Describe any online/mobile tools for demonstrating to participants savings associated with changing medications from their current prescriptions.

91. Describe areas of innovation that your organization has developed and implemented that improves the quality of care provided to participants, or improves cost control for your clients.

92. Does your organization release communications to participants that are negatively impacted by changes to the preferred drug list? How often? Please provide a sample of the most recent communications release. Confirm that your cost is included in the bundled administrative fee for supplying this service, including the cost of mailing any preferred drug list changes to participant home locations.

93. How do you track and monitor participant and provider inquiries? What is your turn around time in responding to participant complaints?

94. Define your telephone service objectives in terms of: 1. Average call pick-up time; 2. Average time on hold; 3. Percentage of calls receiving busy signals; and 4. Abandonment rates. In each of these service areas, please provide the actual results for the last twelve months that were measured by your organization.

95. Describe your formal grievance procedure for addressing participant problems.

96. Please describe the participant appeals process. Specifically, your response should indicate how first level appeals are managed, who is responsible for making the determination and the timing for issuing a response.

97. What information is required to be contained on the ID card given to participants? Include a sample ID card. Can the ID card be customized for the Board? At a minimum, ID cards must include the participant name, participant identification number, the network name and the toll free customer service line number. Can the medical identification number be used as the pharmacy card identification number if provided by the medical claim administrator?

98. You are required to generate ID cards and distribute the ID cards to participants. Confirm that your cost is included in the bundled administrative fee for all costs related to ID cards, including the cost of mailing the ID cards to participant home addresses.

99. Do you provide an annual explanation of pharmacy benefits (EOB) to participants? Does the explanation of pharmacy benefits include cost saving alternative recommendations for the participant? Please provide a sample including a list of all messages that can be displayed on the EOB.

100. The PBM shall maintain on file, at a minimum, the following information relative to each processed claim: the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed, amount applied to the deductible, and reason codes. Confirm that you will comply with this requirement.

5.5 Claims Administration

101. Describe your procedure for processing paper and out of network claims submissions. Provide turnaround statistics for paper and out-of-network claims processed during the most recent twelve months.

102. Describe your process and capabilities for real time, point of sale coordination of benefits?

103. Describe the situations where you would utilize a retrospective (off-line) process for coordinating benefits and payments. Describe your process for retroactive collection of payments from primary payers identified. If your organization does not perform such collections directly, describe your process for collecting information about other primary payment amounts.

104. Does your claims system have the capability to identify approval of prescription drugs by exception? (e.g. normally excluded by the plan, excluded by participant group)

105. Does the system comply with the National Council on Prescription Drug Program (NCPDP) standards?

106. What process is required from your network pharmacies when submitting claims for compounded drugs? What pricing algorithm do you use for pricing these drugs? Do you support and does your network use the NCPDP D.0 transaction standard format which allows listing of all ingredients?

107. Does the pharmacist have the capability to override the system? Please provide an example of a situation where the pharmacist might apply the override capability.

108. Describe the online systems access that will be granted to the Board for viewing data including, but not limited to: participant benefits, eligibility, participant and group records, prescription information, formulary lists, prior authorizations, accumulators, claim detail, claim data as submitted at point-of-sale, point-of-sale denials, COB data, drug pricing, historical data, mail service prescription data, transaction audit trails, MAC pricing files, specialty drug lists, etc.

109. Describe your capability to administer a plan design that includes the use of Health Reimbursement Accounts and integrated deductibles with the health plan.

110. Confirm that your organization will issue 1099s to pharmacies that receive payments under the Plan, as required by applicable and/or required by law.

5.6 System Interface

111. You are required to work with the medical claims administrator to develop system interfaces for accepting eligibility information, including ongoing additions/deletions of participants. Please confirm your ability to comply with this requirement.

112. Does your system flag participant ID numbers when an ID card is reported as lost or stolen to prevent fraudulent claims? What procedures are pharmacies instructed to follow when an individual tries to use a lost or stolen card?

113. Does your system monitor and flag early drug refills? What consumption percentage is your standard policy? Can this function be overridden for vacations, lost medicine, etc.?

114. Does the system track physician-specific data and dispensing patterns? How is this information used to change physician behavior? Are you willing to share this information with the Board?

115. Do you issue report cards on physicians? What information is captured on these report cards? Explain how this information is shared with physicians and how frequently. Are you willing to share this information with the Board? Provide an example, if applicable.

116. Does the system maintain patient medication profiles? What information is captured on these profiles? Provide an example, if applicable.

117. Discuss situations where your participating pharmacists have been unable to access the system and the number and frequency of such incidents. Describe the procedures used for dispensing prescription drugs to participants in cases where there are problems accessing the computer network system. What was the percent of time your system was unavailable to pharmacies during calendar year 2014?

118. Confirm that you have the capability to coordinate deductible accumulations with the medical claims administrator for participants covered under a High Deductible Health Plan, and include any data interface costs in your proposal.

5.7 Data Reporting

119. Due to potential time delays associated with the existing eligibility reporting process, do you have a standard report that would capture claims data for employees who receive prescription drugs after their termination under the Plan?

120. Describe the type and frequency of reports routinely provided to your clients. Provide examples in an appendix to your proposal.

121. Does your system provide web-based reporting tools that allow the client to view, print, and download reports? If so, please describe reporting capabilities, claim look-up functions, standard report writers, and any associated costs assuming five users. Describe any ad hoc reporting capabilities provided through these web-based tools. In what formats can the reports be downloaded? How many months of reports are maintained online? Also, explain what type of security is offered to protect the information.

122. Confirm that you can interface with the Board's data management PBM, Truven Health Analytics Inc. Confirm that your proposal includes the cost of this requirement.

123. Describe your capability to produce ad hoc reports. Provide examples of previously prepared ad hoc reports and associated programming charges. What is the typical turnaround time for producing ad hoc reports?

124. Do you sell or report any data from your clients, either specifically or in aggregate, to any organizations? If so, please disclose these arrangements in detail.

5.8 Clinical Programs and Utilization Management

125. Describe your drug utilization review (DUR) and management services, such as:
    A. Prospective DUR
    B. Concurrent DUR
    C. Retrospective DUR
    D. Physician profiling
    E. Case Management and Medication Therapy Management
    F. Prior Authorization

G. Dosage and Quantity Limitations

H. Step Therapy

I. Dose Optimization

126. Describe your DUR problem identification process for all three levels of DUR (Prospective, Concurrent, and Retrospective), the intervention process, including methods, frequency, and success rates. Please describe three significant retrospective DUR cases that demonstrate the value of such services in terms of tangible results.

127. Describe how you manage requests from participants for early refills or advance supplies of medications.

128. Describe the dedicated clinical resources that support your DUR and cost containment efforts. Provide names and resumes of key staff members.

129. Does your organization perform internal analyses of client specific data to develop recommendations for program improvement? What factors do you take into consideration when evaluating recommendations? Specifically address who would be conducting the analysis and provide their qualifications and experience.

130. How are physicians educated about drug utilization? Formularies and preferred drug lists? Generic therapeutic substitution? Provide samples of provider educational materials. Do you conduct any detailing of physicians? What have been the results of these efforts?

131. What is the average percentage savings from your DUR interventions? For purposes of this statistic, percentage savings is defined as DUR savings compared to total claims actually paid.

132. Please describe your medication adherence program including your experience in positively impacting physician and participant behavior relating to medication adherence. How long has your medication adherence program been in place?

133. Describe your drug limitation program for medications which are indicated only for a specific therapeutic period or are limited to certain amounts.

134. Please describe your prior authorization process including who performs the medical authorization function.

135. Confirm that utilization management rules will apply to all channels (retail, mail, and specialty), and then also across channels.

136. Describe available medication therapy management (MTM) programs

137. Do you contact patients to remind them of upcoming refills, to verify receipt of medications, to confirm the patient's understanding of proper administration of medications, etc.? Please describe these interactions.

138. Provide examples of communications that are distributed to patients and physicians through your specialty pharmacy program.

139. Are you offering clinical guarantees to the Board? If yes, please describe the guarantee and your savings calculation methodology.

5.9 Legal and Liability Issues

140. Provide copies of all liability insurance certificates, including stated maximums and events covered. Would you be willing to list the Board as an additional insured?

141. Please indicate the liability insurance requirements that each pharmacy must maintain to be considered a participant in your network. How does your organization verify that each participating pharmacy has complied with the insurance requirements, and how do you monitor the renewal of insurance protection each year?

142. Please provide a copy of the most recent annual report for your organization, and for your parent organization (if applicable).

143. Please provide your organization's (and those of your parent firm, if applicable) most recent audited financial statements including any auditor's recommendations or opinions.

144. Please attach a copy of your standard contract with participating pharmacies.

5.10 Implementation Services

145. Describe your implementation plan to meet a network start date of January 1, 2016, clearly identifying tasks, critical events, time lines, and the responsible parties.

146. Describe your implementation and plan set-up testing and controls procedures to ensure accurate plan set-up.

147. If your organization is selected by the Board as the PBM on April 22, 2015, will you be fully operational and have all contractual processes and procedures in place by January 1, 2016?

148. Would you be willing to assign an exclusive team to assist with the implementation process? Would you be willing to support the Board with employee meetings at various State agencies, schools, and other employee locations? How many exclusive service representatives would be assigned for the initial implementation, as well as ongoing servicing of the Board's program?

149. Would you willing to assign an individual to be available to DFA during the transition process to work through the details of administration, data reporting, and system interfaces? How many full days would you commit this resource to DFA?

150. Describe the most frequent problems you have encountered during previous transitions for plans of this size. How were these resolved?

151. Provide copies of any standard forms that you use during the transition period.

152. Please confirm that your financial proposal includes all costs associated with implementation services. You must provide a detailed description of any implementation service and/or fee charge not specifically included in your financial proposal.

5.11 References

153. List four (4) current PBM clients (one of which must be a governmental client) who can serve as references. Your references should include at least one account serviced from the office with which you propose to place this business and include the following:

    A. The largest account under contract as of January 1, 2015.

    B. A new account with at least 25,000 covered lives added within the last 24 months

    For each reference, provide a reference name, full address, contact person, title, phone and fax number, membership size, list of services you provide, a description of the results you have achieved (e.g., reduced drug trend, financial savings, etc.), and the duration of the relationship with your organization. If one account matches both of the requirements listed above, provide an additional reference.

154. In addition, please provide the names of accounts with greater than 50,000 covered lives who have terminated their relationship with your organization in the past two years. Include the client name, a contact person, full address, phone and fax number, membership size, broad list of services your PBM provided, duration of relationship, and reason for termination.

5.12 Financial

155. For what period of time are your negotiated rates with participating pharmacies guaranteed? Are there any networking re-contracting efforts either planned or underway that would impact your proposed pricing for this proposal?

156. What is your organization's approach to ensuring the benefit of low cost generic retailers that sell discounted generics (e.g. $4 maintenance generics)? Does your organization have the ability to capture these claims for reporting and clinical edit purposes?

