LAMAR CISD

A PROUD TRADITION | A BRIGHT FUTURE

04-2026TB

Pharmacy Benefit Management Services

Issue Date: 9/8/2026

Questions Deadline: 9/17/2026 12:00 AM (CT)

Response Deadline: 9/24/2026 02:00 PM (CT)

Event Information

Number:	04-2026TB
Title:	Pharmacy Benefit Management Services
Type:	Request for Proposal
Issue Date:	9/8/2026
Question Deadline:	9/17/2026 12:00 AM (CT)
Response Deadline:	9/24/2026 02:00 PM (CT)
Notes:	Lamar CISD (LCISD) is a K-12 public school district in Fort Bend County serving a student enrollment of 50,000. The district currently consists of 58 campuses and 9 district sites with additional campuses pending.

General Information- Please consider the following information for your proposal

Effective Date: September 1, 2027

Client Name: Lamar Consolidated ISD

Segment Type: Employer

Incumbent PBM Vendor: UHC

Geographic Location (Headquarters): Rosenberg, TX

About Client: Lamar Consolidated ISD- About Lamar CISD

Total Relevant Plan Members: 5683

Plan Design and Clinical Rules: To be provided upon receipt of vendor's intent to Bid

Claims Data File: To be provided upon receipt of vendor's intent to Bid

Contract Term Requested: 1 year contract with four (4) optional renewals that allows the CLIENT to terminate the agreement with or without cause, and without termination charges, after the first year (as long as 90 days written notice is given). CLIENT will be the only party to have termination for convenience rights. 1 year contract with 4 (four) annual renewal options.

Formulary Requested: Exclusionary

Rebate Guarantee Requested: Per Brand Claim Rebate Guarantees

Pricing Format Requested: Pass-Through

Specialty Arrangement Requested: Exclusive

Retail 90 Pricing Requested: Broad R90

Network Requested: Broad

Terms and Conditions

Texas Education Code 44.031
Purchasing and Acquisition, LCISD Policy CH (Legal)
Purchasing and Acquisition, LCISD Policy CH (Local)

LCISD reserves the right to award this contract as best meets the district needs to include primary and alternate, dual or multiple award. The District will not provide any guarantee on the amount of work awarded.

Response Requirements
LCISD will accept electronic proposals only as it helps to expedite the bidding process and alleviates errors. Electronic responses are due by the stated close date and time. No paper, emailed, or faxed responses will be accepted.

For technical assistance, please contact Ion Wave Support:
844-226-3862
support.ionwave@eunasolutions.com

Bid Attachments

Lamar CISD Claims FD.xlsx — View Online
Lamar CISD Claims FD

Data Dictionary.xlsx — View Online
Data Dictionary

Pharmacy Dispenser Type.xlsx — View Online
Pharmacy Dispenser Type

W9.pdf — View Online
W9

1295 Instructions.pdf — View Online
Form 1295

CIQ.pdf — Download
Conflict Of Interest Questionnaire

Edgar Certifications.pdf — View Online
Edgar Certifications

Lamar CISD - Terms & Conditions.pdf — View Online
Lamar CISD Terms & Conditions

Reference Questionnaire.pdf — View Online
Reference Questionnaire

Non-Maintenance 2T to 3T.xlsx — View Online
Non- Maintenance 2T to 3T

Maintenance 2T to 3T.xlsx — View Online
Maintenance 2T to 3T

Non-Maintenanc 3T to 2T.xlsx — View Online
Non- Maintenance 3T to 2T

Maintenance 3T to 2T.xlsx — View Online
Maintenance 3T to 2T

Exclusions- Non-Maintenance.xlsx View Online

Exclusions - Non-Maintenance

Exclusions- Maintenance Drugs.xlsx View Online

Exclusions - Maintenance Drugs

Rebate Credit List.xlsx View Online

Rebate Credit List

Exclusions.xlsx View Online

Exclusions

Specialty List.xlsx View Online

Specialty List

Network Disruption.xlsx View Online

Network Disruption

Mfc Coupon Programs.xlsx View Online

Mfc Coupon Programs

Administrative Ancillary Fees.xlsx View Online

Administrative Ancillary Fees

Financial Offer.xlsx View Online

Financial Offer

Claims and Trend Assumption.xlsx View Online

Claims and Trend Assumption

Requested Attachments

Conflict of Interest Form

(Attachment required)

Please download and complete the Conflict of Interest form, located on the "Attachments" tab. Upload the completed form.

Completed 1295 Form

(Attachment required)

Go to https://prd.tecprd.ethicsefile.com/TECCertInt/pages/login/certLogin.jsf

Completed W-9 Form

(Attachment required)

Please download and complete the W-9 form, located on the "Attachments" tab. Upload the completed form.

Reference Questionnaire

(Attachment required)

Upload completed questionnaire

Reference Questionnaire

(Attachment required)

Upload completed questionnaire

Reference Questionnaire

(Attachment required)

Upload completed questionnaire

Edgar Certifications

(Attachment required)

Non- Maintenance 2T to 3T

(Attachment required)

Maintenance 2T to 3T
(Attachment required)

Non- Maintenance 3T to 2T
(Attachment required)

Maintenance 3T to 2T
(Attachment required)

Exclusions - Non-Maintenance
(Attachment required)

Exclusions - Maintenance Drugs
(Attachment required)

Rebate Credit List
(Attachment required)

Exclusions
(Attachment required)

Specialty List
(Attachment required)

Network Disruption
(Attachment required)

Mfc Coupon Programs
(Attachment required)

Administrative Ancillary Fees
(Attachment required)

Financial Offer
(Attachment required)

Claims and Trend Assumption
(Attachment required)

Bid Attributes

1	**Introduction** There are attributes, including this one, associated with this solicitation. Some are notes and require no response, but most have a required response. Please select each page on the right-hand side of the blue bar below (at the bottom of this list of attributes) in order to view the next page of Attributes.
2	**Lamar CISD Terms and Conditions** Lamar CISD Terms and Conditions are provided in an attachment to the proposal. Please check if you agree or disagree to the terms and conditions of this proposal. This is your electronic signature. ☐ Agree ☐ Do Not Agree *(Required: Check only one)*
3	**Scope of Work** The Scope of Work is provided in an attachment to the proposal. Please check if you agree or disagree to the Scope of Work of this proposal. This is your electronic signature. ☐ Agree ☐ Do Not Agree *(Required: Check only one)*

4 Contact Name

List the name of the person who submitted this proposal.

(Required: Maximum 1000 characters allowed)

5 Contact Phone Number

List phone number of person who submitted this proposal. Include area code. List direct phone number when possible, or list phone number with extension.

(Required: Maximum 1000 characters allowed)

6 Email Address

List email address of person submitting proposal. This email address will be used for any questions concerning this solicitation and for notification of award.

(Required: Maximum 1000 characters allowed)

7 Purchase Order Information

Please provide legal business name.

(Required: Maximum 1000 characters allowed)

8 Purchase Order Information

Please provide company address.

(Required: Maximum 1000 characters allowed)

9 Purchase Order Information

Please provide email address that POs should be sent to.

(Required: Maximum 1000 characters allowed)

10 Remittance Information

Please specify the correct legal business name, contact person, address, phone and fax numbers that should be used as the remittance address.

(Required: Maximum 4000 characters allowed)

11 Conflict of Interest

It is the vendor's responsibility to notify the school district if there is a conflict of interest.
Website: https://www.ethics.state.tx.us/forms/conflict/
By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person becomes aware of facts that require the statement to be filed. See Section 176.006, Local Government Code. A person commits an offense if the person violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor. (Ref H.B. 23.).
Conflict of Interest Questionnaire (CIQ) form and instructions for completion are found under the "Attachments" tab of this solicitation. If you have a Conflict of Interest, the completed form (including signature) must be attached under #2 in the "Response Attachments" tab of this solicitation. If nothing to disclose, you do not need to complete and attach the form with your response.
Do you have a conflict of interest with a Lamar CISD official to report or disclose under this statutory requirement?

☐ yes ☐ no
(Required: Check only one)

12 Code of Silence

As part of the District's commitment to transparency and fairness during the competitive procurement process, we are implementing a Code of Silence.

"Code of Silence" shall mean a prohibition on any communication regarding any competitive procurement between:
-Any person who seeks an award from the District or its affiliated entities, including a potential vendor or vendor's representative; and
-The Superintendent or any chief officer, assistant superintendent, executive director, principal, department head, director, manager, or other District representative who has influence on or is participating in the evaluation or selection process.
-The Code of Silence shall not apply to communication with the purchasing staff.

The Code of Silence time period shall begin 30 days before the issuance of a competitive procurement solicitation and will officially end when the contract is awarded by the Board of Trustees.

☐ I have read and understand.
(Required: Check if applicable)

13 Submission Response

Lamar CISD requires proposal responses to be submitted electronically via this system as it expedites the solicitation process and helps to alleviate errors.

☐ I have read and understand.
(Required: Check if applicable)

14 Solicitation Questions

All questions regarding this solicitation must be asked using the QUESTIONS Tab within the system.

☐ I have read, understand, and agree.
(Required: Check if applicable)

15 Non-Exclusive Contract

To allow for competition as the District utilizes funding to make day-to-day purchases, it is the intent of the District to award multiple vendors as determined to be the best value by Lamar CISD.

(Optional: Maximum 4000 characters allowed)

16 Interlocal Agreement Clause

Lamar CISD is a member in good standing of the Central Texas Purchasing Alliance (CTPA) an alliance of over 40 school districts in Texas representing over a million students, sharing information, services and contractual opportunities. CTPA is an alliance created in accordance with Section 791.001 of the Texas Government Code through interlocal agreements.

In support of this collaborative effort, all awards made by Lamar CISD may be adopted by other active CTPA member districts. By adopting a contract from another CTPA member district, the adopting district has met the competitive bidding requirements established by the Texas Education Code, Section 44.031(a)(4) and as required by the adopting district's policies. There is no obligation on either party to participate unless both parties agree. The goods and services provided under the contract will be at the same or better contract pricing and purchasing terms established by the originating district.

The adopting district shall be responsible for the management of the new contract and all payments to the contracted vendor. The originating district shall have no responsibilities under the new contract agreement. If a member district chooses to utilize this solicitation and subsequent contract, contracts will be awarded individually by those districts.

(Required: Maximum 4000 characters allowed)

17	**Pricing Requirements** 1. Pricing shall remain fixed for the full initial term of this contract. Any requests for a price increase may be presented in writing to the District for consideration only at the contract renewal points and must be accompanied by a proper justification. The District expects suppliers to avoid cost increases and to negotiate with their own suppliers or manufacturers in order to achieve this objective. Any price increase requests that are accompanied by proper justification should limit the increase to no more than 3% over the previous year's costs. The District reserves the right to contest and negotiate any price increase requests. 2. Proposer are not required to submit pricing on all items; however, proposers who submit pricing on all items all or most items may have a better chance of being awarded part or all of the contract. Please select ”No Bid” for those items you decide not to submit pricing on. The District reserves the right to issue a partial award or award for all items based on the submitted proposals. 3. If varying minimum order quantities are required for any particular item, or if Manufacturer price increases have occurred, the District reserves the right to price quote those items from any of the awarded vendors and to add the desired item to the contract of the vendor whose proposal offers the best value to the District, considering all relevant factors including but not limited to pricing, availability, product quality, expected delivery lead times, etc. 4. The unit pricing proposed for the products listed in the Line Items tab shall represent the maximum price the District would pay for such products; however, the District reserves the right to negotiate better pricing based on large orders associated with special projects. *(Optional: Maximum 4000 characters allowed)*
18	**Attachments Required** Be sure to upload all required documents and forms to the RESPONSE ATTACHMENTS tab of this solicitation.

19 **Evaluation Criteria**

The District will evaluate the initial response documentation from all responsive proposers to this solicitation based on the criteria and weighted values listed below.

Fixed Costs - 30%
a) Total Medical Fees
b) Allowances
c) Ancillary Fees

Cost of Care - 40%
a) Indicated plan design can be accommodated
b) Network and Access
c) Claims Repricing

Quality of Goods and Services - 20%
a) Response to contract terms/banking arrangements/timelines
b) Experience and Qualifications of Client/Customer Service Team
c) Performance Standards and Guarantees

Credibility and Proposal Specification - 10%
a) Financial Stability - AM Best
b) Years Writing Proposed Benefits
c) Adherence to Proposal Specifications

The District reserves the right to include additional evaluation criteria beyond the initial review to include, but not limited to the criteria identified in Texas Education Code 44.031(b). The District reserves the right to add additional evaluation steps, such as interviews, demonstrations, sample products, etc., to determine which response best meets the needs of the District. The District reserves the right to negotiate price, final terms and conditions, and/or any relevant factors prior to award.

20 **Award Information**

Being an awarded vendor signifies that your company is authorized to accept and fulfill orders received from authorized District staff; however, as an awarded vendor the District does not guarantee that your company will receive any business.

☐ I have read and understand.
(Required: Check if applicable)

21 **Contract Term**

An award recommendation will be made at the Lamar CISD Board of Trustees meeting scheduled on December 2026. If the award recommendation is approved, the initial term of this contract ("Contract") will be for one (1) year from December 2026 - December 2031. Thereafter, the District reserves the right to either renew the contract annually for up to four (4) additional one-year terms ("Renewal Terms") or to extend the contract on a month-to-month basis to prevent a lapse in the contract term until the District re-bids the Contract.

This contract may be terminated by the District at any time with or without cause and without penalty to the District. In the event of termination by the District prior to completion of the contract, compensation shall be prorated on the services actually performed, and the Contractor shall only be entitled to receive compensation for satisfactory work completed up to the date of termination.

☐ I have read, understand, and accept.
(Required: Check if applicable)

22	**Late Proposals Not Accepted** The "Close Date & Time" referenced on this solicitation is the deadline by which responses must be submitted via the Lamar CISD's web-based e-sourcing system. **LATE SUBMISSIONS WILL NOT BE ACCEPTED.** Please give yourself ample time to enter your submission online prior to the deadline, at which time the online system will lock and will not accept any submissions. **IMPORTANT NOTES TO SUPPLIERS:** - Lamar CISD highly recommends that vendors submit their completed proposals 4 to 24 hours prior to the submission deadline in order to have time to address any errors they may encounter during the proposal submission process. - Lamar CISD will not be responsible for any late responses or for any technical issues that are out of the District's control.
23	**Section 2** **PROPOSAL REQUIREMENTS** **The following items require an answer**
24	**Debarment or Suspension Certification** Non-Federal entities are prohibited from contracting with or making sub-awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement of good or services equal to or in excess of $100,000. Vendors receiving individual awards of $100,000 or more and all sub-recipients must certify that the organizations and its principals are not suspended or debarred. (I) Certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department of agency under the Federal OMB, A-102, common rule. Failure to certify will render bidder non-responsive and will not be considered for award. ☐ [Please select] ☐ Agree ☐ Do not agree *(Required: Check only one)*
25	**Felony Conviction Notice** Texas Education Code, Section 44.034, Texas Education Code, Notification of Criminal History, Subsection (a), states "A person or business entity that enters into a contract with a school district must give advance notice to the district if the person or an owner or operator of the business entity has been convicted of a felony. The notice must include a general description of the conduct resulting in the conviction of a felony." Subsection (b) states "A school district may terminate a contract with a person or business entity if the district determines that the person or business entity failed to give notice as required by Subsection (a) or misrepresented the conduct resulting in the conviction. The district must compensate the person or business entity for services performed before the termination of the contract." Is your firm owned or operated by anyone who has been convicted of a felony? ☐ Yes ☐ No *(Required: Check only one)*

26 Felony Conviction Details

If your firm is owned or operated by anyone who has been convicted of a felony, please list their name and the details of the conviction. If not applicable, please enter N/A (not applicable).

(Required: Maximum 4000 characters allowed)

27 Criminal Background Check Requirement

If an employee of a contractor is covered under SB 9, the contractor must bear the burden of obtaining a national, fingerprint-based criminal history check. Under Section 22.0834 of the Education Code, the contractor is then required to certify to the district that the criminal history check has been performed. The contractor, not the district, is responsible for contacting DPS directly to set up an account for the purposes of obtaining criminal history record information. Under the statute SB 9, a contractor is required to conduct a criminal history review on an employee only when the following criteria have been met: *The employer has contracted with district to provide services. *The particular employee will have continuing duties relating to the contract with the district. * The particular employee will have contact with students. A contractor or sub-contractor may not work on District property or any location the District deems a place where students are regularly present when *they have been convicted of a felony or misdemeanor involving moral turpitude, as defined by Texas law or any other offense the District believes might compromise the safety of student, staff or property.

A Proposer's violation of this section shall constitute substantial failure. If the Proposer is the person or owner or operator of the business entity, that individual may not self-certify regarding the criminal history record information and its review, and must submit original evidence acceptable to the district with this Agreement showing compliance. Possession of fire arms, alcohol and/or drugs, even in vehicles, is strictly prohibited on school/district property. The use of tobacco products are not allowed on school district property. ~~~This is your electronic signature.

☐ Agree ☐ Do Not Agree

(Required: Check only one)

28 Non-resident Bidder's Certification

Non-resident Bidder of Texas as defined in Texas Government Code Section 2252.001(3) ~~~ If your firm is not a Resident Bidder of Texas as defined in Texas Government Code Section 2252.001(4), indicate your firm's principal place of business City and State. If not applicable, please enter N/A (not applicable).

(Required: Maximum 4000 characters allowed)

29 **Conflict of Interest Questionnaire**

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. See Section 176.006(a-1), Local Government Code.

A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

Does this vendor have conflict of interest with Lamar CISD?

☐ Yes ☐ No

(Required: Check only one)

30 **Anti-Collusion Statement**

I affirm that I am duly authorized to execute this contract; that this company, corporation, firm, partnership or individual has not prepared this bid in collusion with any other Bidder, and that the contents of this bid as to prices, terms or conditions of said bid have not been communicated by the undersigned nor by any employee or agent to any other person engaged in this type of business prior to the official opening of this bid.

☐ I agree.

(Required: Check if applicable)

31 **No Israel Boycott Certification**

Effective September 1, 2017, a Texas governmental entity may not enter into a contract with a company for goods or services unless the contract contains a written verification from the company that it:

(1) does not boycott Israel; and
(2) will not boycott Israel during the term of the contract. (TEX. GOV'T CODE Ch. 2270)

"Boycott Israel" means refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations specifically with Israel, or with a person or entity doing business in Israel or in an Israeli-controlled territory, but does not include an action made for ordinary business purposes. TEX. GOV'T CODE §808.001(1)

Vendor certifies that they do not boycott Israel, will not boycott Israel during the term of this Agreement, and are in compliance with Section 2270.002 of the Texas Government Code.

☐ Agree

(Required: Check if applicable)

32 **No Excluded Nation or Foreign Terrorist Organization Certification**

Effective September 1, 2017, Chapter 2252 of the Texas Government Code provides that a Texas governmental entity may not enter into a contract with a company engaged in active business operations with Sudan, Iran, or a foreign terrorist organization - specifically, any company identified on a list prepared and maintained by the Texas Comptroller under Texas Government Code §§806.051, 807.051, or 2252.153. (A company that the U.S. Government affirmatively declares to be excluded from its federal sanctions regime relating to Sudan, Iran, or any other federal sanctions regime relating to a foreign terrorist organization is not subject to the contract prohibition.)

Vendor certifies that they do not support foreign terrorist organizations and are in compliance with Sections 2252.152-154 of the Texas Government Code.

☐ Agree

(Required: Check if applicable)

33 No Deviations or Exceptions

I certify that there are NO deviations or exceptions from the attached specific terms, conditions, and specifications.

☐ [Please select] ☐ Agree - No Deviations ☐ Do Not Agree - Please see below

(Required: Check only one)

34 Deviations and Exceptions

If your company intends to deviate from the Specifications listed in the attached documents, all such deviations and exceptions must be listed here, with complete and detailed conditions and information included. The District will consider any deviations or exceptions in its bid award decisions. The District reserves the right to accept or reject any proposals based upon any deviations indicated below. If none, please enter N/A (Not Applicable).

(Required: Maximum 4000 characters allowed)

35 Purchasing Cooperative

Has your company been awarded a purchasing cooperative contract? If yes, please list the names of the Cooperatives and the contract numbers you have with each. If none, please enter N/A (not applicable).

(Required: Maximum 4000 characters allowed)

36 Texas Public Information Act

The District is a public entity subject to the Texas Public Information Act (Tex. Govt. Code Ch. 552, "The Act"). Responses to this invitation are subject to release as public information unless the response or specific parts of the response are exempted from public disclosure under such Act. Respondents should consult with their legal counsel regarding disclosure issues and take the appropriate precautions to safeguard trade secrets or any other proprietary information before responding to this invitation. The Act permits you, upon request for information from a member of the public, to make arguments to the attorney general that disclosure of the information would implicate your property or privacy interest.

☐ I have read and understand.

(Required: Check if applicable)

37	**Certificate of Interested Parties (Form 1295)** Pursuant HB 1295, the addition of section 2252.908 of the Government Code, all awarded vendors must fill out electronically, with the Texas Ethics Commission's online filing application. The law states that a governmental entity or state may not enter into certain contract with a business entity unless the business entity submits a disclosure of Interested Parties (Form 1295) to the governmental entity or state agency at the time the business entity submits the signed contract to the governmental entity or state agency. The Texas Ethics Commission has adopted rules requiring the business to file Form 1295 electronically with the Commission. This form must then be signed and attached under the "Response Attachments" tab of this RFP, prior to any business transaction. The 1295 filing application can be located at: https://www.ethics.state.tx.us/filinginfo/1295/ Following is a link to a video, which explains this process and how to fill out the form: https://www.ethics.state.tx.us/filinginfo/videos/Form1295/FirstLogin-Business/Form1295Login-Business.html **Instructions:** 1. Create a login and password on the Texas Ethics website. (If you already have a login, you may skip this step) 2. **Login** and select **Manage My 1295 Forms** 3. Select **Start a New Certificate** **Business Name:** Enter your business name, city, state and country of your place of business. **Who is the Contract With?** Select “Other Governmental Entity" **Governmental Entity Name:** Lamar CISD **Contract ID Number:** Enter the Lamar CISD Contract ID number. This will be the RFP number that you are responding to. **Select Add More** to add the names of any Interested Parties. **Select Next** when there are no additional interested parties to add. **Select the button** next to "I swear, or affirm...that information provided is true and correct" **Enter name** of individual filling out the form 4. **Print** the form and fill out the Unsworn Declaration, section 6. **It must be signed and dated.** 5. **Upload** the completed, signed form to your Bid Response Attachments. A new form must be completed for each contract entered into with Lamar CISD. A sample Certificate of Interested Parties (Form 1295) form has been included for your reference in the "Attachments" tab of this RFP. Questions? Check the 1295 FAQs at the following URL: https://www.ethics.state.tx.us/resources/FAQs/FAQ_Form1295.php _____ _____ _____ _____ _____ _____ *(Optional: Maximum 4000 characters allowed)*

38 **Compliance with Texas Law Regarding Foreign Organizations and Israel Boycotts Texas SB 252, HB 89 & HB 793**

This section applies only to a contract that: (1) is between a governmental entity and a company with 10 or more full-time employees; and (2) has a value of $100,000 or more that is to be paid wholly or partly from public funds of the governmental entity. Proposer hereby certifies that it is not a company identified on the Texas Comptroller's list of companies known to have contracts with, or provide supplies or services to, a foreign organization designated as a Foreign Terrorist Organization by the U.S. Secretary of State (the "Foreign Organization List"). In the event that Proposer is added to the Foreign Organization List at any time during the term of this Contract, Proposer shall promptly provide notice to Lamar CISD. Lamar CISD may, at its discretion, terminate this Contract immediately upon receipt and verification of information, by any means, that Proposer has been added to the Foreign Organization List. Proposer further certifies and verifies that neither Proposer, nor any affiliate, subsidiary, or parent company of Proposer, if any (the "Related Companies"), currently boycotts Israel, and Proposer agrees that Proposer and Related Companies will not boycott Israel during the term of this Contract. For purposes of this Contract, the term "boycott" shall mean refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations specifically with Israel, or with a person or entity doing business in Israel or in an Israeli-controlled territory. The term "boycott" shall not include an action made for ordinary business purposes.