157. What is the data source you currently use for drug reimbursement (e.g., Medi-Span, etc.)?

158. Confirm that the Average Wholesale Price (AWP) information used for pricing discount purposes will be obtained from a single nationally recognized organization (Medi-Span) or published reference, and will not be altered or changed by the PBM in any manner. If not, please describe.

159. Does your PBM engage in any cost shifting from either external or internal sources which improve the actual or perceived price of one service while increasing the actual or perceived price of another service provided by the PBM to the Board? Explain.

160. What percentage of retail and mail order claims are currently priced at MAC? Are you willing to guarantee a MAC inclusion rate for retail and/or mail if applicable? If so, state the guarantee.

161. What percent of your total claims paid in 2014 have been paid at U&C? What is the average discount for U&C brand claims? What is the average discount for U&C generic claims?

162. Confirm that for every claim paid at the provider's U&C amount, the PBM shall allocate the entire U&C amount to the Ingredient Cost, and shall not allocate any of the U&C amount to the dispensing fee.

163. What other pricing arrangements can you support (e.g. ASP, WAC, ACQ)?

164. Provide a detailed methodology for the calculation of each of the guaranteed financial terms listed in ***Section 7 – Financial Proposal***. Describe any variation in the calculation of the guaranteed financial terms from the methodology required to re-price the claim file that is required for this RFP.

165. Provide a detailed methodology description for the calculation of each of the performance standards listed in ***Section 4 Performance Standards*** of this RFP.

166. Describe how/if specialty drug guaranteed discounts are updated and the frequency of the updates?

167. The Board describes a "script" as a paid prescription only (excludes duplicates, reversals, etc.). Confirm you will abide by this definition in calculating any fees based on a per script basis.

168. Confirm that all discount guarantees are direct savings off of AWP and not the result of incremental savings due to repackaging of prescriptions or other clinical services. Does your mail order pricing assume a specific package size? If so, describe the package size used in mail order.

169. When a prescription costs less than the co-payment amount at either retail or mail, how do you ensure that the participant will pay the lowest amount?

170. For your current book of business, please provide the following annual statistics. Please indicate the time period represented and whether data reflects active employees only, or active employees and retirees, dependents.

    A. Cost per participant (paid claim)

    B. Cost per insured employee (paid claim)

    C. Number of prescriptions per participant

    D. Number of prescriptions per insured employee

    E. Average day supply per prescription

    F. Average ingredient cost – per brand, generic

171. For your current book of business, what is the most recent statistic (percentage) of drugs which were dispensed as generic? If possible, distinguish between clients who include any pharmacy incentive programs or MAC plan designs. Please indicate any new program that might be employed by the Board to improve this statistical average.

172. Please summarize how you handle (a) MAC; (b) lower of U&C and plan pricing, and (c) acquisition package size pricing compliance by pharmacies in the network you propose.

173. Do you maintain more than one MAC list? If so, will more than one MAC list be used for the Board's program? Please describe how more than one MAC list is utilized.

174. For each MAC list used for the Board's program, please identify whether there will be different MAC prices associated with those MAC lists. Please describe how those different MAC prices are applied.

175. For the Board's program, will you apply the same MAC list and MAC pricing for both the retail and mail channels?

176. How many drugs are on your MAC list? How often do you change MAC pricing? What method do you use to communicate with clients any updates in your MAC pricing and MAC lists?

177. Confirm that you have completed proposed specialty drug list and provided guaranteed discounts (see *Appendix E – Specialty Drug List and Guaranteed Discounts).*

178. Confirm that you have provided the rebate guarantees you will provide the Board. The rebate guarantee should be based on a per brand script basis only. You may list separate guarantees for retail, specialty and mail.

179. Confirm that you are willing to make the Board whole in the event you fail to meet pricing and/or rebate guarantees by individual guarantees without offsets of one financial guarantee's potential under-performance with another financial guarantee's potential over-performance.

180. What is the lag time for these rebates to be paid to the Board? How frequent will the Board receive its rebates? Will you guarantee a minimal turn-around time? Confirm that the Board will receive a detailed explanation on how its rebates are calculated.

181. Describe the payment cycle for compensating pharmacies.

182. Describe your preferred billing cycle for claims, and for administrative fees to the Board.

5.13 Fees

183. Complete the "Financial Proposal" form located in ***Section 7 Financial Proposal***. Confirm that all fees are guaranteed through the potential five-year term of the contract.

184. Confirm that your proposal is valid for **180 days** from the date proposals are due.

Section 6. CLAIMS RE-PRICING

1. The Board requires a claim re-pricing and formulary analysis using the proposed pharmacy network and PBM proposed contracted rates. The claim file will be distributed to proposers after they return the Intent to Propose and the executed Non-Disclosure Agreement (NDA) found in *Appendix G – Non-Disclosure Agreement*.

2. The claim file will be sent to qualifying proposers overnight via an encrypted DVD after receiving the executed NDA. The claim file will contain three months of claims history in the following layout (NDC, Quantity, Day Supply, Date Filled, DAW code, Retail/Mail Indicator, and Formulary Flag). You should not be concerned with U&C, Zero Balance, Full Copay or Submitted pricing, as the Board intends to use the data to compare your AWP discounts, dispensing fee, MAC and Specialty Pricing in a manner which does not contain alternative assumptions by proposing PBMs. In addition, all ancillary assumptions and caveats used in your analysis should be thoroughly detailed with your submission. Please use your proposed discounts, current MAC pricing where applicable, and AWP as published on July 1, 2014.

3. PBM's should take the following into account for both claims adjudication and aggregate discount guarantees. The Board's expectation is that Medi-Span Multi-Source Indicator should be used. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as generic claims.

4. The claims re-pricing response file should include all provided fields as well as the addition of your MAC Flag, MAC unit price, Billed Ingredient Cost, Billed Dispense Fee, Total Drug Cost, Final Pricing Indicator (how you would have priced the claim; AWP Discount or MAC) and Tier Indicator (applying the proposed formulary) for each claim. In addition, populate the table attached in *Appendix C – Drug Claim Re-Pricing Template.*

5. Re-price all claims using proposed discounts and pricing, but if additional savings opportunities are identified during re-pricing, these savings opportunities can be included and explained as notes in the table attached in *Appendix C – Drug Claim Re-Pricing Template.*

6. Please identify how the methodology used in the re-pricing (other than the fixed AWP date of July 1, 2014) varies from any future calculation methodologies used by your PBM, should it be selected, in calculating performance guarantees or related discount performance during the term of the contract.

Section 7. FINANCIAL PROPOSAL

Please complete the following "Financial Proposal" form. Rates for each of the five (5) years must be included.

FINANCIAL PROPOSAL

PHARMACY BENEFIT MANAGER

	Year 1 – 2016	Year 2 - 2017	Year 3 – 2018	Year 4 – 2019	Year 5 – 2020
***** All Fees are assumed guaranteed unless otherwise noted**					
Retail Network:					
Discount from AWP Brand Retail (provide guarantee with and without zero balance claims)	%	%	%	%	%
Discount from AWP Generic Retail (must include all generic drugs including MAC, non-MAC, single source any drug with a generic code number) based on a percentage of AWP even if you are proposing MAC pricing (provide guarantee with and without zero balance claims)	%	%	%	%	%
Dispensing Fee Brand	$	$	$	$	$
Dispensing Fee Generic	$	$	$	$	$
Administrative Services for Retail Network					
Electronic Claims Processing (per script)	$	$	$	$	$
Paper Claims Processing (per script)	$	$	$	$	$
Mail Order Network					
Is the mail order facility owned by your company? ☐Yes ☐No					
Discount from AWP Brand (provide guarantee with and without zero balance claims)	%	%	%	%	%
Discount from AWP Generic Retail (must include all generic drugs including MAC, non-MAC, single source any drug with a generic code number.) based on a percentage of AWP even if you are proposing MAC pricing. (provide guarantee with and without zero balance claims)	%	%	%	%	%
Dispensing Fee Brand	$	$	$	$	$
Dispensing Fee Generic	$	$	$	$	$
Specialty Drugs					
Aggregate AWP discount					
Administrative Services for Mail Order Network					
Electronic Claims Processing (per script)	$	$	$	$	$
Paper Claims Processing (per script)	$	$	$	$	$
Rebates					
Guaranteed rebate per retail Brand claim	$	$	$	$	$
Guaranteed rebate per mail Brand claim	$	$	$	$	$
Guaranteed rebate per Specialty Claim	$	$	$	$	$
Administrative fees for Rebate program (provide the basis for the fee such as per script, PPPM, etc.)	$	$	$	$	$
Miscellaneous Services					
Please indicate with "included" if cost is in base administrative fee, or indicate the additional cost if not included in base fee and provide the basis for the fee (e.g. per script, PEPM, etc.)					
Drug Utilization Review					
Employee Communications					
Employee ID cards					

	Year 1 – 2016	Year 2 - 2017	Year 3 – 2018	Year 4 – 2019	Year 5 – 2020
Postage/handling to mail ID cards to employee homes					
Provider directories/updates					
Standard Reports					
Ad-hoc Reports					
Programming Charges					
Fraud Protection					
Enrollment Support (cost per additional day of support beyond assumed support levels)					
Prior authorization					
Step Therapy					
Medication Adherence Program					
Medication Therapy Management Program (MTM)					
On-site claim audits					
COB					
Annual Explanation of Benefits					
Postage/Other Distribution Charges for Mail Order Drugs (Describe in detail any instances in which postage or other distribution fees are charged including average amount of cost per item described)					
Computer Programming					
Other (Please describe)					

[1] The Board's expectation is that Medi-Span multi-source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as generic claims.

[2] The Board will not pay any up-front fees prior to the January 1, 2016, effective date for services. All implementation fees or charges must be included in the administration fees quoted above. All fees or charges related to PBM services must be identified in the fee proposal above.

Please confirm that the financial proposal is valid for at least 180 days subsequent to the date of submission.

Section 8. STATUTORY REQUIREMENT

Statutory Requirement

Section 25-15-9(1)(a), Mississippi Code Ann., states in part:

"…The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid…."

In accordance with Section 25-15-9(1)(a) of the Mississippi Code, each entity that submits a proposal in response to this RFP must provide a disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or DFA in the development of the Plan including any resulting compensation for these services. If you did not provide such assistance to the Board and/or DFA, indicate in your statement that this provision does not apply to you. Failure to provide this disclosure statement will result in your proposal being eliminated from further consideration

A list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the State of Mississippi State and School Employees' Life and Health Insurance Plan follows:

Wm. Lynn Townsend, FSA, MAAA

Cavanaugh Macdonald Consulting, LLC

PricewaterhouseCoopers, LLP

Truven Health Analytics, Inc.

Blue Cross & Blue Shield of Mississippi

Catamaran PBM of Maryland, Inc.