☐ Agree

(Required: Check if applicable)

39 **Certificate of Residency**

Pursuant to Government Code, Chapter 2252, Sub-chapter A, the District must be provided the following information for a response to be accepted. "A governmental entity may not award a governmental contract to a nonresident prosper unless the nonresident under Bids the lowest Bid submitted by a responsible resident bidder by an amount that is not less than the amount by which a resident bidder would be required to under Bid the nonresident bidder to obtain a comparable contract in the state in which the nonresident's principal place of business is located."

"Resident bidder" refers to a person whose principal place of business is in this state, including a contractor whose ultimate parent company or majority owner has its principal place of business in this state.

"Nonresident bidder" refers to a person who is not a resident.

☐ My company is a "nonresident bidder"

☐ My company is a "resident bidder"

(Required: Check all that apply)

40 **Certificate of Residency**

If answering the question above "My company is a non-resident bidder", please use this box to list State your company is located and the percentage amount (if required) your State requires your company to under-bid.

(Required: Maximum 4000 characters allowed)

41 **Clean Air and Water Act Certification**

I certify that my company is in compliance with all applicable standards, orders of regulations issued pursuant to the Clean Air Act of 1970, as amended (42 U.S.C. 1857 (h). Section 508 of the Clean Water Act, as amended (33 U.S.C. 1368), Executive Order 117389 and Environmental Protection Agency Regulation, 40 CFR Part 15 as required under OMS Circular A-102, Attachment O, Paragraph 14 (1) regarding reporting violations to the grantor agency and to the United States Environmental Protection Agency Assistant Administrator for the Enforcement. I (We) the undersigned, agent for the firm, named below certify that the above information is true to the best of my knowledge.

☐ Agree

(Required: Check if applicable)

42 **Reference #1**

Please list School District or Business Name, Contact Person's Name, Phone Number and Email Address.

(Required: Maximum 4000 characters allowed)

43 **Reference #2**

Please list School District or Business Name, Contact Person's Name, Phone Number and Email Address.

(Required: Maximum 4000 characters allowed)

44 **Reference #3**

Please list School District or Business Name, Contact Person's Name, Phone Number and Email Address.

(Required: Maximum 4000 characters allowed)

45 **Place of Business**

Does your ultimate parent company or majority owner have its principal place of business in the state of Texas?

☐ Yes ☐ No

(Required: Check only one)

46 **Place of Business**

Does your ultimate parent company or majority owner employ at least 500 people in the state of Texas?

☐ Yes ☐ No

(Required: Check only one)

47 .

RFP Rules

Answer all questions on this section. It is strongly encouraged that your organization agree with each item. Failure to do so could materially impact the scoring of your RFP response, and may potentially disqualify your bid at CLIENT's discretion.

Regarding questions in the RFP Rules Section. If "YES" is selected, no further explanation is needed. Please enter N/A in the explanation line. If "NO" is selected please provided a detail explanation. These responses will not be considered in the evaluation of your proposal.

48 **Do you agree that information provided in accordance with this RFP is the only information that may be submitted as part of your offer?**

No additional documentation may be submitted (or incorporated by reference) unless specifically requested and/or approved by Lamar CISD.
Any additional documentation provided by you will not be reviewed, will not modify or condition your offer, and will not be incorporated into the contract, unless specifically requested by Lamar CISD.

Any deviations from the requested terms and conditions in the RFP must be expressly stated within the space provided in this RFP. Any failure to comply with these requirements constitutes grounds for rejection of your proposal.

☐ No ☐ Yes
(Required: Check only one)

49 **Please provide an explanation regarding your response to Line #49**

(Required: Maximum 4000 characters allowed)

50 **You agree that all correspondence regarding this RFP shall be done exclusively through Lamar CISD**

and under no circumstance will CLIENT and/or its Board Members be contacted directly, unless directed otherwise. Failure to adhere to this requirement may result in disqualification of your bid.

☐ No ☐ Yes
(Required: Check only one)

51 **Please provide an explanation regarding your response to Line #51**

(Required: Maximum 4000 characters allowed)

52	**The general information contained in this RFP is complete and accurate to the best knowledge of CLIENT.** However, the information contained in this RFP and any data provided to you by Lamar CISD are representations only and not warranties of CLIENT. All information contained herein is deemed confidential. Each company submitting a proposal shall assume sole responsibility for reliance upon information included in this RFP, and neither CLIENT nor Lamar CISD shall have any liability for any inaccuracy contained herein. ☐ No ☐ Yes *(Required: Check only one)*
53	**Please provide an explanation regarding your response to Line #53** *(Required: Maximum 4000 characters allowed)*
54	**You agree to not modify or reformat tis RFP document. Doing so may result in disqualification of your bid. You will also answer questions where asked, and not refer to other areas.** ☐ No ☐ Yes *(Required: Check only one)*
55	**Please provide an explanation regarding your response to Line #56** *(Required: Maximum 4000 characters allowed)*
56	**You agree to provide an executable contract with your RFP response.** The executable contract must include, but is not limited to, your definitions, terms and conditions, scope of services, service levels, performance guarantees, and pricing, that aligns with your response to this RFP. Thus, the executable contract submitted must not be your standard contract template. The executable contract submitted must be based on your responses and commitments to the RFP for this specific client. **Provide as "Exhibit - <Vendor Name> - CLIENT Executable Contract for RFP.** ☐ No ☐ Yes *(Required: Check only one)*
57	**Please provide an explanation regarding your response to Line #57** *(Required: Maximum 4000 characters allowed)*

58	**In accepting proposals,** CLIENT reserves the right to reject any and all proposals and to take actions which it deems in its sole discretion to be in its best interest. CLIENT is not obligated to accept any response, or the lowest-cost response, to this RFP. This RFP does not obligate CLIENT to pay any costs incurred by you in responding to this RFP. Further, this RFP does not obligate CLIENT to accept or contract for any expressed or implied services. ☐ No ☐ Yes *(Required: Check only one)*
59	**Please provide an explanation regarding your response to Line #59** *(Required: Maximum 4000 characters allowed)*
60	**Provide a binding electronic signature from an officer of your PBM to back up this RFP response.** Provide as: **"Exhibit <Vendor Name> Binding Electronic Signature of PBM Official" include the following information with the signature** ***PBM name** ***PBM signatory's name** ***PBM signatory's job title/position** ***Signature date** ☐ No ☐ Yes *(Required: Check only one)*
61	**Please provide an explanation regarding your response to Line #61** *(Required: Maximum 4000 characters allowed)*
62	. **Terms & Definitions** It is strongly encouraged that your organization agree with each item. Failure to do so could materially impact the scoring of your RFP response, and may potentially disqualify your bid at CLIENT's discretion. Pasting in your organization's standard contract definitions is not an acceptable response and will be returned to your organization to respond to as requested. Regarding questions in the Terms & Definitions Section. If "YES" is selected, no further explanation is needed. Please enter N/A in the explanation line. If "NO" is selected please provided a detail explanation. These responses will not be considered in the evaluation of your proposal.

63	**100% Member Paid Claims** "100% Member Paid Claims" shall mean claims for Covered Products that are paid 100% by the member outside of the deductible phase. For clarification purposes, claims that applied towards member deductibles shall not be considered 100% member paid claims. ☐ No ☐ Yes *(Required: Check only one)*
64	**Please provide an explanation regarding your response to Line #64** *(Required: Maximum 4000 characters allowed)*
65	**100% Member Paid Program Claims (e.g., Discount Card)** "100% Member Paid Program Claims" shall mean claims for Covered Products that are dispensed under a Discount Card, or other like program, operated outside of the vendor or has no affiliation with the vendor. ☐ No ☐ Yes *(Required: Check only one)*
66	**Please provide an explanation regarding your response to Line #66** *(Required: Maximum 4000 characters allowed)*
67	**340B Eligible Claim** "340B Eligible Claim" shall mean a claim for a Covered Product that meets the requirements as defined by the Public Health Service Act and submitted with a submission clarification code of 20 and contracted pharmacies which are categorized as Type 39 or Type 38. Not all claims from covered entities and contracted covered entities are eligible, unless the claim is identified specifically as a 340B Eligible Claim via reconciliation and audit trail. Your organization's definition of "340B Eligible Claim" MUST be consistent for all purposes including, but not limited to, discount and dispensing fee guarantee reconciliation and rebate guarantee reconciliation. ☐ No ☐ Yes *(Required: Check only one)*
68	**Please provide an explanation regarding your response to Line #68** *(Required: Maximum 4000 characters allowed)*

69	**Administrative Fee** "Administrative Fee" shall mean the amount per final net paid claim, if any, payable to the vendor for the performance of services. Administrative fees are exclusive and separate from any ingredient cost dispensing fees, pharmacy related fees, ancillary service fees, or optional service fees, if any payable to the vendor. ☐ No ☐ Yes *(Required: Check only one)*
70	**Please provide an explanation regarding your response to Line #70** *(Required: Maximum 4000 characters allowed)*
71	**Authorized Generics** "Authorized Generics" shall mean prescription drugs that are produced by an innovator (i.e., the brand manufacturer) under a New Drug Application (NDA), or licensed to be produced by a generic company under the New Drug Application (NDA), and are marketed, sold and/or distributed as generics under private label. Further, an Authorized Generic is identical to its brand counterpart in dosage form, safety, strength, route of administration, intended use, active and inactive ingredients and, as applicable, size, shape, color, taste, smell and mouth feel. ☐ No ☐ Yes *(Required: Check only one)*
72	**Please provide an explanation regarding your response to Line #72** *(Required: Maximum 4000 characters allowed)*
73	**AWP** "Average Wholesale Price" or "AWP" shall mean the "average wholesale price" for a Covered Product based on the most current pricing information published by MediSpan for the date and time the Covered Product is dispensed by the pharmacy. The AWP of a Covered Product will be the AWP unit price as published by MediSpan for the 11 digit NDC. Vendor shall not allow adjudication of NDCs of licensed re-packagers where the date source identifies the licensed re-packagers AWP is greater that the original pharmaceutical AWP. Vendor shall update AWP date no less than weekly. ☐ No ☐ Yes *(Required: Check only one)*

74	**Please provide an explanation regarding your response to Line #74** *(Required: Maximum 4000 characters allowed)*

75	**Biosimilars** "Biosimilars" shall mean a type of biological product that is licensed (i.e., approved) by the Food and Drug Administration (FDA) because the product is highly similar to an already FDA-approved biological product, known as the reference product, and has been shown to have no clinically meaningful differences from the reference product. Biosimilars shall also include an "interchangeable biological product" which, in addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient. Biosimilars are determined by the FDA from time to time and are listed in the FDA's Purple Book (presently found at: https://purplebooksearch.fda.gov/) Biosimilars are Brand Drugs, unless they are required to be classified as Generic Drugs under CMS regulations or FDA standards. ☐ No ☐ Yes *(Required: Check only one)*

76	**Please provide an explanation regarding your response to Line #76** *(Required: Maximum 4000 characters allowed)*

77	**Brand Drug** "Brand Drug" shall mean a Covered Product that is defined by MediSpan as a "M", "N", "O", with exception of Authorized Generics. When a drug is classified as a Brand Drug, it shall be considered a Brand Drug for the purposes of measuring and reconciling financial guarantees. ☐ No ☐ Yes *(Required: Check only one)*

78	**Please provide an explanation regarding your response to Line #78** *(Required: Maximum 4000 characters allowed)*

79	**Claims** "Claims" shall mean those claims processed for payment for Eligible Members ☐ No ☐ Yes *(Required: Check only one)*

80	**Please provide an explanation regarding your response to Line #80** *(Required: Maximum 4000 characters allowed)*
81	**COB (Secondary Payor) Claim** "COB" (Secondary Payor) Claim" shall mean a claim which processed with an Other Coverage Code of 2 or 8 indicating that the Client is the secondary payer. ☐ No ☐ Yes *(Required: Check only one)*
82	**Please provide an explanation regarding your response to Line #82** *(Required: Maximum 4000 characters allowed)*
83	**Compound Drug** "Compound Drug" shall mean a claim where two or more solid, semi-solid, or liquid medications are mixed together. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring coloring, or sodium chloride solutions are added. Compound Drugs shall be priced using the NCPDP D.0 standard which shall capture each ingredient used in the medication. ☐ No ☐ Yes *(Required: Check only one)*
84	**Please provide an explanation regarding your response to Line #84** *(Required: Maximum 4000 characters allowed)*
85	**Controlled Substance** "Controlled Substance" shall mean products with the MediSpan Controlled Substance Code: 2,3,4, or 5 ☐ No ☐ Yes *(Required: Check only one)*

86 **Please provide an explanation regarding your response to Line #86**

(Required: Maximum 4000 characters allowed)

87 **Covered Product**

"Covered Product" shall mean those prescription drugs, supplies, devices and any other related products or services, and other items that are covered under the plan, each as indicated as covered on the vendor's Client set-up forms. For avoidance of doubt, this shall include OTC's and Vaccines.

☐ No ☐ Yes

(Required: Check only one)

88 **Please provide an explanation regarding your response to Line #88**

(Required: Maximum 4000 characters allowed)

89 **COVID Testing**

"COVID Testing" shall mean products with the MediSpan GPI-8 codes: 94101024, 94101025, 94101026

☐ No ☐ Yes

(Required: Check only one)

90 **Please provide an explanation regarding your response to Line #90**

(Required: Maximum 4000 characters allowed)

91 **COVID Treatment**

"COVID Treatment" shall mean products with the MediSpan GPI-8 codes: 12700046, 12700080, 19502080, 19502020, 19502022, 19502025, 19502030, 19502035 or drug name PAXLOVID

☐ No ☐ Yes

(Required: Check only one)

92 **Please provide an explanation regarding your response to Line #92**

(Required: Maximum 4000 characters allowed)

93 **COVID- 19 Vaccine**

"COVID Vaccine" shall mean products with the MediSpan GPI-8 codes: 17100002, 19509902, 19502063

☐ No ☐ Yes

(Required: Check only one)

94 **Please provide an explanation regarding your response to Line #94**

(Required: Maximum 4000 characters allowed)

95 **Custom Formulary**

"Custom Formulary" shall mean the list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines, and clinical guidelines for detailing coverage of such products, which is developed and approved by the Client's Pharmacy and Therapeutics (P&T) Committee.

☐ No ☐ Yes

(Required: Check only one)

96 **Please provide an explanation regarding your response to Line #96**

(Required: Maximum 4000 characters allowed)

97 **Dedicated**

"Dedicated" shall mean those vendor employees or resources that are 100% of the time working on the Client's services.

☐ No ☐ Yes

(Required: Check only one)

98	**Please provide an explanation regarding your response to Line #98** *(Required: Maximum 4000 characters allowed)*
99	**Designated** "Designated" shall mean those vendor employees and resources that must prioritize work for the Client's services. ☐ No ☐ Yes *(Required: Check only one)*
100	**Please provide an explanation regarding your response to Line #100** *(Required: Maximum 4000 characters allowed)*
101	**Delivery Channel** "Delivery Channel" shall mean Retail 30, Retail 90, Retail Specialty, Mail and Mail Specialty, individually, for example. ☐ No ☐ Yes *(Required: Check only one)*
102	**Please provide an explanation regarding your response to Line #102** *(Required: Maximum 4000 characters allowed)*
103	**Diabetic Supplies** "Diabetic Supplies" shall mean products with the MediSpan GPI-6 code 972020*. ☐ No ☐ Yes *(Required: Check only one)*

104	**Please provide an explanation regarding your response to Line #104** *(Required: Maximum 4000 characters allowed)*
105	**Diabetic Test Strips** "Diabetic Test Strips" shall mean products with the MediSpan GPI codes 94100030006020 and 94100030006100 only. ☐ No ☐ Yes *(Required: Check only one)*
106	**Please provide an explanation regarding your response to Line #106** *(Required: Maximum 4000 characters allowed)*
107	**Dispensing Fee** "Dispensing Fee" shall mean the service fee or amount payable to a pharmacy to cover the cost of dispensing a Covered Product. The Dispensing Fee is added to the discounted AWP or MAC. No Dispensing Fee is added to the U&C. ☐ No ☐ Yes *(Required: Check only one)*
108	**Please provide an explanation regarding your response to Line #108** *(Required: Maximum 4000 characters allowed)*
109	**Eligible Member** "Eligible Member" shall mean a person covered under any of the Client's prescription drug plans. ☐ No ☐ Yes *(Required: Check only one)*

110	**Please provide an explanation regarding your response to Line #110** *(Required: Maximum 4000 characters allowed)*
111	**Eligible Member Cost Share** "Eligible Member Cost Share" shall mean the amount which an Eligible Member is required to pay for a Covered Product in accordance with the plan design. Eligible Member Cost Share includes any coinsurance (the percentage or portion of the cost of care or service that an eligible Member may be obligated to pay for a Covered Product at the time the care and/or service is provided), copayment/copay (the fixed dollar amount that an Eligible Member may be obligated to pay for a Covered Product at the time the Covered Product is provided), or deductible (the amount of out-of-pocket expenses that an Eligible Member is responsible to pay for Covered Product prior to being eligible to received benefits from the Client's prescription drug plan). ☐ No ☐ Yes *(Required: Check only one)*
112	**Please provide an explanation regarding your response to Line #112** *(Required: Maximum 4000 characters allowed)*
113	**Flu Vaccine** "Flu Vaccine" shall mean a claim for a Covered Product within the MediSpan Drug Group of Vaccines or Toxoids that is administered for influenza. ☐ No ☐ Yes *(Required: Check only one)*
114	**Please provide an explanation regarding your response to Line #114** *(Required: Maximum 4000 characters allowed)*

115	**Formulary** "Formulary" shall mean the list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines, and clinical guidelines for detailing coverage of such products. For Medicare Part D, the "Formulary" is developed and approved by the vendor's P&T Committee and adopted by the Client. For Medicaid and Commercial lines of business, the "Formulary" may be developed and approved by the vendor's P&T Committee and/or the Client's P&T Committee. ☐ No ☐ Yes *(Required: Check only one)*
116	**Please provide an explanation regarding your response to Line #116** *(Required: Maximum 4000 characters allowed)*
117	**Generic Drug** "Generic Drug" shall mean a Covered Product as defined by MediSpan as a "Y". Generic Drugs also shall include Brand Drugs that are treated as "house" generic drugs (dispense-as-written (DAW) 5) by the pharmacy, Single Source Generic Drugs, and Authorized Generics. When a drug is classified as a Generic Drug, it shall be considered a Generic Drug for the purposes of measuring and reconciling financial guarantees. ☐ No ☐ Yes *(Required: Check only one)*
118	**Please provide an explanation regarding your response to Line #118** *(Required: Maximum 4000 characters allowed)*
119	**Hep-C** "Hep-C' shall mean a product within the MediSpan Drug Class of Hepatitis Agents. ☐ No ☐ Yes *(Required: Check only one)*
120	**Please provide an explanation regarding your response to Line #120** *(Required: Maximum 4000 characters allowed)*

121 **Ingredient Cost**

"Ingredient Cost" shall mean the component of the price that represents the cost of the Covered Product, excluding the Dispensing Fee and taxes.

☐ No ☐ Yes

(Required: Check only one)

122 **Please provide an explanation regarding your response to Line #122**

(Required: Maximum 4000 characters allowed)

123 **Inflammatory Conditions**

"Inflammatory Conditions" shall mean products with the MediSpan GPI-8 codes 66290030*, 66270015*, 66270040*, 52504070*, 90250585*.

The GPI-8 codes listed in this definition are not meant to capture a comprehensive drug group/class, but rather a specific subset of drugs. Includes biosimilars.

☐ No ☐ Yes

(Required: Check only one)

124 **Please provide an explanation regarding your response to Line #124**

(Required: Maximum 4000 characters allowed)

125 **Insulins**

"Insulins" shall mean products with the MediSpan GPI-4 code 2710*.

Includes biosimilars.

☐ No ☐ Yes

(Required: Check only one)

126 **Please provide an explanation regarding your response to Line #126**

(Required: Maximum 4000 characters allowed)

127	**Limited Distribution Drug (LDD)** "Limited Distribution Drug" or "LDD" shall mean a Specialty Drug that is used to treat conditions affecting only a small group of patients across several disease states, (i.e., oncology, growth hormone treatments, and multiple sclerosis) and refers to injectable, infusion, and other specialty products, whose dispensing is restricted by the pharmaceutical manufacturer to only 3 or fewer pharmacies. ☐ No ☐ Yes *(Required: Check only one)*
128	**Please provide an explanation regarding your response to Line #128** *(Required: Maximum 4000 characters allowed)*
129	**Limited Distribution Drug (LDD) Pharmacy** "Limited Distribution Pharmacy" or "LDD Pharmacy" shall mean a licensed pharmacy authorized by pharmaceutical manufacturer to dispense the LDD injectable, infusion, and other specialty products. ☐ No ☐ Yes *(Required: Check only one)*
130	**Please provide an explanation regarding your response to Line #130** *(Required: Maximum 4000 characters allowed)*
131	**Mail Order Pharmacy** "Mail Order Pharmacy" shall mean a duly licensed pharmacy that primarily dispenses prescriptions (but not primarily Specialty Products) through mail deliver service that is contracted with and/or owned or operated by the vendor. ☐ No ☐ Yes *(Required: Check only one)*
132	**Please provide an explanation regarding your response to Line #132** *(Required: Maximum 4000 characters allowed)*

133 **Maximum Allowable Cost (MAC)**

"Maximum Allowable Cost" or "MAC" shall mean the unit price that has been established by the vendor for a Brand Drug or Generic Drug included on the vendor's MAC list, which may be amended from time to time by the vendor.

☐ No ☐ Yes

(Required: Check only one)

134 **Please provide an explanation regarding your response to Line #134**

(Required: Maximum 4000 characters allowed)

135 **Medical Devices and Supplies**

"Medical Devices and Supplies" shall mean products within the MediSpan Drug Group of Medical Devices and Supplies.

☐ No ☐ Yes

(Required: Check only one)

136 **Please provide an explanation regarding your response to Line #136**

(Required: Maximum 4000 characters allowed)

137 **NDC-11**

"NDC-11" shall mean the full National Drug Code.

☐ No ☐ Yes

(Required: Check only one)

138 **Please provide an explanation regarding your response to Line #138**

(Required: Maximum 4000 characters allowed)

139 **New to Market**

"New to Market" shall mean a Brand Covered Product that has been on the market for no longer than 180 days, as of the effective date in MediSpan.