Advanced Health Systems, Inc.

ActiveHealth Management, Inc.

Claim Technologies, Incorporated

Minnesota Life Insurance Company

BKD, LLP

Department of Finance and Administration

Kevin J. Upchurch, – Executive Director; Office of Insurance Staff: Richard D. Self – State Insurance Administrator; Cindy Bradshaw – Deputy Director; Edie Ivey – Director, Benefits and Participant Services; Steven May – Director, Accounting and Analysis; Curt Hubbard – Director of Compliance and Audit; Chris Shaman – Director of Communications and Special Projects

Health Insurance Management Board

Kevin Upchurch (Chairman) – Executive Director, Department of Finance and Administration; Larry Fortenberry (Vice-Chairman) – President, Executive Planning Group; Christopher J. Burkhalter – Consulting Actuary, Burkhalter Consulting Actuaries; Liles Williams – Chairman, Workers' Compensation Commission; Mike Chaney – Commissioner of Insurance; Dr. Hank Bounds – Commissioner, Institutions of Higher Learning; Dr. Carey Wright – State Superintendent of Education; Deanne Mosley – Executive Director, State Personnel Board; Pat Robertson – Executive Director, Public Employees' Retirement System; Dr. Eric Clark – Executive Director, Mississippi Community College Board; The Honorable Videt Carmichael – Chairman, Senate Insurance Committee; The Honorable Gary Chism – Chairman, House Insurance Committee; The Honorable Eugene Clarke – Chairman, Senate Appropriations Committee; and The Honorable Herb Frierson – Chairman, House Appropriations Committee

Section 9. STATEMENT OF COMPLIANCE

This Section contains the Statement of Compliance. If you object to any of the terms and conditions included in the draft contract provided in *Appendix A – Draft Pharmacy Benefit Manager Administrative Contract*, or any requirements listed in this RFP, please note and explain your objections on the Statement of Compliance.

Statement of Compliance

We agree to adhere to all conditions and requirements as set forth in the Mississippi State and School Employees Health Insurance Management Board's Request for Proposal for Pharmacy Benefit Manager, dated January 30, 2015, including the conditions contained in the draft contract included as *Appendix A – Draft Pharmacy Benefit Manager Administrative Contract*, except as listed below:

We hereby certify that the fees submitted in response to the RFP have been arrived at independently and without, for the purpose of restricting competition, any consultation, communication, or agreement with any other proposer or competitor relating to those fees, the intention to submit a proposal, or the methods or factors used to calculate the fees proposed.

We hereby certify that we have not retained any person or agency on a percentage, commission, or other contingent arrangement to secure a contract.

An original signature is required below.

_____ _____

Name Date

_____

Title

_____

Company

Please have the appropriate officer sign this statement and include it as a part of your proposal.

Appendix A – Draft PBM Administrative Contract

PHARAMCY BENEFIT MANAGER ADMINISTRATIVE CONTRACT

This Pharmacy Benefit Manager Administrative Contract (Contract) is made by and between the Mississippi State and School Employees Health Insurance Management Board (Board), acting administratively through the Department of Finance and Administration, a state agency, (DFA) whose address is 501 North West Street, Suite 1301 Woolfolk Building, Jackson, Mississippi 39201, and *VENDOR* (Vendor) whose address is *ADDRESS*, under which the Vendor agrees to provide services to the Board beginning January 1, 2016, subject to the following terms and conditions:

1. Identity and Relationship Between the Parties

A. The Vendor, a corporation organized under the laws of the state of *STATE*, is a pharmacy benefit manager (PBM) organized for the purpose of facilitating the delivery of quality prescription drug services through discount arrangements or other financial contracts with participating providers as described herein.

B. The Board, acting administratively through the DFA, administers the Plan. DFA acts on behalf of the Board in executing the Board's day-to-day operational responsibilities concerning the Plan's administration.

C. The Vendor and the Board are independent legal entities. Nothing in this Contract shall be construed to create the relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Contract.

D. Neither the Vendor nor the Board nor any of their respective agents or employees shall control or have any right to control the activities of the other party in carrying out the terms of this Contract, nor shall either party, its respective agents or employees, be liable to third parties for any act or omission of the other party.

E. Nothing in this Contract is intended to be construed, nor shall it be deemed to create, any right or remedy in any third party.

2. Definitions

A. "Allowable Charge" means the lesser of the amount payable to a participating provider under the terms of the participating provider's contract with the Vendor for a covered service or the cash price inclusive of all applicable customer discounts which a cash paying customer of the participating provider pays for a covered service.

B. "AWP" means the "average wholesale price" for a standard package size of a prescription drug from the most current pricing information provided to PBM by First DataBank®, Medi-Span Prescription Pricing Guide (with supplements), or following notice to the Board, any other nationally available reporting service of pharmaceutical prices as utilized by PBM as a pricing source for prescription drug pricing. The standard package size applicable to a mail service pharmacy shall mean the actual package size dispensed. The standard package size applicable to a participating provider shall be the actual package size dispensed from a participating provider as reported by such participating provider to the PBM.

C. "Brand Name Drug" means drug that has a trade name and is protected by a patent. A brand name drug may only be produced and sold by the pharmaceutical company holding the patent or a pharmaceutical company that has been licensed and authorized by the patent holder to produce and sell the drug. The Board's expectation is that Medi-Span Multi-Source Indicator

will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a Multi-Source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the Multi-Source indicator is a "Y" on the date dispensed will be considered as Generic claims.

D. "Claims Administrator" means the organization under contract to the Board responsible for processing all medical claims, other than claims for prescription drug services, received from participants.

E. "Co-payment" means that portion of the allowable charge for a given covered service which, under the terms of the Health Benefit Plan, is required to be paid by the participant directly to the participating provider of Prescription Drug Services.

F. "Complete Claim" means necessary information required by the PBM to adjudicate the claim for Prescription Drug Services.

G. "Covered Service" means a Prescription Drug Service provided under the terms of this Contract for which payment may be requested under terms of the Plan.

H. "Direct Price" means the direct price of a prescription drug, as determined by the current edition of the Medi-Span Master Drug Data Base, including supplements thereto, or any other nationally recognized publication that PBM may designate from time to time.

I. "Employee" means an eligible person who has satisfied the specifications of the Plan's Plan Document's Schedule of Eligibility and has enrolled for coverage under the Plan. Unless otherwise indicated, "Employee" refers to an active employee, a retired employee or a COBRA participant.

J. "Factor" means the number which when multiplied by the Identified Cost Source will result in the AWP for a prescription drug.

K. "Generic Drug" means a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand Name Drug and that generally is made available when patent protection expires on the Brand Name Drug. The Board's expectation is that Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a Multi-Source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the Multi-Source indicator is a "Y" on the date dispensed will be considered as Generic claims.

L. "Health Benefit Plan" or "Plan" means the self-insured Mississippi State and School Employees' Life and Health Insurance Plan as defined in §Section 25-15-1 et. seq.

M. "Health Insurance Portability and Accountability Act (HIPAA)" shall refer to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

N. "Health Management Vendor" is the vendor that provides health management services to the Plan including, but not limited to, hospital management services, continued stay management, discharge planning, retrospective review, review of high cost diagnostic procedures, and medical necessity review for specified medical services. This vendor also provides wellness and health promotion services, case management, and disease management.

O. "Identified Cost Source" means the underlying cost source such as WAC or Direct Price identified by First DataBank, Inc., Medi-Span, or any other nationally recognized publication that PBM may designate from time to time from which AWP is derived for a prescription drug.

P. "Maximum Allowable Charge" means the maximum reimbursement payable to a participating provider for covered services under the terms of this Contract.

Q. "Maximum Allowable Cost" or "MAC" means the unit price that has been established by PBM for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to the Board, which list may be amended from time to time by PBM in maintaining its generic pricing program. A copy of such MAC drug list shall be provided to the Board prior to execution of this Contract and thereafter upon the Board's reasonable request. The Board acknowledges that the MAC list applicable to the Board is not the same as the MAC list published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC").

R. "Participant" means an individual who is eligible to receive Prescription Drug Services for which payment may be sought under the terms of the Plan.

S. "Participating Provider" means a pharmacy or pharmacist which has entered into a contract with the PBM to provide Prescription Drug Services under this Contract. All pharmacists employed by a participating provider are subject to all requirements imposed on participating providers under this Contract.

T. "Plan Document" (PD) is the document that states the benefits and eligibility terms of the Plan. This document is published and maintained by the Board. All benefits under the Plan are subject to the PD.

U. "PDL" or "Formulary" means the PBM Performance Drug List, which is a list of preferred pharmaceutical products, created and maintained by PBM, as amended from time to time, which: (a) has been approved by PBM's pharmacy and therapeutics committee; (b) reflects PBM's recommendations as to which pharmaceutical products should be given favorable consideration by plans and their participants and (c) includes all standard clinical programs, including but not limited to prescribing guidelines such as prior authorization, step therapy, and quantity level limits.

V. "Prescription Drug Service" means drugs provided by a participating provider, including generic drugs and brand name drugs, that under Federal or State law may be dispensed only by written prescription and which are approved for general use by the Food and Drug Administration.

W. "Script" means a paid prescription only (excludes duplicates, reversals, etc.).

X. "Usual and Customary" or "U&C" means the amount a participating provider would charge to a cash paying customer for same strength, quantity, and dosage form of a covered drug, as of the date the prescription is filled.

Y. "Wholesale Acquisition Cost" or "WAC" means the wholesale acquisition cost of a prescription drug, as determined by the current edition of the Medi-Span Master Drug Data Base, including supplements thereto, or any other nationally recognized publication that PBM may designate from time to time

3. Responsibilities of the Vendor

A. The PBM shall arrange for and facilitate the delivery of quality Prescription Drug Services to participants through discount arrangements or other financial contracts with participating providers. Prescription Drug Services provided under this Contract shall be of the same quality and provided in the same manner as Prescription Drug Services provided to all other customers of the participating provider.

B. The PBM guarantees the minimum discounts provided in Exhibit A, Financial Exhibit – Fees, Discounts, and Rebates for the term of this Contract. If, when measured on a Contract year basis, the guaranteed minimum discounts are not obtained, PBM will reimburse the Board the difference between the actual aggregate discount obtained and the guaranteed amount, for each category. Guaranteed discounts will not include savings for drug utilization review (DUR), prior Authorization or other clinical programs. Discount guarantees will not be offset against one another, nor will they be subject to any limits on recoveries. If, after the Contract has been executed, applicable law, regulation, administrative or judicial interpretation or ruling or substantial changes in national industry practice, transition from Average Wholesale Pricing (AWP) to another national benchmark or the level of an industry pricing benchmark, ("External Event"), the PBM and Board agree to renegotiate in good faith the financial terms outlined in Exhibit A. The PBM agrees that the discounts provided to the Board after the External Event will be equivalent to the discounts previously provided. At the discretion of the Board, the Board may utilize the services of an independent reviewer to determine the equivalency of such discounts.