☐ No ☐ Yes

(Required: Check only one)

140	**Please provide an explanation regarding your response to Line #140** *(Required: Maximum 4000 characters allowed)*
141	**Non Formulary Brand Drugs** "Non Formulary Brand Drugs" shall mean the drugs that are not included in the list of preferred medications and/or not included in the drug list approved by the Client. When a drug is identified as a Non-Formulary Brand Drug, it shall be considered a Non-Formulary Brand Drug for all purposes, including Eligible Member Cost Share, therapeutic classification, pricing and all related guarantees. ☐ No ☐ Yes *(Required: Check only one)*
142	**Please provide an explanation regarding your response to Line #142** *(Required: Maximum 4000 characters allowed)*
143	**Non Standard Retail Pharmacies (LTC, Infusion, ITU)** "Non Standard Retail Pharmacies" shall include, but not be limited to, Long Term Care, Home Infusion, Indian/Tribal/Urban (I/T/U), or VA pharmacies. ☐ No ☐ Yes *(Required: Check only one)*
144	**Please provide an explanation regarding your response to Line #144** *(Required: Maximum 4000 characters allowed)*
145	**Other Vaccine** "Other Vaccine" shall mean products with the MediSpan GPI-8 codes: 19509902, 19502063 or with the MediSpan GPI-4 codes: 1710, 1720, 1799, 1899. ☐ No ☐ Yes *(Required: Check only one)*

146	**Please provide an explanation regarding your response to Line #146** *(Required: Maximum 4000 characters allowed)*
147	**Over-the-Counter (OTC)** "Over-the-Counter" or "OTC" shall mean products that are identified by MediSpan RXOTC Indicator as OTC. ☐ No ☐ Yes *(Required: Check only one)*
148	**Please provide an explanation regarding your response to Line #148** *(Required: Maximum 4000 characters allowed)*
149	**Paper Claim** "Paper Claim" shall mean a manual/paper claim submitted by an Eligible Member for Covered Product dispensed by a pharmacy for which the Eligible Member paid cash. ☐ No ☐ Yes *(Required: Check only one)*
150	**Please provide an explanation regarding your response to Line #150** *(Required: Maximum 4000 characters allowed)*
151	**PCSK9** "PCSK9s" shall mean a product within MediSpan GPI-4 or 3935 ☐ No ☐ Yes *(Required: Check only one)*

152	**Please provide an explanation regarding your response to Line #152** *(Required: Maximum 4000 characters allowed)*

153	**Prescription Drug Services** "Prescription Drug Services" shall mean those Covered Products and related services, which are prescribed by a prescriber and dispensed, furnished or administered to Eligible Members by pharmacies or other authorized health care providers. ☐ No ☐ Yes *(Required: Check only one)*

154	**Please provide an explanation regarding your response to Line #154** *(Required: Maximum 4000 characters allowed)*

155	**Pricing Component** "Pricing Component" shall mean brand discounts, generic discounts, brand dispensing fees, and generic dispensing fees. ☐ No ☐ Yes *(Required: Check only one)*

156	**Please provide an explanation regarding your response to Line #156** *(Required: Maximum 4000 characters allowed)*

157	**Rebates** "Rebates" shall mean, and include, the components as agreed below that are attributable to Covered Products dispensed to its Eligible Members, *regardless of whether such amounts are collected by PBM or its GPO/subcontractors.* Base Incentive Portfolio Market Share Price Protection Manufacturer Administrative Fees Value-Based Remuneration Indication-based Remuneration Specify any other monies collected by vendor (or its affiliates, intermediaries, or rebate aggregators) for the Client from various pharmaceutical companies. ☐ No ☐ Yes *(Required: Check only one)*
158	**Please provide an explanation regarding your response to Line #158** _____ _____ _____ _____ _____ _____ *(Required: Maximum 4000 characters allowed)*
159	**Retail Network Pharmacy** "Retail Network Pharmacy" shall mean any licensed pharmacy, including retail pharmacies, I/T/U pharmacies, pharmacies operated by federally qualified health centers and rural health centers, Long Term Care pharmacies, and Home Infusion pharmacies with which the vendor has contracted to participate in one or more pharmacy networks. Mail Order Pharmacies and Specialty Network Pharmacies are not considered Retail Network Pharmacies. ☐ No ☐ Yes *(Required: Check only one)*
160	**Please provide an explanation regarding your response to Line #160** _____ _____ _____ _____ _____ _____ *(Required: Maximum 4000 characters allowed)*

161	**Single Source Generic Drugs (SSGs)** "Single Source Generic Drugs" or "SSGs" shall mean those Generic Drugs that are only available from one manufacturer and labeler, including generics with limited availability, exclusivity, or competition, including Authorized Generics. When a drug is identified as Single Source Generic Drug, it shall be considered a Single Source Generic Drug for all purposes, including Eligible Member Cost Share, therapeutic classification, pricing and all related guarantees. ☐ No ☐ Yes *(Required: Check only one)*
162	**Please provide an explanation regarding your response to Line #162** *(Required: Maximum 4000 characters allowed)*
163	**Specialty Drug List** "Specialty Drug List" shall mean an agreed upon list of Specialty Drugs. ☐ No ☐ Yes *(Required: Check only one)*
164	**Please provide an explanation regarding your response to Line #164** *(Required: Maximum 4000 characters allowed)*
165	**Specialty Network Pharmacy** "Specialty Network Pharmacy" shall mean a pharmacy network or individual pharmacy that primarily dispenses Specialty Drugs and provides specialty services. ☐ No ☐ Yes *(Required: Check only one)*
166	**Please provide an explanation regarding your response to Line #166** *(Required: Maximum 4000 characters allowed)*

167	**Subrogation Claim** "Subrogation Claim" shall mean a claim submitted by any state or a person or entity acting on behalf of a state under Medicaid or similar United States or state government health care programs, for which the Client is deemed to be the primary payor by operation of applicable federal or state laws. ☐ No ☐ Yes *(Required: Check only one)*
168	**Please provide an explanation regarding your response to Line #168** *(Required: Maximum 4000 characters allowed)*
169	**Usual and Customary Price (U&C)** "Usual and Customary" or "U&C" shall mean the lowest price, including any Dispensing Fee, a pharmacy would charge a customer without any insurance coverage if such customer were paying cash for the identical drug on the date dispensed. This includes any applicable discounts, including but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to customers. ☐ No ☐ Yes *(Required: Check only one)*
170	**Please provide an explanation regarding your response to Line #170** *(Required: Maximum 4000 characters allowed)*
171	**Zero Balance Claim or Zero Balance Due** "Zero Balance Claim" or "Zero Balance Due" shall mean a claim for which there is no balance due from the Client following the application of the Eligible Member Cost Shar to the cost of the claim. ☐ No ☐ Yes *(Required: Check only one)*
172	**Please provide an explanation regarding your response to Line #172** *(Required: Maximum 4000 characters allowed)*

173	.

Financial Requirements

Pharmacy Request for Proposal: RFP Rules

Instructions: If "Not Confirmed" is selected, provide further explanation in the additional line.

If "Confirmed" is selected, no further explanation is needed, please enter N/A in the explanation line. If "Not Confirmed" is selected please provided a detail explanation. These responses will not be considered in the evaluation of your proposal.

174	.

PBM Procurement and Audit Fees

175	**PBM/Carrier, upon being named winner, agrees to directly pay Gallagher Pharmacy Practice (GPP) $70,000 for the consulting services provided during the procurement process as per our payment terms.**

At no time will CLIENT be invoiced for this fee. All fees have been fully-disclosed to CLIENT. PBM/Carrier will invoiced upon notice of award. Payment will be sent within thirty (30) days of receipt of invoice. PBM/Carrier agrees to this payment timeline and agrees that payment is not contingent on the timing of CLIENT executing an agreement with PBM/Carrier. **PBM/Carrier agree to this payment regardless of any Consultant or Broker of Record (BOR) change that could occur during the term of the PBM Agreement.** NOTE THAT IF YOUR ORGANIZATION DOES NOT AGREE TO THESE TERMS, THEN YOUR ORGANIZATION MAY BE DISQUALIFIED AS A POTENTIAL VENDOR.

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

176	**Please provide an explanation regarding your response to Line #175**

(Required: Maximum 4000 characters allowed)

177	**PBM/Carrier, upon being named winner, agrees to directly pay Gallagher Pharmacy Practice (GPP) $55,000 EACH**

for two annual financial claims audits **upon kick-off of those audits**. The audits will be conducted within the second and third years of the contact. At no time will CLIENT be invoiced for these fees. All fees have been fully-disclosed to CLIENT. **PBM/Carrier will be invoiced upon notice of award.** Payment for the financial claims audits will be sent within thirty (30) days of receipt of invoices. **PBM/Carrier agrees to this payment timeline and agrees that payment is not contingent on the timing of CLIENT executing an agreement with PBM/Carrier. PBM/Carrier agree to this payment regardless of any Consultant or Broker or Record (BOR) change that could occur during the term of the PBM Agreement. NOTE THAT IF YOUR ORGANIZATION DOES NOT AGREE TO THESE TERMS, THEN YOUR ORGANIZATION MAY BE DISQUALIFIED AS A POTENTIAL VENDOR.**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

178	**Please provide an explanation regarding your response to Line #177** *(Required: Maximum 4000 characters allowed)*
179	**PBM/Carrier, upon being named winner, agrees to directly pay Gallagher Pharmacy Practice (GPP) $60,000 for the ongoing consulting services provided during this contract period as per our payment terms.** At no time will CLIENT be invoiced for this fee. All fees have been fully-disclosed to CLIENT. **PBM/Carrier will be invoiced. upon notice of award.** Payment will be sent within thirty (30) days of receipt of invoice. **PBM/Carrier agrees to this payment timeline and agrees that payment is not contingent on the timing of CLIENT executing an agreement with PBM/Carrier. PBM/Carrier agree to this payment regardless of any Consultant or Broker of Record (BOR) change that could occur during the term of the PBM Agreement. NOTE THAT IF YOUR ORGANIZATION DOES NOT AGREE TO THESE TERMS, THEN YOUR ORGANIZATION MAY BE DISQUALIFIED AS A POTENTIAL VENDOR.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
180	**Please provide an explanation regarding your response to Line #179** *(Required: Maximum 4000 characters allowed)*
181	**PBM/Carrier, upon being named winner, agrees to submit their Non-Disclosure Agreement (NDA) to CLIENT** and Gallagher Pharmacy Practice (GPP) so that claims files may be released for future audits and procurement upon signature. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
182	**Please provide an explanation regarding your response to Line #181** *(Required: Maximum 4000 characters allowed)*

183	**Confirm that your organization will be obligated to pay Gallagher Pharmacy Practice (GPP) for any audit of the client's contracted period,** including after the termination of contract between CLIENT and your organization. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
184	**Please provide an explanation regarding your response to Line #183** *(Required: Maximum 4000 characters allowed)*
185	. ***General***
186	**Confirm that your organization will propose 1 year contract terms, with four 1 Year renewal options, with contract year rate guarantees.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
187	**Please provide an explanation regarding your response to Line #187** *(Required: Maximum 4000 characters allowed)*
188	**Confirm that your organization's proposed pricing is not contingent upon a minimum number of lives at the time of implementation or throughout the contract term.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
189	**Please provide an explanation regarding your response to Line #189** *(Required: Maximum 4000 characters allowed)*

190	**Confirm that your organization's proposed pricing is not contingent upon claims volume reflected in the RFP claims data.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
191	**Please provide an explanation regarding your response to Line #191** *(Required: Maximum 4000 characters allowed)*
192	**Confirm that your organization's guarantees are not contingent on continued utilization of current volume of certain therapeutic classes reflected in the RFP claims data.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
193	**Please provide an explanation regarding your response to Line #193** *(Required: Maximum 4000 characters allowed)*
194	**For Pass Through Offers, "Pass Through Pricing" shall mean the PBM's pharmacy network pricing and the amount paid by the PBM to the PBM's network pharmacies are equal to the amount billed to CLIENT.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
195	**Please provide an explanation regarding your response to Line #195** *(Required: Maximum 4000 characters allowed)*
196	**For Pass Through Offers, confirm that you will agree to Pass Through Pricing at retail pharmacies.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