C. The PBM shall provide all services directly related to this Contract from an office(s) located within the continental United States.

D. The PBM shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should PBM default in these or other responsibilities, jeopardizing PBM's ability to perform services effectively, at the Board's sole discretion, this Contract may be terminated for default.

E. The PBM shall hire and maintain sufficient staff to meet the needs of the Board and the participants.

F. The PBM must assign a dedicated clinical pharmacist to participate in activities relative to all aspects of this Contract between the Board and the PBM and to meet with the Board on a quarterly basis. Duties of the clinical pharmacist will include, but are not limited to, advice regarding drugs which the Plan may require prior authorization for coverage, notification of block buster or pipe-line drugs and FDA approval of new generic drugs, and education regarding therapeutic substitutions.

G. The PBM shall have a dedicated account manager to participate in activities relative to all aspects of the Contract between the Board and the PBM and to meet with the Board on a quarterly basis to review Plan utilization, attend the Board's monthly meetings and make recommendations regarding services and/or programs.

H. The PBM agrees to participate in activities with the Claims Administrator and/or the Board in responding to participant or Provider inquiries or complaints relating to Pharmacy Benefit Management Services.

I. The PBM shall cooperate with the Board and with all other contractors of the Board with respect to ongoing coordination and delivery of Pharmacy Benefit Management Services and in any transition of responsibilities.

J. The PBM agrees to provide whatever information is deemed necessary by the Board, the Board's consultants and/or other Board vendors, and has in place (or is able to establish) data interface with the Board's vendors, for the transmittal/receipt of required data elements. The Board agrees, however, that the Board and any of its vendors or consultants shall recognize the confidential and proprietary nature of such information, and shall agree not to use or disclose it except as necessary for the purpose of this Contract, or as required by law.

K. The PBM agrees to assist the Board in responding in a timely manner to participant or participating provider inquiries or complaints regarding services provided by PBM pursuant to this Contract.

L. The PBM, at its own cost, agrees to participate in approximately fifty (50) benefit fairs per year to educate participants.

M. The PBM shall be in compliance with all applicable requirements of HIPAA including the Standards for Privacy of Individually Identifiable Health Information and Security Rule provisions, applicable provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), and the regulations promulgated thereunder.

N. The PBM will develop and maintain a searchable public website that contains at a minimum: a current provider directory, claim forms for both primary and secondary coverage, on-line mail order refill capabilities, mail order forms, formulary or preferred drug list, alternative drug price check functionality, and health/wellness information. The website must be accessible to participants and providers with no access restriction or registration requirement except for those functions which allow for review of a participant's prescription claim history or that include other forms of personal health information. A link from the Plan's web site to the PBM's website must be allowed.

O. The PBM, at its own cost, shall supply all forms and materials necessary and required to install and administer the services provided by the PBM. Loading eligibility data and establishing data transfer and system interface according to the specifications in the Request for Proposals will not result in any additional fees to the Board. In the event the Board contracts with vendors different from those under contract with the Board effective January 1, 2011, and the PBM's file specification is not used, any programming or software development required by the PBM to interface with the vendors will be billed to the Board at the rate referenced in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates of this Contract.

P. The PBM shall design, print, and distribute brochures, preferred drug lists and forms, with the Board's approval, as necessary and required to install and administer pharmacy services and programs. The PBM shall provide the PBM's informational materials to all participants enrolled in the Plan at the time of implementation including the cost of mailing any communication materials to participant home locations. The PBM shall provide and maintain a supply of PBM's informational materials to the Board. The PBM shall provide a supply of the PBM's informational materials to all departments, agencies, universities, community/junior colleges, public school districts, and public libraries at the time of implementation and throughout the terms of this Contract when requested by a department, agency, university, community/junior college, public school district, or public library. The Board may use the Communication Fund, referenced in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates, to cover the costs of these materials.

Q. To assist the Board in addressing clinical quality issues and quality improvement initiatives, the PBM shall provide to the Board a quarterly outcomes summary report, as agreed upon by the Board and the PBM.

R. The PBM shall furnish standard reports in a form and content approved by the Board and illustrated in Exhibit E, Reports of this Contract. These reports shall be provided, at the Board's request, in a hard copy and/or electronic media format. Additionally, the PBM shall provide custom reports at the Board's request. The PBM shall provide the Board, for the Board's approval, the time and cost for the development of custom reports. The cost of custom reports shall be based upon the number of hours required for programming at the hourly programming cost indicated in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates of this Contract.

S. The PBM shall provide optional services, as requested by the Board, for which the PBM has the technical capability to render, and as agreed to in writing by the Board and PBM.

T. The PBM shall provide the services under this Contract in accordance with the rates, terms and conditions listed in the Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates of this Contract.

U. The PBM warrants that each participating provider shall have undergone a credentialing process in accordance with the PBM's standards listed in Exhibit F, Provider Standards of this Contract. The PBM will notify the Board of any punitive action taken against a participating provider. The PBM shall provide for a credentialing process at least every two years.

V. The PBM shall require that each participating provider maintain, throughout the term of this Contract, licensure by the state in which the participating provider operates. The professional responsibility to the participants for the delivery of Prescription Drug Services shall at all times remain with the participating provider. Neither the PBM nor the Board shall in any way interfere with the professional judgment of the participating provider in the scope of his/her practice.

W. Each participating provider shall be required to maintain, throughout the term of this Contract, at its own expense, professional and comprehensive general liability insurance in such amounts as are reasonable for the industry and for a provider of Prescription Drug Services of the type and size of the participating provider which shall in no event be less than that required by applicable law.

X. The PBM will use reasonable and good faith efforts to maintain the general composition of and number of participating providers as illustrated in the PBM's response to the Request for Proposal for Pharmacy Benefit Manager dated January 15, 2010. The PBM shall notify the Board of significant changes to the composition of and number of participating providers in advance of such changes. A significant change is defined as any of the following: A decrease in the total number of participating providers by more than ten percent (10%) or a loss of a participating provider in an area within the State of Mississippi or within fifty (50) miles of the Mississippi border where another participating provider of equal service ability is not available within fifteen (15) miles. Participating providers may be added, subject to the conditions of this Contract, at the PBM's discretion. Substantial changes, as ruled by the Board, to the number or types of participating providers which materially and adversely impact the Plan and/or the participants' benefits, will be a valid reason for termination of this Contract. The PBM shall provide on-line access to a roster of participating providers, including their names, addresses and telephone numbers. The PBM shall regularly maintain and update participating provider information.

Y. The PBM shall require participating providers to collect no more than the Co-payment amount for covered services, as defined by the Plan, from participants. If a participating provider breaches this provision, the Board, at its discretion, may request termination of that participating provider as it relates to this Contract.

Z. The PBM, at its own cost, shall adequately communicate the Plan's program to all participating providers to ensure compliance with the terms of this Contract. The PBM, at its own cost, shall provide a toll-free number accessible to all participating providers whereby a participating provider may have access to the names, addresses, and phone numbers of other participating providers.

AA. The PBM, at its own cost, shall maintain a toll free customer service line and the appropriate and adequate customer service staff consisting of pharmacy technicians and clinical pharmacists, trained to answer questions and manage inquiries from participants, participating providers, and pharmacies 24 hours a day, seven days a week.

BB. The PBM shall provide routine distribution of ID cards, including printing, mailing, and postage. The PBM shall provide ID cards directly to the participant's home address for (1) the initial enrollment of the Plan, (2) future new hires, (3) participants who change coverage category (e.g. single to family) and (4) replacement of lost cards. Participants with single coverage should receive one (1) ID card; participants with dependent coverage should receive two (2) ID cards. The information to be printed on each ID card will include, at a minimum, the participant's name and identification number, Plan name, the PBM name and toll free customer service line number, in the Board's specifications. The Board may use the Communication Fund, referenced in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates, to cover the costs of these ID cards.

CC. The PBM shall conduct one (1) participant survey annually. The contents of the satisfaction survey must be agreed upon by the Board and the PBM. The Board may use the Communication Fund, referenced in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates, to cover the costs of this survey.

DD. The PBM is required to notify and receive approval from the Board prior to any change in the core services to be provided by the PBM pursuant to this Contract. Failure of the PBM to receive approval from the Board prior to any change in the core services pursuant to this Contract may be considered breach of contract and reason and cause for immediate cancellation of this Contract.

EE. The PBM is required to notify and receive approval from the Board prior to using the Board's or the Plan's name, or Plan benefit information in any publications or printed material or mailing or distributing materials to participants. Breach of any one of these is reason and cause for immediate cancellation of this Contract.

FF. At least one member of the PBM's account management staff assigned to the Board shall be available to the Board, Monday through Friday, each week of the year between the hours of 8:00 a.m. and 5:00 p.m. Central Time, excluding holiday schedules as agreed upon by the PBM and the Board.

GG. The PBM agrees the Plan's eligibility information is the property of the Board and prior approval of the Board must be received for any utilization of this information.

HH. The PBM, upon the Board's request, shall provide consultative services regarding pharmacy benefit design including, but not limited to, formularies, allowable charges, generic drug incentives, implementation of programs which control utilization and optimize health, utilization review services, and evaluation of drug use and cost data.

II. The PBM, as of the effective date of the services to be provided under this Contract and continuing for the duration of this Contract, shall process all claims for Prescription Drug Services that are provided before the termination date of this Contract. Upon termination of this Contract, the PBM shall process all claims for Prescription Drug Services that are provided before the termination date of this Contract and are received by the PBM within 180 days after the termination date of this Contract.

JJ. The PBM's claims processing services shall include, at a minimum but is not limited to, the following;

1. verification of eligibility of the employee and dependent participants based on the Board provided enrollment and termination information on participants;

2. review of claims submitted to determine the coverage of Prescription Drug Services in accordance with the Plan's parameters

3. receipt, processing, adjustment, and authorization of claim payments for the Plan in accordance with the terms of the Plan;

4. provision of claim forms;

5. provision of explanation of benefit (EOB) forms to participants with respect to all paper claims and maintenance of the following information with respect to all claims: Employee name, Employee identification number, patient name or other specific identifier, claim number, provider number, provider name, service date, type of service, amount of charges, co-payment amount, deductible amount, amount allowed to the claimant, and reason codes that specify the reason for claim payment or denial;

6. provision of 1099 forms for providers, to the extent required by Federal law;

7. assignment of adequate staff to perform timely and accurate claims processing and customer service, including staff to answer phone inquiries and correspondence regarding benefits, claim status and verification of eligibility, appeals and the timely communication of the outcome, and those other functions deemed necessary as mutually agreed by the parties;

8. apply quality control processes to regularly evaluate the performance and accuracy of the claims processing systems and the claims processing staff, and at the request of the Board, but at least annually, make resulting findings of such evaluation available to the Board;

9. upon a change in Federal Law that would require the filing of reports with the Federal Government by the Board in connection with this Contract, the PBM and the Board will discuss and negotiate the preparation of such reports for the approval and signature of the Board.