197	**Please provide an explanation regarding your response to Line #197** *(Required: Maximum 4000 characters allowed)*
198	**For Pass Through Offers, confirm that you will agree to Pass Through Pricing at retail specialty pharmacies.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
199	**Please provide an explanation regarding your response to Line #199** *(Required: Maximum 4000 characters allowed)*
200	**Confirm that your organization's financial proposal will include an "all in" aggregate annual guaranteed Genetic Drug** discount using the RFP's Brand Drug and Generic Drug Definitions. To be clear, this include Single Source Generic Drugs. *You must adhere to the exclusions show on the "Exclusions" attachment. "Confirmed" if you are in agreement with the pre-populated* *Excluded/Included designations on the "Exclusions" attachment; otherwise, select "Not Confirmed" and change the pre-populated* *Excluded/Included designations on the "Exclusions" attachment accordingly.* ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
201	**Please provide an explanation regarding your response to Line #201** *(Required: Maximum 4000 characters allowed)*
202	**Confirm that you will agree to Pass Through Pricing at retail pharmacies.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

203	**Please provide an explanation regarding your response to Line #203** *(Required: Maximum 4000 characters allowed)*
204	**Confirm that you will agree to Pass Through Pricing at retail specialty pharmacies.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
205	**Please provide an explanation regarding your response to Line #205** *(Required: Maximum 4000 characters allowed)*
206	**Confirm that ALL exclusions to your aggregate annual guaranteed Generic Drug discount are listed on the Exclusions attachment.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
207	**Please provide an explanation regarding your response to Line #207** *(Required: Maximum 4000 characters allowed)*
208	**Confirm that your aggregate annual guaranteed Generic Drug discount includes Single Generic Drugs.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
209	**Please provide an explanation regarding your response to Line #209** *(Required: Maximum 4000 characters allowed)*

210	**For Pass Through Offers, confirm that your organization's financial proposal will include an "all in"** aggregate annual guaranteed **Brand Drug** discount using this RFP's Brand Drug and Generic Drug definitions. *You must adhere to the exclusions shown on the "Exclusions" attachment. "Confirmed" if you are in agreement with the pre-populated Excluded/Included designations on the "Exclusions" attachment; otherwise, select "Not Confirmed" and change the pre-populated Excluded/Included designations on the "Exclusions" attachment accordingly.* ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
211	**Please provide an explanation regarding your response to Line #211** *(Required: Maximum 4000 characters allowed)*
212	**Confirm that all financial guarantees in your organization's financial proposal will be guaranteed on a contract year basis.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
213	**Please provide an explanation regarding your response to Line #213** *(Required: Maximum 4000 characters allowed)*
214	**Confirm that all discount, dispensing fee and rebate guarantees are guaranteed at the individual group level, rather than at a book of business or coalition level.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
215	**Please provide an explanation regarding your response to Line #215** *(Required: Maximum 4000 characters allowed)*

216	**Confirm that all discount and dispensing fee guarantees will be reconciled/reported/paid no later than 90 days after the end of each contract year for annual true up.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
217	**Please provide an explanation regarding your response to Line #217** *(Required: Maximum 4000 characters allowed)*
218	**Confirm that all discount and dispensing fee guarantees will be trued up individually by Delivery Channel and by Pricing Component;** no guarantees can be cross-subsidized (surplus offsetting shortfalls, etc.,) **"Delivery Channel" shall mean Retail 30, Retail 90, Retail Specialty, Mail and Mail Specialty, individually, for example.** **"Pricing Component" shall mean brand discounts, generic discounts, brand dispensing fees, and generic dispensing fees.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
219	**Please provide an explanation regarding your response to Line #219** *(Required: Maximum 4000 characters allowed)*
220	**Confirm that all rebate guarantees will be reconciled/reported/paid not later than 180 days after the end of each contract year for the annual true up.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
221	**Please provide an explanation regarding your response to Line #221** *(Required: Maximum 4000 characters allowed)*

222	**Confirm that guarantee reconciliations, and any amounts due, will be reported and paid proactively by PBM, and will not need to be requested by CLIENT.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
223	**Please provide an explanation regarding your response to Line #223** *(Required: Maximum 4000 characters allowed)*
224	**Confirm that any Eligible Member Cost Share or ancillary fees will not be included in any discount calculation (billing, guarantee or otherwise).** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
225	**Please provide an explanation regarding your response to Line #225** *(Required: Maximum 4000 characters allowed)*
226	**Confirm your agreement with the following method used to calculate of the % discount off AWP which would apply for billing and guarantee purposes.** If the AWP of a generic product is $10, the discounted cost is $6 and the Eligible Member Cost Share is also $6 (leaving a zero balance due from the plan), the discount % off the AWP for both billing and guarantee purposes would be 40% off the AWP. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
227	**Please provide an explanation regarding your response to Line #227** *(Required: Maximum 4000 characters allowed)*
228	**Confirm that no other monies (audit/clinical/therapeutic interchange, DUR savings) will be included in any calculations: Calculations include adjudication, billing, guarantee reconciliation, etc.,** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

229	**Please provide an explanation regarding your response to Line #229** *(Required: Maximum 4000 characters allowed)*
230	**Confirm that all rebates guarantees will be trued up individually by delivery channel; no guarantees can be cross- subsidized (surplus offsetting shortfalls etc.,).** Retail 30, Retail 90, Retail Specialty, Mail and Mail Specialty are considered separate delivery channels. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
231	**Please provide an explanation regarding your response to Line #231** *(Required: Maximum 4000 characters allowed)*
232	**Confirm that the risk on guarantees is dollar for dollar on any shortfall with no limit tot he amount at risk.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
233	**Please provide an explanation regarding your response to Line #233** *(Required: Maximum 4000 characters allowed)*
234	**Confirm that any surplus on any financial guarantee is retained 100% by CLIENT. The amount at risk will be the full value of the missed performance, not a calculation of CLIENT's net plan cost impact.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

235	**Please provide an explanation regarding your response to Line #235** *(Required: Maximum 4000 characters allowed)*
236	**Confirm that your organization's financial proposal is based on the plan design, clinical rules and data contained within this RFP. (No changes need to be made by CLIENT in order to attain the financial pricing terms offered.)** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
237	**Please provide an explanation regarding your response to Line #237** *(Required: Maximum 4000 characters allowed)*
238	**Confirm that your organization's financial proposal is not contingent upon the adoption of any ancillary services including any clinical programs (QL, PA, ST, etc.,)** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
239	**Please provide an explanation regarding your response to Line #239** *(Required: Maximum 4000 characters allowed)*
240	**If your organization's financial proposal is contingent upon adoption of additional programs, all fees associated with these programs MUST be noted on the "Administrative Ancillary Fees" attachment within this RFP.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

241	**Please provide an explanation regarding your response to Line #241** *(Required: Maximum 4000 characters allowed)*
242	**Confirm that your organization will use MediSpan as the source of AWP.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
243	**Please provide an explanation regarding your response to Line #243** *(Required: Maximum 4000 characters allowed)*
244	**Confirm that the AWP price will be based on the actual 11 digit NDC of the package size dispensed on the date dispensed. This will apply to adjudication, billing, guarantee reconciliation, etc.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
245	**Please provide an explanation regarding your response to Line #245** *(Required: Maximum 4000 characters allowed)*
246	**Confirm that your organization will use the NDC of the original packaging manufacturer rather than repackaged NDC.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

247	**Please provide an explanation regarding your response to Line #247** *(Required: Maximum 4000 characters allowed)*
248	**Confirm that your organization agrees to utilize the RFP definitions of "Brand Drug" and "Genetic Drug".** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
249	**Please provide an explanation regarding your response to Line #249** *(Required: Maximum 4000 characters allowed)*
250	**Confirm that for any scenarios where a brand is preferred over a generic, the Eligible Member Cost Share will be for the generic.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
251	**Please provide an explanation regarding your response to Line #251** *(Required: Maximum 4000 characters allowed)*
252	**Confirm that any postage increases, shipping & handling increases, will not result in increases to ANY fees or any other pricing component within your organization's proposal in this RFP and will NOT be billed back to the CLIENT.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

253	**Please provide an explanation regarding your response to Line #253** *(Required: Maximum 4000 characters allowed)*
254	**Confirm that your organization's proposal accounts for any conforms with State and Federal Regulations (fees, if any, should be expressly noted in the Administrative Fees).** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
255	**Please provide an explanation regarding your response to Line #255** *(Required: Maximum 4000 characters allowed)*
256	**Confirm that your organization's proposed pricing does not require implementation of prescription savings card/discount card programs.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
257	**Please provide an explanation regarding your response to Line #257** *(Required: Maximum 4000 characters allowed)*
258	**Confirm that if implemented during the term of the contract, your organization will not adjust proposed guarantees due integrating prescription savings card/discount card programs.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

259	**Please provide an explanation regarding your response to Line #259** *(Required: Maximum 4000 characters allowed)*
260	**Confirm that your organization does not charge for integrating prescription savings card/discount card programs within the proposed pricing.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
261	**Please provide an explanation regarding your response to Line #261** *(Required: Maximum 4000 characters allowed)*
262	**Confirm that your organization will exclude prescription savings card/discount card program claims in the reconciliation of pricing guarantees.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
263	**Please provide an explanation regarding your response to Line #263** *(Required: Maximum 4000 characters allowed)*
264	**.** ***Billing/Invoicing***
265	**Confirm that the frequency of claims invoices will be twice per month** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

266 **Please provide an explanation regarding your response to Line #266**

(Required: Maximum 4000 characters allowed)

267 **Confirm that claims invoices are allowed to be paid within 10 business days**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

268 **Please provide an explanation regarding your response to Line #268**

(Required: Maximum 4000 characters allowed)

269 **Confirm that the frequency of administrative invoices will be monthly**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

270 **Please provide an explanation regarding your response to Line #270**

(Required: Maximum 4000 characters allowed)

271 **Confirm that administrative invoices are allowed to be paid within 10 business days**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

272 **Please provide an explanation regarding your response to Line #272**

(Required: Maximum 4000 characters allowed)

273	**Confirm that there will be a grace period for late payments of 2 weeks** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
274	**Please provide an explanation regarding your response to Line #274** *(Required: Maximum 4000 characters allowed)*
275	. ***All Retail Network Pricing (Retail, Retail 90, LTC, Infusion, I/T/U, Retail Specialty, etc.)***
276	**Confirm that your organization's contract and adjudication system will reflect the below claim billing formula: Lower of AWP-X%+dispensing fee, MAC+ dispensing fee, or U&C** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
277	**Please provide an explanation regarding your response to Line #277** *(Required: Maximum 4000 characters allowed)*
278	**For Pass Through Offers:** AWP-X% represents your organization's most aggressive retail pharmacy contract rate with each pharmacy **PROVIDE YOUR ORGANIZATION'S PROPOSED AGGREGATE ANNUAL GUARANTEED BRAND DISCOUNT ON THE "FINANCIAL OFFER" ATTACHMENT** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
279	**Please provide an explanation regarding your response to Line #279** *(Required: Maximum 4000 characters allowed)*
280	**Confirm that CLIENT will always pay the lowest of discounted price, MAC or U&C** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

281 **Please provide an explanation regarding your response to Line #281**

(Required: Maximum 4000 characters allowed)

282 **Confirm that a dispensing fee will not apply to U&C claims**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

283 **Please provide an explanation regarding your response to Line #283**

(Required: Maximum 4000 characters allowed)

284 **Confirm that the member will always pay the lowest of the client negotiated price or Eligible Member Cost Share. Any excess Eligible Member Cost Share will not be retained by your organization.**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

285 **Please provide an explanation regarding your response to Line #285**

(Required: Maximum 4000 characters allowed)

286 **Confirm that there is no minimum charge at retail for any transaction at any retail network store.**

☐ Confirmed ☐ Not Confirmed

(Required: Check only one)

287 **Please provide an explanation regarding your response to Line #287**

(Required: Maximum 4000 characters allowed)