KK. The PBM shall provide initial claims review upon the request of a participant with respect to Prescription Drug Service claims partially or fully denied for payment by the PBM. The PBM agrees that a participant may request a review of any partially or fully denied claim to the PBM. The PBM agrees that if after the claim has been reviewed and benefits are again partially or fully denied, the participant will be informed of such decision in one of the following methods; (1) no written response is required, unless requested by the participant, if the appeal is initiated by phone and a verbal response from the PBM is provided and documented or (2) the decision of the PBM shall be in writing if the appeal is initiated by a written request or requested by the participant. This written response will include the specific reasons why benefits are partially or fully denied, with reference to the Plan provisions on which the decision is based. In any individual case, the PBM agrees that the Board has the right to direct the PBM to pay or provide Prescription Drug Services.

LL. The PBM shall provide coordination of benefits services. The Plan's medical claims administrator shall provide information regarding a participant's COB status to the PBM. The PBM shall reject primary payment for participants for whom the Plan is secondary and shall provide for secondary payment of prescription drug claims, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable co-payment for that prescription drug.

MM. If applicable, and so requested by the Board, the PBM shall provide coordination of benefits services for participants with primary Medicare coverage. The Plan's medical claims administrator shall provide information regarding a participant's Medicare status to the PBM. The PBM shall reject primary payment for participants for whom Medicare is primary and shall provide for secondary payment of prescription drug claims, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable co-payment for that prescription drug.

NN. The PBM shall be responsible for addressing and correcting, in a timely manner, any errors detected during any audit. Any claim processing error will be adjusted to the proper account.

OO. The PBM shall provide prior authorization services to promote cost management while ensuring that participants can access needed prescription drugs. The prior authorization program must use evidence based guidelines and the latest clinical literature and outcomes data, as well as FDA guidelines. The PBM shall advise the Board regarding those drugs for which the Plan may benefit by requiring prior authorization for coverage. The PBM's staff, under the supervision of clinical pharmacists, will review participant prescriptions for those drugs requiring prior authorization and/or medical necessity review in accordance with criteria, definitions and procedures developed by the PBM.

PP. The PBM shall provide access to its claims processing system to Board staff. Access by the Board's staff must include, at a minimum, review of participant claims history, the ability to update eligibility, and override or authorize drug coverage.

QQ. The PBM shall provide a limitation program for drugs which are indicated only for a specific therapeutic period or are limited to certain amounts. If, based on on-line adjudication, the quantity of a covered drug is not approved by the PBM, the prescribing physician must be allowed to contact the PBM for prior approval of additional quantities based on documentation of medical necessity.

RR. The PBM shall process requests from participants, pharmacists and providers for early refills or advance supplies of a medication due to vacations, dosage changes or for lost or destroyed medication.

SS. The PBM's designated specialty pharmacy shall provide prescription fulfillment and distribution of specialty medications and supplies, pharmaceutical care management services, customer service, utilization and clinical management, integrated reporting, and claims processing. The specialty medication program must include, at a minimum, patient assessments focusing on the appropriateness of specialty medication therapy and care and the prevention of drug-drug interactions; patient education materials; and services driving compliance. Programs such as drug utilization review, drug limitation, and prior authorization services must be extended to the specialty medication program. Specialty medications must be deliverable to the participant's residence or the participant's physician's office. The PBM shall provide to participants toll free telephone access to a registered nurse, pharmacist, or patient care coordinator (as appropriate) twenty-four (24) hours per day, seven (7) days per week.

TT. The PBM shall provide a mail order prescription drug program to process and dispense covered prescription drugs. Programs such as drug utilization review, drug limitation, and prior authorization services must be extended to mail order services. PBM's designated mail order pharmacy shall provide to participants toll free telephone access to a pharmacist and customer service representative. Access to a pharmacist pursuant to the foregoing will be available to participants twenty-four (24) hours per day, seven (7) days per week.

UU. The PBM shall provide the drug utilization review program as proposed in the PBM's response to the Request for Proposal.

VV. The PBM shall provide a step therapy program designed to optimize rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history.

WW. The PBM shall provide a dose optimization program designed to slow the rising cost of prescription drugs and help increase patient compliance with drug therapies. As part of the dose optimization program, the PBM shall work with the participants, the health-care providers and pharmacists to replace multiple doses of lower strength medications with a single dose of higher-strength medications where appropriate.

XX. The PBM shall provide a comprehensive pharmacy care program to improve medication adherence for participants with chronic conditions for the fee set forth in Exhibit A, Financial Exhibit - Fees, Discounts, and Rebates of this Contract. As part of the medication adherence program, the PBM shall provide telephone coaching that will involve phone calls from a health educator who is specially trained in the chronic condition. Physicians of participants shall receive written educational information on the rates of medication adherence, implications of non-adherence, and methods for improving adherence. Physicians will also receive alerts on any participant who is not filling his/her medication prescriptions. The structure, content, and scope of this program will be based on the Medication Therapy Management program described in the PBM's response to the Request for Proposal, with the final content and activation schedule to be mutually determined by the PBM and the Board.

YY. The PBM shall provide field and desk audit services and such services shall be included in the administrative fee and the PBM shall provide an annual report of audit activities and findings. Any errors will be addressed and corrected in a timely manner by the PBM. Any amounts recovered due to a field audit or desk audit will be 100% refunded to the Board.

ZZ. The PBM shall provide web-based reporting tools that allow the Board to view, print, and download reports to spreadsheet software.

AAA. The Vendor must provide an annual Statement on Standards for Attestation Engagements (SSAE) No. 16 report or equivalent prepared by a qualified Certified Public Accountant at its own expense for each year of the term of this Contract.

4. Transparency

A. The Vendor must provide a transparent financial pricing arrangement. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts & dispensing fees, etc.). The Board must receive the full and complete amount of any discounts received by the PBM from any and all retail pharmacies. The PBM will not retain a differential (i.e. spread) between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM.

B. The Board will not apply the above standard to mail order or specialty pharmaceutical transactions when owned by the PBM. For these mail order or specialty pharmaceuticals the Board will accept the best possible discount arrangements from the PBM as it relates to a discount from AWP. Rebates generated through mail order or specialty pharmaceuticals will be subject to the transparency requirement described below.

C. The Board must receive all rebates received by the PBM attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers. A "rebate" will include any amounts received directly or indirectly by the PBM, regardless of title or description, whether by cash, credit or other in kind methodologies attributable to the Board's utilization. Reimbursement for research projects based on data analysis not specifically attributable to the Board's utilization data is not included in this requirement and may be retained by the PBM.

D. The only compensation the PBM will receive from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal or agreed upon in writing through subsequent discussion with the Board.

5. Full Disclosure and Independent Review

The Board must have access to all of the PBM's financial records including the MAC list used to adjudicate the Board's claims, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the Transparency requirement is being met by the PBM during the period covered by the contractual term. Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

A. Any amount paid for the Plan by the PBM to retail pharmacies under contract with the PBM's retail network is subject to audit even though the PBM may deem said contracts proprietary and confidential;

B. Fees, which include administrative fees, paid to the PBM by pharmaceutical manufacturers are subject to review for audit purposes;

C. Any amount paid for the Plan by the selected PBM to a mail order or specialty pharmacy, when not owned by the selected PBM, will be subject to audit, whether or not the contract is considered proprietary and confidential by the selected PBM;

D. Discounts negotiated directly by the selected PBM with manufacturers shall be subject to audit; and

E. Aggregate rebate reporting.

The Board at its discretion may use the services of an Independent Reviewer to perform reviews/audits of the PBM's records on behalf of the Board. The Board and its Independent Reviewer will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board has the right to review/audit records for the entire term of the agreement without limitation up to two times per calendar year. Any claims information, documents, etc. which the PBM may deem as containing "trade secrets" will not preclude an examination of such items through the audit process. The PBM will provide the Board assistance in the audit reviews by providing access to records, copies of claims data tapes, access to reasonable support staff, etc. at no cost to the Board. The PBM will cooperate with the Independent Reviewer and agree to respond to any inquiries by the Independent Reviewer within 45 days. The PBM will not restrict the size of the claims sample reviewed by the Independent Reviewer which may include a review of 100% of all claims for the period under review. The Board will bear the cost of any fees charged by its Independent Reviewer.

6. Market Checks

The Board at its discretion may use the services of an independent consultant to perform Market Checks on behalf of the Board. The market check is used to assess if the current program pricing terms are competitive to the pricing terms and conditions available in the market, including brand and generic discounts by channel (Retail and Mail), Rebates, and guaranteed specialty discounts.

7. Responsibilities of the Board, Administrator of the Plan

A. The Board reserves the exclusive right to amend, reduce, or eliminate any part of the Plan or change any benefits at any time. To the extent that such amendment, reduction, elimination, or change materially affects the services provided by the PBM under this Contract, the Board shall notify the PBM of such change via a letter of authorization in a timely manner and in advance of such change. In case of conflict between this Contract and the Plan Document, the Plan Document will prevail.

B. The Board or its designee shall provide educational material to all participants explaining conditions of coverage, cost sharing, benefit design, and financial incentives encouraging compliance with the Plan's Pharmacy Benefit Management program.

C. The Board shall have final authority on any appeal, application, and interpretation of the Plan's benefits or eligibility policies.

D. The Board will not disseminate, sell, or license any proprietary information belonging to the PBM to others without the PBM's prior written approval, unless the information is subject to the Public Records Law of the State or is required to be released by law.

8. Contract Term

A. The effective date of this Contract will be January 1, 2016. The term of the Contract will be four (4) years with one (1) option to renew for one (1) additional year at the Board's discretion. By October 31, 2018, the Board will notify the Vendor, in writing, of the Board's intent regarding renewal of the Contract for one (1) additional year.

B. This Contract may be terminated by either party, with or without cause, upon at least thirty (30) days prior written notice of intent to terminate provided to the other party.

C. All records and information provided by the Board or through its vendors to the Vendor are the sole property of the Board and shall be returned to the Board within thirty (30) days of the termination date of this Contract if so required by the Board. The Vendor shall be entitled to retain and utilize data that have been captured, computed, or stored in the Vendor's databases to the extent that such data cannot be identified or linked to the Board, Plan, or an individual participant with the restrictions described in Item 11, "Confidential Information" of this Contract to apply.

D. Upon termination of this Contract, the Vendor shall fully cooperate with the Board and the new Vendor during the transition of the Plan to the new Vendor. Upon request of the Board, the Vendor shall provide all information maintained by the Vendor in relation to the Plan in a time frame specified by the Board. Information provided shall be in a format designated by the Board. The Vendor shall provide such explanation of the information provided in order to facilitate a smooth transition.