288	**Confirm that if the number of retail pharmacies in your organization's network is reduced by more than 5% prior to the effective date** or during the contract term your organization will provide CLIENT an improved financial proposal for the smaller retail network at least 90 days prior to the effective date of the reduction in network size. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
289	**Please provide an explanation regarding your response to Line #289** *(Required: Maximum 4000 characters allowed)*
290	. ***Mail Pricing***
291	**Confirm that your organization will propose MAC pricing at mail. The Mail MAC list and price schedule will be the same (or better) as the Retail MAC list and pricing schedule.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
292	**Please provide an explanation regarding your response to Line #292** *(Required: Maximum 4000 characters allowed)*
293	**Confirm that your organization's contract and adjudication system will reflect the below claim billing formula: Lower of AWP-X% + dispensing fee or MAC + dispensing fee.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
294	**Please provide an explanation regarding your response to Line #294** *(Required: Maximum 4000 characters allowed)*

295	**AWP-X% represents a minimum fixed discount for all claims should the MAC price be less aggressive** **CONFIRM THAT YOUR ORGANIZATION IS NOT PROPOSING AN AGGREGATE ANNUAL GUARANTEED BRAND DISCOUNT** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
296	**Please provide an explanation regarding your response to Line #296** *(Required: Maximum 4000 characters allowed)*
297	**Confirm that CLIENT will always pay the lowest of discounted price or MAC.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
298	**Please provide an explanation regarding your response to Line #298** *(Required: Maximum 4000 characters allowed)*
299	**Confirm that the member will always pay the lowest of the client negotiated price or Eligible Member Cost Share. Any excess Eligible Member Cost Share will not be retained by your organization.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
300	**Please provide an explanation regarding your response to Line #300** *(Optional: Maximum 4000 characters allowed)*
301	**Confirm that there is no minimum charge at mail for any transaction.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

302	**Please provide an explanation regarding your response to Line #302** *(Required: Maximum 4000 characters allowed)*
303	**Confirm that mail pricing will not be dependent on the days' supply of a claim.** For example, your organization will not price mail claims at the retail rate if below a days' supply threshold. **This requirement pertains not only to claim-level mail pricing, but to aggregate mail guarantees as well.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
304	**Please provide an explanation regarding your response to Line #304** *(Required: Maximum 4000 characters allowed)*
305	**Confirm that products requiring cold pack shipping will incur no additional shipping fees.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
306	**Please provide an explanation regarding your response to Line #306** *(Required: Maximum 4000 characters allowed)*
307	**Confirm that your organization agrees to absorb any unpaid member balances associated with your mail service facility.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

308	**Please provide an explanation regarding your response to Line #308** *(Required: Maximum 4000 characters allowed)*
309	**.** ***Specialty Pricing***
310	**Confirm that your organization's financial proposal will include an ""all in"" aggregate annual minimum Specialty Drug guarantee using this RFP's Specialty Drug definition.** *Confirm any and all exclusions shown on the 'Exclusions' attachment.* ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
311	**Please provide an explanation regarding your response to Line #311** *(Required: Maximum 4000 characters allowed)*
312	**Confirm that your organization's contract and adjudication system will reflect the below claim billing formula: Lower of AWP-X% + dispensing fee or MAC + dispensing fee.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
313	**Please provide an explanation regarding your response to Line #313** *(Required: Maximum 4000 characters allowed)*
314	**Confirm that Limited Distribution Drugs are products that are only available through three (3) or less pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

315	**Please provide an explanation regarding your response to Line #315** *(Required: Maximum 4000 characters allowed)*
316	**Confirm that your maximum days supply for Specialty Drugs is 30 days.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
317	**Please provide an explanation regarding your response to Line #317** *(Required: Maximum 4000 characters allowed)*
318	**Confirm that new drugs in existing classes will be priced no less favorable than the mode of the existing drugs** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
319	**Please provide an explanation regarding your response to Line #319** *(Required: Maximum 4000 characters allowed)*
320	**Confirm that a New to Market Product shall be considered New to Market for no longer than 180 days.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
321	**Please provide an explanation regarding your response to Line #321** *(Required: Maximum 4000 characters allowed)*

322	**Confirm that any new specialty generics OR biosimilars will have a minimum guaranteed discount set to: Lower of AWP discount for corresponding Brand/Reference or MAC at launch date per MediSpan.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
323	**Please provide an explanation regarding your response to Line #323** *(Required: Maximum 4000 characters allowed)*
324	**Confirm that HIV drugs are included on the specialty list. If so, confirm that HIV drugs receive the specialty guarantee.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
325	**Please provide an explanation regarding your response to Line #325** *(Required: Maximum 4000 characters allowed)*
326	**Confirm that Dupixent is included on your specialty list and is treated as specialty for all financial guarantees including rebates.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
327	**Please provide an explanation regarding your response to Line #327** *(Required: Maximum 4000 characters allowed)*
328	**What is Humira's formulary status (i.e. preferred, co-preferred, excluded) as of the following dates:** Current Date status: Implementation Date status: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

329	**Please provide an explanation regarding your response to Line #329** *(Required: Maximum 4000 characters allowed)*
330	**List preferred and/or co-preferred Humira Biosimilars on your formulary, including the following information (as of the Implementation Date):** Name: NDC: Formulary Status: Anticipated % drug cost reduction from Humira: Anticipated % volume shift from Humira: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
331	**Please provide an explanation regarding your response to Line #331** *(Required: Maximum 4000 characters allowed)*
332	**List Humira Biosimilars that are excluded from your formulary:** Name: NDC: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
333	**Please provide an explanation regarding your response to Line #333** *(Required: Maximum 4000 characters allowed)*
334	**What is Stelara's formulary status (i.e. preferred, co-preferred, excluded) as of the following dates:** Current Date status: Implementation Date status: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

335	**Please provide an explanation regarding your response to Line #335** *(Required: Maximum 4000 characters allowed)*
336	**List preferred and/or co-preferred Stelara Biosimilars on your formulary, including the following information (as of the Implementation Date):** Name: NDC: Formulary Status: Anticipated % drug cost reduction from Stelara: Anticipated % volume shift from Stelara: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
337	**Please provide an explanation regarding your response to Line #337** *(Required: Maximum 4000 characters allowed)*
338	**List Stelara Biosimilars that are excluded from your formulary:** Name: NDC: ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
339	**Please provide an explanation regarding your response to Line #339** *(Required: Maximum 4000 characters allowed)*
340	**Confirm CLIENT will have the right to carve out specialty at a later date, if requested. Client acknowledges that proposed pricing may require renegotiation at a later date in order for your organization to allow carve out of specialty.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

341	**Please provide an explanation regarding your response to Line #341** *(Required: Maximum 4000 characters allowed)*
342	**.** ***Formulary Rebates***
343	**Confirm that your organization will pass through 100% of all Rebates (as defined in the Terms and Definitions tab) to CLIENT.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
344	**Please provide an explanation regarding your response to Line #344** *(Required: Maximum 4000 characters allowed)*
345	**Confirm that Client will receive the greater of the aggregate Guaranteed Rebate Amounts plus 100% of any Rebates** plus Manufacturer Administrative Fees received for claims excluded from the Guaranteed Rebate Amounts or 100% of Rebates plus Manufacturer Administrative Fees. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
346	**Please provide an explanation regarding your response to Line #346** *(Required: Maximum 4000 characters allowed)*
347	**Confirm that, in no instances, will the cost difference between one product and another product be considered "Rebate."** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

348	**Please provide an explanation regarding your response to Line #348** *(Required: Maximum 4000 characters allowed)*
349	**Confirm that all branded product Claims defined by MediSpan as a "M", ""N"", ""O"" (single source, multi-source, formulary, non-formulary etc.) will be included in the minimum rebate guarantee, regardless of DAW penalty.** Minimum rebate guarantee cannot exclude any brand product that is filled as brand claim, regardless of how the claim is billed. *You must adhere to the exclusions shown on the 'Exclusions' attachment." "Confirmed" if you are in agreement with the pre-populated Excluded/Included designations on the 'Exclusions' attachment; otherwise, select "Not Confirmed" and change the pre-populated Excluded/Included designations on the 'Exclusions' attachment accordingly.* ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
350	**Please provide an explanation regarding your response to Line #350** *(Required: Maximum 4000 characters allowed)*
351	**Confirm that brand claims where the member paid 100% of the claim (Zero Balance Due from plan) will be included in the brand claim count of the calculation.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
352	**Please provide an explanation regarding your response to Line #352** *(Required: Maximum 4000 characters allowed)*
353	**Confirm that rebate guarantee reconciliations will include all claims for high deductible plans regardless of member cost share.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

354	**Please provide an explanation regarding your response to Line #354** *(Required: Maximum 4000 characters allowed)*
355	**Confirm ""Minimum Rebate Guarantee"" shall equal the product of:** (a) the number of paid Claims less exclusions processed by the PBM during the applicable period; and (b) the Rebate Rate for the Guarantee Year. *You must adhere to the exclusions shown on the 'Exclusions' attachment.* ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
356	**Please provide an explanation regarding your response to Line #356** *(Required: Maximum 4000 characters allowed)*
357	**Confirm that the Specialty minimum rebate guarantees apply to all specialty brand drugs regardless of dispensing channel.** If there are any specialty drugs/classes that are exempt from receiving the specialty rebate minimum guarantee, it MUST be noted and provided in explanation. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
358	**Please provide an explanation regarding your response to Line #358** *(Required: Maximum 4000 characters allowed)*
359	**Confirm that rebate guarantees are for actual rebates received from pharmaceutical manufacturers and do not include other amounts including, but not limited to, therapeutic interchange savings.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

360	**Please provide an explanation regarding your response to Line #360** *(Required: Maximum 4000 characters allowed)*
361	**Confirm CLIENT will receive the greater of the aggregate Guaranteed Rebate Amounts or 100% of Rebates received for non-excluded claims. AND** Separately, CLIENT will be passed through 100% of any Rebates received for claims excluded from the Guaranteed Rebate Amounts. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
362	**Please provide an explanation regarding your response to Line #362** *(Required: Maximum 4000 characters allowed)*
363	**Although Rebates received for claims not included in the minimum Rebate guarantees will be passed through at the quoted percentage,** Rebates received for claims not included in the minimum Rebate guarantee payments may not be used to offset any deficits calculated during the reconciliation between minimum Rebate guarantees/payments and pass through of the claims included in the minimum Rebate guarantees. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
364	**Please provide an explanation regarding your response to Line #364** *(Required: Maximum 4000 characters allowed)*
365	**Confirm CLIENT will receive payment equivalent to the minimum guaranteed rebate amount no later than 90 days following the quarter in which the claim adjudicated.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

366	**Please provide an explanation regarding your response to Line #366** *(Required: Maximum 4000 characters allowed)*
367	**Confirm that your organization's rebate guarantee payment will not be adjusted on the average days' supply of claims in any contract period.** The full rebate credit will be provided to CLIENT provided that the plan allows up to 30 days' supply at retail and up to 90 days' supply at mail. Your organization will not prorate guarantees based on the utilized days' supply or set a minimum days' supply amount upon which rebate guarantees are contingent. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
368	**Please provide an explanation regarding your response to Line #368** *(Required: Maximum 4000 characters allowed)*
369	**Confirm that total expected quarterly rebates will be reported to CLIENT within 45 days after the end of the quarter.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
370	**Please provide an explanation regarding your response to Line #370** *(Required: Maximum 4000 characters allowed)*
371	**Confirm that your organization will provide Quarterly Rebate Reporting showing Billing/Invoiced/Collected/Paid amounts.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

372	**Please provide an explanation regarding your response to Line #372** *(Required: Maximum 4000 characters allowed)*
373	**Confirm that your rebate payments and guarantees in your offer are based on the plan design and clinical programs as outlined in this RFP without alteration, including but not limited to weight loss products.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
374	**Please provide an explanation regarding your response to Line #374** *(Required: Maximum 4000 characters allowed)*
375	**Confirm that the rebate guarantee amounts will not be altered during the term of the contract for any reason other than:** (a) A change in government legislation which materially impacts the current economics of the rebating process between manufacturers and managed care organizations which then has a material adverse impact on the rebates that your organization receives, OR (b) A generic product is introduced to the market ahead of the anticipated generic launch date based upon your organization's current published generic pipeline report. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
376	**Please provide an explanation regarding your response to Line #376** *(Required: Maximum 4000 characters allowed)*
377	**Confirm that there is no level of formulary compliance that must be achieved to obtain stated discounts and rebate guarantees.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