9. Consideration

The Board agrees to compensate the Vendor for services approved by the Board and performed by the Vendor under the terms of this Contract as follows:

A. The administrative fees listed in Exhibit A - Fee Schedule, of this Contract shall constitute the entire compensation due to the Vendor for services and all of the Vendor's obligations hereunder regardless of the difficulty, materials, or equipment required. The unit rates include, but are not limited to, all applicable taxes, fees, general office expense, travel, overhead, profit, and all other direct and indirect costs, incurred or to be incurred, by the Vendor. No additional compensation will be provided by the Board for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the Board.

B. The unit rates listed in Exhibit A - Fee Schedule, of this Contract are firm for the duration of this Contract and are not subject to escalation for any reason, unless this Contract is duly amended.

C. The Board shall not provide any prepayments or initial deposits in advance of services being rendered. Only those services agreed to by Contract shall be considered for reimbursement or compensation by the Board. Payment for any and all services provided by the Vendor to the Board and/or the Plan shall be made only after said services have been duly performed and properly invoiced.

D. In consideration for the services provided by the PBM under this Contract, the Board shall compensate the PBM through administrative fees illustrated in Exhibit A – Fee Schedule of this Contract. In accordance with State law and applicable Contract conditions, the Board will compensate the PBM such fees after the appropriate services have been rendered. The PBM must submit all invoices, in a form acceptable to the Board with all the necessary supporting

documentation, prior to any payment to the PBM of any administrative fees. Administrative fees must be invoiced in sufficient detail and format as determined by the Board. Such invoices shall include, at a minimum, a description of the service(s) provided, the quantity or number of units billed, the compensation rate, the time period in which services were provided, total compensation requested for each individual service being billed, and total administrative fees requested for the period being invoiced. The Board agrees to make payment to the PBM on any undisputed amounts within ten (10) days from the date services were rendered or the date of receipt of the invoice, whichever comes last. Upon the effective date of termination of this Contract, the PBM's obligation to provide any further services under this Contract shall cease. The PBM shall, however, remain liable for any obligations arising hereunder prior to the effective date of such termination as outlined in *Section 7 item II. Responsibilies of the PBM* of this Contract.

E. The PBM is contractually responsible for the claims adjudication component of the retail and mail order prescription drug program. The PBM shall electronically submit an invoice to the Board for claims payments at the end of each semi-monthly billing cycle. The PBM must submit all invoices in a format mutually agreed upon by the Board and the PBM prior to any payment of allowable costs. The Board agrees to reimburse the PBM for amounts disbursed for prescription drug claims payments within ten (10) days of receipt of an invoice. As with payments for administrative services, the PBM's invoice and/or payment for claims may be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board not to constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices. The PBM agrees to the guaranteed discounts and rebate guarantees included in Exhibit A – Fee Schedule, to the performance standards and liquidated damages relative to the services outlined in Exhibit B - Performance Standards and Liquidated Damages, and to the savings guarantees included in Exhibit C - Savings Guarantees of this Contract.

F. The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. Vendor's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the Vendor, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the Vendor under Contract between the parties; or (2) request and receive payment directly from the Vendor within fifteen (15) days of such request, at the Board's sole discretion.

G. The Board reserves the right to deduct from amounts which are or shall become due and payable to the Vendor under this Contract between the parties any amounts which are or shall become due and payable to the Board by the Vendor. Notwithstanding anything to the contrary herein, any reduction of payments to Vendor shall be made only with the prior agreement of both parties. In addition, in the event of termination of this Contract for any reason, Vendor shall be paid for services rendered and allowable expenses incurred up to the effective date of termination.

10. E-Payment

The Vendor agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The DFA agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of the invoice. Miss. Code Ann. § 31-7-301, et seq. (1972, as amended).

11. Paymode

Payments by state agencies using the statewide accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Vendor's choice. The State may, at its sole discretion, require the Vendor to submit invoices and supporting documentation electronically at any time during the term of this Contract. The Vendor understands and agrees that the State is exempt from the payment of taxes. All payments shall be in United States currency.

12. Availability of Funds

It is expressly understood and agreed that the obligation of the Board to proceed under this Contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of state and/or federal funds. If the funds anticipated for the continuing fulfillment of the Contract are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the DFA, the Board shall have the right upon ten (10) working days written notice to the Vendor, to terminate this Contract without damage, penalty, cost or expenses to the Board of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

13. Record Retention and Access to Records

The Vendor agrees that the Board or any of its duly authorized representatives at any time during the term of this Contract shall have unimpeded, prompt access to and the right to audit and examine any pertinent books, documents, papers, and records of the Vendor related to the Vendor's charges and performance under this Contract. All records related to this Contract shall be kept by the Vendor for a period of six (6) years after final payment under this Contract and all pending matters are closed unless the Board authorizes their earlier disposition. However, if any litigation, claim, negotiation, audit or other action arising out of or related in any way to this Contract has been started before the expiration of the six (6) year period, the records shall be retained for one (1) year after all issues arising out of the action are finally resolved. The Vendor agrees to refund to the DFA any overpayment disclosed by any such audit arising out of or related in any way to this Contract.

14. Applicable Law

The Contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. The Vendor shall comply with applicable federal, state, and local laws and regulations.

15. Assignment

The Vendor shall not assign, subcontract or otherwise transfer in whole or in part, its rights or obligations under this Contract without prior written consent of the Board. Any attempted assignment or transfer without said consent shall be void and of no effect.

16. Compliance with Laws

The Vendor understands that the Board is an equal opportunity employer and therefore maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and the Vendor agrees during the term of the Contract that the Vendor will strictly adhere to this policy in its employment practices and provision of services. The Vendor shall comply with, and all activities under this Contract shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

17. Confidential Information

"Confidential Information" includes: (a) those materials, documents, data, and other information which the Vendor has designated in writing as confidential; (b) all data and information which the Vendor acquires as a result of its contact with and efforts on behalf of the Board and any other information designated in writing as confidential by the Board; and (c) "Vendor Proprietary Information" which means the data, databases and all other tangible and intangible information used, developed or provided by Vendor pursuant to the Contract, including without limitation, operating systems, application programs, applications, database systems and, for purposes of this Contract, Third Party Licensor products, together with all related specifications, documentation, methodologies, techniques, ideas and formulas and any enhancements, formatting and modifications thereto, content, and all other data, databases, software, reports, analyses, studies, operating systems, application programs and database systems, together with all related specifications, documentation, methodologies, applications, techniques, ideas and formulas, all enhancements, formatting and modifications thereto and all other information and trade secrets used, developed, licensed or provided by Vendor under or in connection with this Contract; provided, however, that Vendor Proprietary Information does not include (i) Board Confidential Information (ii) final deliverables customized and developed exclusively for the Board as part of the Services.

Each party to this agreement agrees to the following:

A. To protect all confidential information provided by one party to the other;

B. To treat all such confidential information as confidential to the extent that confidential treatment is allowed under State and/or federal law; and,

C. Except as otherwise required by law, not to publish or disclose such information to any third party without the other party's written permission; and,

D. To do so by using those methods and procedures normally used to protect the party's own confidential information.

Any liability resulting from the wrongful disclosure of confidential information on the part of the Vendor or its subcontractor shall rest with Vendor.

18. Transparency

This Contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," codified as Section 25-61-1 et seq., Mississippi Code Annotated and exceptions found in Section 79-23-1 of the Mississippi Code Annotated (1972, as amended). In addition, this Contract is subject to provisions of the Mississippi Accountability and Transparency Act of 2008 (MATA), codified as Section 27-104-151 of the Mississippi Code Annotated (1972, as amended). Unless exempted from disclosure due to a court-issued protective order, this Contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access. Prior to posting the Contract to the website, any information identified by the Vendor as trade secrets, or other proprietary information including confidential vendor information, or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes will be redacted. A fully executed copy of this Contract shall be posted to the State of Mississippi's accountability website at: http://www.transparency.mississippi.gov.

19. Employee Status Verification System

If applicable, the Vendor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act of 2008, Section 71-11-1, *et seq*. of the Mississippi Code Annotated (Supp 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The Vendor agrees to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. The Vendor further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. The Vendor understands and agrees that any breach of these warranties may subject the Vendor to the following: (a) termination of this Contract and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to the Vendor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such cancellation/termination, the Vendor would also be liable for any additional costs incurred by the State due to the contract cancellation or loss of license or permit.

20. Independent Contractor

The Vendor shall perform all services as an Independent Contractor and shall at no time act as an agent for the Board or DFA. No act performed or representation made, whether oral or written, by the Vendor with respect to third parties shall be binding on the Board. Neither the Vendor nor his employees shall, under any circumstances, be considered servants, agents, or employees of the Board or DFA; and neither the Board nor DFA shall at any time be legally responsible for any negligence or other wrongdoing by the Vendor, his servants, agents, or employees.

21. Modification or Renegotiation

This Contract may be modified, altered or changed only by written agreement signed by the parties hereto. The parties agree to renegotiate the Contract if federal, State and/or the DFA revisions of any applicable laws or regulations make changes in this Contract necessary.

22. Procurement Regulations

The Contract shall be governed by the applicable provisions of the Personal Service Contract Review Board Regulations, a copy of which is available at 210 East Capitol Street, Suite 800, Jackson, MS, 39201 for inspection or downloadable at www.mspb.ms.gov.

23. Representation Regarding Contingent Fees

The Vendor represents that he has not retained a person to solicit or secure a Board contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee.