378	**Please provide an explanation regarding your response to Line #378** *(Required: Maximum 4000 characters allowed)*
379	**Confirm that there is no days' supply minimum imposed for rebates obtained through mail.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
380	**Please provide an explanation regarding your response to Line #380** *(Required: Maximum 4000 characters allowed)*
381	**Confirm that rebate guarantees are not based on an expectation of certain % inflation increases in WAC or AWP,and will not be adjusted at any time during the term as a result of those expectations not coming to fruition.** For example, if your organization proposes rebate guarantees based on an underwriting assumption that WAC or AWP will increase 15%, rebate guarantees will not be adjusted if WAC or AWP increases at a lower rate of 10%. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
382	**Please provide an explanation regarding your response to Line #382** *(Required: Maximum 4000 characters allowed)*
383	**Confirm your organization will provide reporting applicable to brands that are excluded from the minimum Rebate guarantees upon CLIENT's request.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

384	**Please provide an explanation regarding your response to Line #384** *(Required: Maximum 4000 characters allowed)*
385	**Confirm that a list of New-to-Market products is maintained, along with the dates products are added and/or removed, and will be provided upon request, but no more frequently than quarterly.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
386	**Please provide an explanation regarding your response to Line #386** *(Required: Maximum 4000 characters allowed)*
387	**Confirm that any post-true up reconciliation for 340B will be limited to a maximum of 18 months.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
388	**Please provide an explanation regarding your response to Line #388** *(Required: Maximum 4000 characters allowed)*
389	**Confirm that in addition to summary level rebate reporting, rebate reports at the claim level and by NDC are provided.** Provide an example report labelled **"Exhibit 3 - - Rebate Reporting".** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

390	**Please provide an explanation regarding your response to Line #390** *(Required: Maximum 4000 characters allowed)*
391	**Does your organization utilize/propose to include MS-Brands as Tier-1 products (Tier-1 Brand) and/or use a DAW-9 strategy?** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
392	**Please provide an explanation regarding your response to Line #392** *(Required: Maximum 4000 characters allowed)*
393	**If your organization uses a Tier-1 Brand or DAW-9 strategy, confirm that claims processed using the Tier-1 Brand or DAW-9 strategy will be included in the Generic AWP discount rate guarantee for reconciliation purposes.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
394	**Please provide an explanation regarding your response to Line #394** *(Required: Maximum 4000 characters allowed)*
395	**If your organization uses a Tier-1 Brand or DAW-9 strategy, confirm that claims processed using the Tier-1 Brand or DAW-9 strategy will be included in the minimum Rebate guarantee calculation and in the Rebate pass-through reconciliation.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

396	**If your organization uses a Tier-1 Brand or DAW-9 strategy, confirm you will provide a report annually to determine if the policy resulted in lower net rebate costs (discounted ingredient costs less rebates) for the products included in the DAW 9 policy.** If the report finds the policy resulted in higher net rebate costs, you will pay CLIENT the difference dollar-for-dollar. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
397	**Please provide an explanation regarding your response to Line #397** *(Required: Maximum 4000 characters allowed)*
398	**Confirm that your organization agrees to notify CLIENT in advance of any plans to use a Brand drug as the "House Generic (via DAW-5 coding)"** and/or a Tier-1 Brand/DAW-9 strategy and to provide CLIENT information necessary to ensure cost neutrality to the plan. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
399	**Please provide an explanation regarding your response to Line #399** *(Required: Maximum 4000 characters allowed)*
400	**.** ***Audit***
401	**Confirm for rebate audits, CLIENT or its auditor will have access to rebate manufacturer contracts whether those contracts are held directly or indirectly through an aggregator or GPO arrangement upon execution of a Non-Disclosure agreement.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
402	**Please provide an explanation regarding your response to Line #402** *(Required: Maximum 4000 characters allowed)*

403	**In the event that rebates are being processed and paid through a third party Group Purchasing Organization (GPO), client and its auditor of choice will have access to manufacturer rebate contracts consisting of:** • Contract between PBM and GPO; • Contract between GPO and Pharmaceutical Manufacturer; • Contracts will include but not limited to: o Base Rebates o Incentive Rebates o Manufacturer admin fees o Inflation Protection o Market Share • Auditing will be subject to those manufactures that make up a minimum of 50% of rebate dollars ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
404	**Please provide an explanation regarding your response to Line #404** *(Required: Maximum 4000 characters allowed)*
405	**Confirm that your organization will allow a maximum of 300 sample claims to be submitted for your organization's review and response** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
406	**Please provide an explanation regarding your response to Line #406** *(Required: Maximum 4000 characters allowed)*
407	**Confirm that CLIENT will have the right to initiate at a minimum two (2) audits during the first year (to account for a post implementation audit and an annual audit) and then an annual audit in Y2 and Y3 with no lookback limitation.** Data will be provided at no additional cost, with full PBM collaboration and support (includes but not limited to Mock audit, Delegation oversight audit, etc.). Note: This is separate from any other CMS, Govt or state initiated/required audits. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

408	**Please provide an explanation regarding your response to Line #408** *(Required: Maximum 4000 characters allowed)*
409	**.** ***Other***
410	**For incumbent vendor(s) only: The expectation is that you will supply a contract amendment, with any changes redlined from the current agreement.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
411	**Please provide an explanation regarding your response to Line #411** *(Required: Maximum 4000 characters allowed)*
412	**For incumbent vendor(s) only: The expectation is that any changes from the current agreement do not impact the client negatively.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
413	**Please provide an explanation regarding your response to Line #413** *(Required: Maximum 4000 characters allowed)*
414	**Confirm that guarantee reconciliations will be completed and any shortfalls paid in the case a contract is not signed but a letter of intent has been executed.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

415	**Please provide an explanation regarding your response to Line #415** *(Required: Maximum 4000 characters allowed)*
416	**Confirm that your organization will allow a fair and flexible market check to be conducted ONCE during the initial agreement to preserve competitiveness of financial terms.** Such market check will be conducted by CLIENT's third party consultant of their choosing. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
417	**Please provide an explanation regarding your response to Line #417** *(Required: Maximum 4000 characters allowed)*
418	**Confirm that your organization will review and evaluate market check results that have been conducted based on similar clients in terms of size, composition, line of business, pricing and network arrangement, and formulary type;** Client, or Client's third party consultant, will provide a blinded comparison of benchmark clients used in the analysis; no other restrictions are required. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
419	**Please provide an explanation regarding your response to Line #419** *(Required: Maximum 4000 characters allowed)*
420	**Confirm that your organization will provide comments on the market check report within 10 business days of receipt** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

421	**Please provide an explanation regarding your response to Line #421** *(Required: Maximum 4000 characters allowed)*
422	**Confirm that if market check report indicates current market conditions can yield a 1% or more savings of net plan costs, the parties will reach mutual agreement on revised pricing terms and other applicable provisions** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
423	**Please provide an explanation regarding your response to Line #423** *(Required: Maximum 4000 characters allowed)*
424	**Confirm that you will allow the client to solicit bids in order to receive the most up date financial offers as part of their market check.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
425	**Please provide an explanation regarding your response to Line #425** *(Required: Maximum 4000 characters allowed)*
426	**Confirm that if mutual agreement cannot be reached within 60 days from the date of the market check report, CLIENT has the right to terminate the agreement upon 30 days prior written notice.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

427	**Please provide an explanation regarding your response to Line #427** *(Required: Maximum 4000 characters allowed)*
428	**Confirm that your organization's contract will contain an auto-renewal condition (one year) that requires no more than 90 days notice.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
429	**Please provide an explanation regarding your response to Line #429** *(Required: Maximum 4000 characters allowed)*
430	**Confirm your organization allows CLIENT to terminate the agreement with or without cause, and without termination charges, with 90 days written notice. CLIENT will be the only party to have termination for convenience rights.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
431	**Please provide an explanation regarding your response to Line #431** *(Required: Maximum 4000 characters allowed)*
432	**Confirm that CLIENT will be allowed to terminate the agreement if CLIENT terminates the benefit plan or prescription drug program defined by the plan.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

433	**Please provide an explanation regarding your response to Line #433** *(Required: Maximum 4000 characters allowed)*
434	**Upon termination, confirm that all pricing guarantees will be trued up, and any shortfalls paid to CLIENT, within 90 days after termination.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
435	**Please provide an explanation regarding your response to Line #435** *(Required: Maximum 4000 characters allowed)*
436	**Upon termination, confirm that all rebates will be paid to CLIENT within 24 months after termination.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
437	**Please provide an explanation regarding your response to Line #437** *(Required: Maximum 4000 characters allowed)*
438	**Upon termination, confirm that all necessary documentation will be provided, such as claims files, prescription history and other data needed for the successful transition of the program to the appointed vendor within a mutually agreed upon due date and** at no additional cost to CLIENT. This includes, but is not limited to all open mail order and specialty pharmacy refill, utilization management edits, formulary and all related drug lists (specific to the client at the time), accumulators used in all plan options and at least six months of historical claims data. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

439	**Please provide an explanation regarding your response to Line #439** *(Required: Maximum 4000 characters allowed)*
440	**Confirm that your organization agrees to provide CLIENT and/or consultant a copy of the actual MAC lists with pricing used for CLIENT, upon request.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
441	**Please provide an explanation regarding your response to Line #441** *(Required: Maximum 4000 characters allowed)*
442	**"Confirm that your organization will support all the tasks necessary to complete and finalize a pre-implementation report at least 10 days prior to the effective date.** *This assumes that CLIENT has signed-off on the benefit set-up 30 business days prior to the effective date. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
443	**Please provide an explanation regarding your response to Line #443** *(Required: Maximum 4000 characters allowed)*
444	**Confirm that your organization will provide a client allowance to be used for expenses associated with the pharmacy benefit, including, but not limited to:** Communications, internal costs, ancillary PBM charges/programs, consulting fees, etc. Funds will be calculated on a per member basis (employee + spouse + dependents) based on enrollment at implementation. Funds will be available during the entire term of the contract, will not expire, and may be carried over from year to year of the contract. ***(Indicate amount offered on ""Financial Offer"" attachment).*** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

445	**Please provide an explanation regarding your response to Line #445** *(Required: Maximum 4000 characters allowed)*
446	**Confirm that your organization will share 100% of all retail/mail audit recoveries with CLIENT on a quarterly basis within 30 days from the close of the contract quarter.** Confirm that your organization will provide reporting to validate recoveries at no cost. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
447	**Please provide an explanation regarding your response to Line #447** *(Required: Maximum 4000 characters allowed)*
448	**Confirm that medical fees will not be impacted as a result of this Pharmacy Financial Offer, if applicable** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
449	**Please provide an explanation regarding your response to Line #449** *(Required: Maximum 4000 characters allowed)*
450	**Confirm non-incumbent PBMs allow grandfathering up to 90 days, post Go Live without impacting proposed financials.** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*

451	**Please provide an explanation regarding your response to Line #451** *(Required: Maximum 4000 characters allowed)*
452	**What fees, if any, will you charge clients in support of the Transparency In Coverage Rule?** ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
453	**Please provide an explanation regarding your response to Line #453** *(Required: Maximum 4000 characters allowed)*
454	**Confirm that PBM set-up errors that result in Client or Member overpayments and** Pharmacy Network underpayments shall be the full responsibility of PBM and PBM will re-process Claims and will assume all financial responsibility including the costs associated with correcting benefit set-up and issuing refunds. ☐ Confirmed ☐ Not Confirmed *(Required: Check only one)*
455	**Please provide an explanation regarding your response to Line #455** *(Required: Maximum 4000 characters allowed)*

Supplier Information

Company Name:

Contact Name:

Address:

Phone:

Fax:

Email:

Supplier Notes

By submitting your response, you certify that you are authorized to represent and bind your company.

Print Name

Signature