24. Representation Regarding Gratuities

The Vendor represents that he has not violated, is not violating, and promises that he will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

25. Termination for Convenience

A. **Termination. The Board may, when the interests of the Board so require, terminate this Contract in whole or in part for the convenience of the Board. The Board shall give written notification of the termination to the Vendor specifying the part of the Contract terminated and when the termination becomes effective.**

B. **Vendor's Obligations. The Vendor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination the Vendor will stop work to the extent specified. The Vendor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The Vendor shall settle the liabilities and claims arising out of the termination of subcontractors and orders connected with the terminated work. The Board may direct the Vendor to assign the Vendor's right, title, and interest under terminated orders or subcontracts to the Board. The Vendor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.**

26. Termination for Default

A. **Default. If the Vendor refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified within this Contract, or any extension thereof, otherwise fails to timely satisfy the contract provisions, or commits any other substantial breach of this Contract, the Board may notify the Vendor in writing of the delay or nonperformance and if not cured within thirty (30) days or any longer time specified in writing by the Board, the Board may terminate the Vendor's right to proceed with the Contract or such part of the Contract as to which there has been delay or failure to properly perform. In the event of termination in whole or in part, the Board may procure similar supplies or services in a manner and upon terms deemed appropriate by the Board. The Vendor shall continue**

performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

B. **Vendor's Duties. Notwithstanding termination of the Contract and subject to any directions from the Board, the Vendor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the Vendor in which the Board has an interest.**

C. **Compensation. Payment for completed services delivered and accepted by the Board shall be at the contract price. The DFA may withhold from amounts due the Vendor such sums as the DFA deems to be necessary to protect the DFA against loss because of outstanding lien holders and to reimburse the DFA for the excess costs incurred in procuring similar goods and services.**

D. **Excuse for Nonperformance or Delayed Performance. Except with respect to defaults of subcontractors, the Vendor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by the Vendor to make progress in the prosecution of the work hereunder which endangers performance) if the Vendor has notified the Board within 15 days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the state and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or make progress, and if such failure arises out of causes similar to those set forth above, the Vendor shall not be deemed to be in default, unless the services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the Vendor to meet the contract requirements. Upon request of the Vendor, the Board shall ascertain the facts and extent of such failure, and, if the Board determines that any failure to perform was occasioned by any one or more of the excusable clauses, and that, but for the excusable cause, the Vendor's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the Board under the clause of this Contract entitled "Termination for Convenience".**

E. **Erroneous Termination for Default. If, after notice of termination of the Vendor's right to proceed under the provisions of this clause, it is determined for any reason that the Contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph D of this clause, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to the clause of this Contract entitled "Termination for Convenience".**

F. **Additional Rights and Remedies. The rights and remedies provided under this clause are in addition to any other rights and remedies provided by law or under this Contract.**

27. Stop Work Order

A. **Order to stop work. The Board may, by written order to the Vendor at any time, and without notice to any surety, require the Vendor to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to the Vendor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to**

this clause. Upon receipt of such an order, the Vendor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Board shall either:

1. **cancel the stop work order; or**

2. **terminate the work covered by such order as provided in the "Termination for Default" clause or the "Termination for Convenience" clause of this Contract.**

B. **Cancellation or Expiration of the Order. If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Vendor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Vendor price, or both, and the Contract shall be modified in writing accordingly, if:**

1. **the stop work order results in an increase in the time required for, or in the Vendor's costs properly allocable to, the performance of any part of this Contract; and**

2. **the Vendor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Board decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.**

C. **Termination of Stopped Work. If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.**

D. **Adjustment of Price. Any adjustment in contract price made pursuant to this clause shall be determined in accordance with the "Modification or Renegotiation" clause of this Contract.**

28. Oral Statements

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to the Contract must be made in writing by the Board and agreed to by the Vendor.

29. Ownership of Documents and Work Papers

The Board shall own all documents, files, reports, work papers and working documentation, electronic or otherwise, created in connection with the project which is the subject of this Contract, except for the Vendor's internal administrative and quality assurance files and internal project correspondence. The Vendor shall deliver such documents and work papers to the Board upon termination or completion of the Contract if so requested by the Board. The foregoing notwithstanding, the Vendor shall be entitled to retain a set of such work papers for his files. The Vendor shall be entitled to use such work papers only after receiving written permission from the Board and subject to any copyright protections.

30. Indemnification

To the fullest extent allowed by law, Vendor shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, its Commissioners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising from wrongful or negligent acts or omissions by Vendor and/or his partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Contract. In the State's sole discretion, Vendor may be allowed to control the defense of any such claim, suit, etc. In the event Vendor defends said claim, suit, etc., Vendor shall use legal counsel acceptable to the State; Vendor shall be solely liable for all reasonable costs and/or expenses associated with such defense and the State shall be entitled to participate in said defense. Vendor shall not settle any claim, suit, etc., without the State's concurrence, which the State shall not unreasonably withhold.

31. Insurance

The Vendor shall maintain, throughout the term of this Contract, at its own expense, professional and comprehensive general liability insurance. Such policy of insurance shall provide a minimum coverage in the amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate through an insurance company licensed by the Mississippi Department of Insurance. The Vendor shall annually provide the Board a current Certificate of Insurance.

32. Third-Party Action Notification

The Vendor shall give the Board prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the Vendor by any entity that may result in litigation related in any way to this Contract. The Board shall give the Vendor prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the Board by any entity that may result in litigation related in any way to this Contract.

33. Notices

All notices required or permitted to be given under this Contract must be in writing and personally delivered or sent by certified United States mail postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address.

If to the Board:
Executive Director
Mississippi Department of Finance and Administration
501 N. West St., Suite 1301 Woolfolk Building
Post Office Box 267
Jackson, Mississippi 39205-0267
Facsimile: (601) 359-2405

With a copy of any notice to:
State Insurance Administrator
Office of Insurance

Mississippi Department of Finance and Administration
501 N. West St., Suite 901-B Woolfolk Building
Post Office Box 24208
Jackson, Mississippi 39225-4208
Facsimile: (601) 359-6568

If to the Vendor:
OFFICER
TITLE
VENDOR
ADDRESS
ADDRESS
Facsimile: *NUMBER*

34. Approval

It is understood that this Contract is void and no payment shall be made in the event that the Personal Service Contract Review Board does not approve this contract.

35. Change in Scope of Work

The Board may order changes in the work consisting of additions, deletions, or other revisions within the general scope of the Contract. No services may be changed, requiring changes to the amount of compensation to the Vendor or other adjustments to the Contract, unless such changes or adjustments have been made by written amendment to the Contract signed by the Board and the Vendor.

If the Vendor believes that any particular work is not within the scope of the project, is a material change, or will otherwise require more compensation to the Vendor, the Vendor must immediately notify the Board in writing of this belief. If the Board believes that the particular work is within the scope of the Contract as written, the Vendor will be ordered to and shall continue the work as changed and at the cost stated for the work within the scope.

36. Contractor Personnel

The Board shall, throughout the life of the Contract, have the right of reasonable rejection and approval of staff or subcontractors assigned to the work by the Vendor. If the Board reasonably rejects staff or subcontractors, the Vendor must provide replacement staff or subcontractors satisfactory to the Board in a timely manner and at no additional cost to the Board. The day-to-day supervision and control of the Vendor's employees and subcontractors is the sole responsibility of the Vendor.

37. Recovery of Money

Whenever, under the Contract, any sum of money shall be recoverable from or payable by the Vendor to the DFA, the same amount may be deducted from any sum due to the Vendor under the Contract or under any other contract between the Vendor and the DFA. The rights of the DFA are in addition and without prejudice to any other right the DFA may have to claim the amount of any loss or damage suffered by the DFA on account of the acts or omissions of the Vendor.

38. Failure to Enforce

Failure by the Board at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the Contract or any part thereof or the right of the Board to enforce any provision at any time in accordance with its terms.

39. Business Associate Statement

In the paragraphs that follow under this section, the term "BA Statement" will refer to this section of the Contract, the term "Business Associate" will refer to the Vendor, and the term "Covered Entity" will refer to the Plan.

The purpose of this BA Statement is to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HHS) (the HIPAA Regulations) and other applicable laws, including the American Recovery and Reinvestment Act (ARRA) of 2009.

The Covered Entity wishes to disclose certain information (Information) to Business Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI).

The Covered Entity desires and directs Business Associate to share PHI with other Business Associates of the Covered Entity.

In consideration of mutual promises below and exchange of information pursuant to this BA Statement, the parties agree as follows:

A. Definitions.

Terms used, but not otherwise defined, in this BA Statement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Information (the Privacy Rule) and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the event of an inconsistency between the provisions of this BA Statement and mandatory provisions of the Privacy Rule and or the Security Standards, as amended, the Privacy Rule and/or the Security Standards shall control. Where provisions of this BA Statement are different than those mandated in the Privacy Rule and/or the Security Standards, but are nonetheless permitted by the Privacy Rule and/or the Security Standards, the provisions of this BA Statement shall control.

1. Breach. Breach shall be as defined in HITECH and the HIPAA regulations at 45 CFR § 164.402.

2. Business Associate. Business Associate shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.

3. Covered Entity. Covered Entity shall have the same meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.

4. Designated Record Set. Designated Record Set shall have the same meaning given to such term under 45 CFR § 164.501 and shall mean a group of records maintained by or for the Covered Entity that is the payment, enrollment, claims adjudication and case or

health management record systems maintained by or for the Covered Entity, or used, in whole or in part, by or for the Covered Entity, to make decisions about Individuals.

5. Electronic Media. Electronic Media has the same meaning as the term “electronic media” in 45 in CFR § 160.103, which is:

   a) Electronic storage material on which data is or may be recorded electronically, including for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

   b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

6. Electronic Protected Health Care Information or (EPHI). EPHI has the same meaning as the term ‘electronic protected health care information’ in 45 CFR § 160.103, and is defined as that PHI that is transmitted by or maintained in electronic media.

7. Individual. 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).

8. Privacy Rule. 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.

9. Protected Health Information or (PHI). PHI shall have the same meaning as the term “protected health information" in 45 CFR § 164.103.

10. Required By Law. Required By Law shall have the same meaning as the defined term “required by law” in 45 § CFR 164.103.

11. Security Incident has the meaning in 45 CFR § 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

12. Security Standards shall mean the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) codified at 45 CFR Parts 160 and 164, subpart C (Security Rule).

13. Unsecured PHI as defined in HIPAA and the HIPAA regulations at 45 CFR § 164.402, means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in guidance issued under 13402(h)(2) of Public Law 111-5 on HHS website.

B. Obligations and Activities of Business Associate.

1. Compliance with Applicable Laws. Business Associate shall fully comply with the standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the HIPAA Regulations) and other applicable laws as of the date(s) the requirements under these laws become effective for Business Associates. This compliance shall include all requirements noted in Section 13404(a), (b) and (c) of the HITECH Act.

2. Business Associate directly subject to certain HIPAA provisions. Under HITECH, Business Associate acknowledges that it is directly subject to certain HIPAA provisions including, but not limited to, Sections 13401, 13404, 13405 of HITECH.

3. Use and Disclosure of Protected Health Information. Business Associate may use and/or disclose the Covered Entity's PHI received by Business Associate pursuant to this BA Statement, the Contract, or as required by law, or as permitted under 45 CFR §164.512, subject to the provisions set forth in this BA Statement. Business Associate may use PHI in its possession for its proper management and administration or to fulfill any of its legal responsibilities. The Covered Entity specifically requests that Business Associate disclose PHI to other Business Associates of the Covered Entity for Health Care Operations of the Covered Entity. The Covered Entity shall provide a list of the affected Business Associates and will request specific disclosures in written format. If any affected Business Associate is no longer under a BA Statement with the Covered Entity, the Covered Entity shall promptly inform Business Associate of such change.

4. Safeguards Against Misuse of Information. Business Associate shall use appropriate safeguards to prevent the use or disclosure of the Covered Entity's PHI in any manner other than as required by this BA Statement or as required by law. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

5. Reporting of Disclosures. Business Associate shall report to the Covered Entity any use or disclosure of the Covered Entity's PHI in violation of this BA Statement or as required by law of which the Business Associate is aware, including Breaches of Unsecured PHI as required by 45 CFR §164.410, and agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of the Covered Entity's PHI by Business Associate in violation of this BA Statement.

6. Business Associate's Agents. Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Business Associate on behalf of) the Covered Entity agree to be bound to by the same restrictions and conditions on the use or disclosure of PHI as apply to Business Associate with respect to such PHI. Business Associate represents that in the event of a disclosure of PHI to any third party, the information disclosed shall be in a limited data set if practicable and in all other cases the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

7. Nondisclosure. Business Associate shall not use or further disclose the Covered Entity's PHI otherwise than as permitted or required by this BA Statement, the Contract, or as required by law.

8. Availability of Information to the Covered Entity and Provision of Access and Accountings. Business Associate shall make available to the Covered Entity such Protected Health Information maintained by the Business Associate in a Designated Record Set as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, or provide a copy of, such Designated Record Set as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.524. Business Associate shall also maintain and make available the information required to provide an accounting of disclosures of Protected Health Information to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528.

9. Amendment of PHI. Business Associate shall make the Covered Entity's PHI available to the Covered Entity as the Covered Entity may require to fulfill the Covered Entity's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR § 164.526 and Business Associate shall, as directed by the Covered Entity, incorporate any amendments to the Covered Entity's PHI into copies of such PHI maintained by Business Associate. Business Associate agrees to make any amendment(s) to Protected Health Information that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity. [45 CFR § 164.504(e)(2)(F)]

10. Internal Practices. Business Associate agrees to make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PHI received from the Covered Entity (or received by Business Associate on behalf of the Covered Entity) available to the Secretary of the U.S. Department of Health and Human Services for inspection and copying for purposes of determining the Covered Entity's compliance with HIPAA and the HIPAA Regulations.

11. Notification of Breach. During the term of this BA Statement, Business Associate shall notify the Covered Entity following discovery and without unreasonable delay (but in no case later than 60 days) any Breach of Unsecured PHI. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

12. Safeguard of EPHI. The Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

13. Subcontractors. The Business Associate will ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate safeguards to protect it.

14. Notification. The Business Associate will report to the Covered Entity through the Mississippi Department of Finance and Administration, Office of Insurance any Breach of Unsecured PHI of which it becomes aware, without unreasonable delay, in the following time and manner:

a) any actual, successful Security Incident will be reported to the Covered Entity in writing, without unreasonable delay; and

b) any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, will be reported to the Covered Entity in writing, on a reasonable basis, at the written request of the Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the Security Rule.

15. Business Associate shall maintain and provide to the Covered Entity without unreasonable delay and in no case later than 60 days of discovery of a Breach of Unsecured PHI, (as these terms are defined in the HIPAA Regulations), the appropriate information to allow the Covered Entity to adhere to Breach notification.

16. The information provided to the Covered Entity must include, at a minimum and to the extent possible, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during the Breach, and the Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in its notification to the Individual following discovery of a Breach and without unreasonable delay or promptly thereafter as information becomes available, including:

a) A brief description of what happened, including the date of the breach, if known, and the date of the discovery of the breach.

b) A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

c) The steps individuals should take to protect themselves from potential harm resulting from the breach.

d) A brief description of what the Business Associate involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

17. Minimum Necessary. Business Associate shall limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR § 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

18. Marketing. Business Associate will not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.

19. Data Aggregation. Business Associate may use PHI in its possession to provide data aggregation services relating to the health care operations of the Covered Entity, as provided for in 45 CFR §164.501.

20. De-identification of PHI. Business Associate may de-identify any and all PHI, provided that the de-identification conforms to the requirements of 45 CFR § 164.514(b), and further provided that Business Associate maintains the documentation required by 45 CFR § 164.514(b), which may be in the form of a written assurance from Business

Associate. Pursuant to 45 CFR § 164.502(d), de-identified information does not constitute PHI and is not subject to the terms of the BA Statement.

C. Obligations of the Covered Entity

1. Covered Entity's Representatives. The Covered Entity shall designate, in writing to Business Associate, individuals to be regarded as the Covered Entity's representatives, so that in reliance upon such designation Business Associate is authorized to make disclosures of PHI to such individuals or to their designee(s).

2. Restrictions on Use or Disclosure of PHI. If the Covered Entity agrees to restrictions on use or disclosure, as provided for in 45 CFR § 164.522 and the HITECH Act, of PHI received or created by Business Associate regarding an Individual, the Covered Entity agrees to pay Business Associate the actual costs incurred by Business Associate in accommodating such voluntary restrictions.

3. Limitation on Requests. The Covered Entity shall not request or require that Business Associate make any use or alteration of PHI that would violate HIPAA or HIPAA Regulations if done by the Covered Entity.

D. Audits, Inspection, and Enforcement.

Upon reasonable notice, upon a reasonable determination by the Covered Entity that Business Associate has breached this BA Statement; the Covered Entity may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BA Statement. Business Associate shall promptly remedy any violation of any term of this BA Statement and shall certify the same to the Covered Entity in writing. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this BA Statement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this BA Statement. Business Associate shall fully cooperate with the U.S. Department of Health and Human Services, as the primary enforcer of the HIPAA, who shall conduct periodic compliance audits to ensure that both Business Associate and the Covered Entity are compliant.

E. Termination.

1. Material Breach. A breach by Business Associate of any provision of this BA Statement, as determined by the Covered Entity, shall constitute a material breach of the BA Statement and shall provide grounds for immediate termination of the BA Statement and the Contract by the Board pursuant to Section E.2. of this BA Statement. [45 CFR § 164.504(e)(3)]

2. Reasonable Steps to Cure Breach. If either Party knows of a pattern of activity or practice of the other that constitutes a material breach or violation of that Party's obligations under the provisions of this BA Statement or another arrangement and does not terminate this BA Statement pursuant to Section E.1., then that Party shall take reasonable steps to cure such breach or end such violation, as applicable. If the Party's efforts to cure such breach or end such violation are unsuccessful, that Party shall either (i) terminate this BA Statement if feasible; or (ii) if termination of this BA Statement is not

feasible, the non-breaching Party shall report the other Party's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]

3. Judicial or Administrative Proceedings. Either party may terminate this BA Statement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

4. Effect of Termination. Upon termination of this BA Statement and the Contract for any reason, Business Associate shall return or destroy all PHI received from the Covered Entity (or created or received by Business Associate on behalf of the Covered Entity) that Business Associate still maintains in any form, and shall retain no copies of such PHI except for one copy that Business Associate will use solely for archival purposes and to defend its work product, provided that documents and data remain confidential and subject to this BA Statement, or, if return or destruction is not feasible, it shall continue to extend the protections of this BA Statement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(I)]

F. Disclaimer.

The Covered Entity makes no warranty or representation that compliance by Business Associate with this BA Statement, HIPAA or the HIPAA Regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

G. Amendment.

Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BA Statement and the Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the Covered Entity must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all PHI that it receives or creates pursuant to this BA Statement. Upon the Covered Entity's request, Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this BA Statement and the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The Covered Entity may terminate this BA Statement upon 90 days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BA Statement and the Contract when requested by the Covered Entity pursuant to this Section; or (ii) Business Associate does not enter into an amendment to this BA Statement and the Contract providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

H. Assistance in Litigation or Administrative Proceedings.

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this BA Statement, available to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

I. No Third Party Beneficiaries.

Nothing expressed or implied in this BA Statement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

J. Effect on Contract.

Except as specifically required to implement the purposes of this BA Statement, or to the extent inconsistent with this BA Statement, all other terms of the Contract shall remain in force and effect.

K. Electronic Health Records (EHR)

If electronic health records are used or maintained with respect to PHI, individuals shall have the right to obtain a copy of such information in "electronic format".

L. No Remuneration for PHI.

Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI, unless it first obtains a valid authorization from the individual whose PHI is being disclosed.

M. Interpretation.

This BA Statement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations and applicable state laws. The parties agree that any ambiguity in this BA Statement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

40. Incorporation of Documents

This Contract consists of and precedence is hereby established by the order of the following documents incorporated herein:

A. This Contract signed by the parties including Exhibit A - Fee Schedule and Exhibit B - Performance Guarantees; and

B. The Vendor's response to the State of Mississippi Request for Proposal for Pharmacy Benefit Manager dated January 30, 2015, attached hereto as Exhibit C and incorporated fully herein by reference;

C. The State of Mississippi Request for Proposal for Pharmacy Benefit Manager dated February 27, 2015, attached hereto as Exhibit D and incorporated fully herein by reference.

This Contract, including the exhibits referenced herein, constitutes the entire Contract of the parties with respect to the subject matter contained herein and supersedes and replaces any and all prior negotiations, understandings and Contracts, written or oral, between the parties relating thereto. Any ambiguities, conflicts, or questions of interpretation of this Contract shall be resolved by first reference to this Contract including Exhibit A and Exhibit B, and if still unresolved, by reference to Exhibit C, and if still unresolved, by reference to Exhibit D. Omission of any term or obligation from this Contract or the attached exhibits shall not be deemed an omission from this Contract if such term or obligation is provided for elsewhere.

Witness our signatures, on the date first written:

VENDOR	**State and School Employees Health Insurance Management Board**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: Chairman
Date: _____	Date: _____

Exhibit A – Fee Schedule

Pharmacy Benefit Manager Administrative Services

Exhibit B - Performance Standards

The Vendor agrees to the following performance guarantees and agrees to the assessment of liquidated damages for failure to meet these guarantees.

- The Vendor guarantees that the system will be available to the Board on-line ninety-eight percent (98%) of the time between 7:00 a.m. and 7:00 p.m. Central Time, Monday through Friday, for other than scheduled maintenance agreed to by the Board. If the vendor is found to be non-compliant with this requirement, the vendor may be assessed a fee of $5,000.00 in liquidated damages per day for which the vendor is non-compliant.
- The Vendor guarantees that the data supplied by the data providers will have passed quality assurance testing and be accurate, complete, and available to Board within 20 calendar days from receipt of clean, useable data from all data providers. If data is not accurate, complete, and available to Board within this time, the vendor will be considered non-compliant with this requirement and may be assessed liquidated damages of $5,000.00 per day for which the vendor is non-compliant.
- The Vendor guarantees for the duration of the contract a toll-free telephone number as well as internet access to a post implementation help desk that offers live assistance or the ability to leave a message twenty-four (24) hours a day, seven (7) days a week. Vendor shall provide non-automated responses to inquiries within one (1) business day. Vendor may be assessed liquidated damages of one percent (1 %) of all annual fees in the event of non-compliance with this requirement.
- The Vendor guarantees to notify the Board within twenty-four hours by phone and by e-mail of any material security breach of the Board's confidential information that is in the vendor's possession including any unauthorized use, dissemination, or access. The vendor may be assessed liquidated damages of $5,000.00 per day for which the vendor is non-compliant.

Exhibit C - Vendor's Response to

Request for Proposal for Pharmacy Benefit Manager

January 27, 2015

Exhibit D - State of Mississippi

Request for Proposal for Pharmacy Benefit Manager

January 27, 2015