Tab A-1: Background and Qualifications

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete each cell with the requested information. Items in the response column with the words, "Select one", contain a drop down list of options. Please select a response from those options as applicable.

I. GENERAL OFFEROR INFORMATION

		Response
1.	Offeror's Legal Name	
2.	Address	
3.	City	
4.	State	
5.	Zip	
	Web Address	
	Operational Date	
	Corporate Tax Status	Select one
	Federal Employer Identification	
	Number	
10.	Ownership/Controlling Interest	
	Describe the Offeror's experience in	
	providing pharmacy benefit	
	management services to South	
	Carolina based clients.	
	How long has the Offeror	
	administered pharmacy benefits to	
	South Carolina based clients?	
	Confirm that the organization is	
	compliant with all applicable HIPAA	
	administrative simplification rules.	Select one
	administrative simplification railes.	
14.	Provide a detailed description of any	
	recent (within 5 years) HIPAA	
	breaches.	
	a.) Will your organization be involved	
	in any acquisitions or mergers within	
	the next 12 months?	Select one
	If yes, please describe.	
	b) Has your organization been	
	involved in any recent acquisitions or	
	mergers?	
	Within the last year?	Select one
	• 1-2 years ago?	Select one
	• 2-5 years ago?	Select one
	None in the last five years	Select one
	If yes, please describe.	
16.	Confirm that your organization has	
	Errors and Omissions Insurance and	Please submit a copy of your certificate(s) of insurance indicating coverage limits and label as
	Commercial General Liability	"Tab A-1: Certificates of Insurance".
	Insurance.	
	• E&O	Select one
	Commercial General Liability	Select one
17.	Please provide a copy of your	
	organization's most recent audited	
	annual and quarterly update financial	Diagonal and an Hilliam A. 1. The control of the control of
	statements, including income	Please label as "Tab A-1: Financial Statements".
	statements and balance sheets.	
18.	Provide a copy of your most recent	
	financial ratings and complete the	Please label as "Tab A-1: Financial Ratings".
	following table.	
	A.M. Best	
ı		

	◆ Current Financial Rating	
	• Date of Rating	
	Prior Financial Rating	
	• Date of rating	
	Standard & Poor's	
	 Current Financial Rating 	
	◆ Date of Rating	
	Prior Financial Rating	
	Date of rating	
	Fitch ◆ Current Financial Rating	
	Date of Rating	
	Prior Financial Rating	
	• Date of rating	
19.	a.) Total number of covered enrollees,	
	as of December 31, 2014	
	b.) Percent of enrollees, as of	
	December 31, 2014, who are covered	
	through an employer group.	
20	Tetal much as of an all and Park	
	Total number of employer clients, as of December 31, 2014	
	Total mail order prescription volume,	
	based on days of therapy, for the	
	period January 1, 2014 through	
	December 31, 2014.	
22.	Total number of mail order	
	prescriptions for the period January	
	1, 2014 through December 31, 2014.	
22	Total astail assassiation assluma	
23.	Total retail prescription volume, based on days of therapy, for the	
	period January 1, 2014 through	
	December 31, 2014.	
24.	Total number of retail prescriptions	
	for the period January 1, 2014	
	through December 31, 2014.	
2.5		
25.	Please provide a distribution of	
	employer clients by number of members in the following categories.	
	(Clients do not need to be identified.)	
	(Chents do not need to be identified.)	
	Less than 1,000 members	
	1,000 - 4,999 members	
	5,000 - 9,999 members	
	10,000 - 49,999 members	
	50,000 - 99,999 members	
	100,000 - 499,999 members 500,000 or more members	
26	Provide the following enrollment	
	history metrics as of January 1st of	
	each year.	
	2013	
	Number of covered lives:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail) Total	0
	Number of employer clients:	U
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	2014	
	Number of covered lives:	
	Retail only	

	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
		U
	Number of employer clients:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	2015	
	Number of covered lives:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	Number of employer clients:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
27.	For the 12 months ending December	
	31, 2014, provide the following for	
	your book of business under your	
	managed retail and mail pharmacy	
	programs. All cost data should be	
	based on total cost before retiree	
	copays/coinsurance.	
	Average Ingredient Cost	
	Single-source	
	Multi-source Brand	
	Generic	
	% Dispensing Rates	
	Single-source	
	Multi-source Brand	
	Generic Generic	
	Prescription Counts	
	Single-source	
	Multi-source Brand	
	Generic Generic	
28	The Offeror shall provide any	
	additional information that indicates	
	that it is capable of administering a	
	program for the Plan the size of the	
	State's, including any experience	
	and/or innovations in the	
	administration of similar contracts.	
	administration of similar contracts.	
29.	a.) Is the Offeror and/or any of its	
	Principals presently debarred,	
	suspended, proposed for debarment,	
	or declared ineligible for the award of	
	contracts by any state or federal	
	agency? "Principals" means officers;	
	directors; owners, partners; and	
		Select one
	persons having primary management or supervisory responsibilities within	53334 010
	a business entity (e.g. general	
	manager; plant manager; head of a	
	subsidiary, division or business	
	segment; and similar positions).	
	b.) If yes, please explain.	
	, jeo, piease explain.	

	a.) Has the Offeror and/or any of its Principals, within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of		
	fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the	Select one	
	submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?		
31.	b.) If yes, please explain. a.) Has the Offeror been the subject of an ERISA investigation?	Select one	
	b.) If yes, please explain. a.) Is the Offeror and/or any of its Principals presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in question #30 above?	Select one	
33.	b.) If yes, please explain. a.) Has the Offeror, within a three-year period preceding this offer, had one or more contracts terminated for default by any public (Federal, state or local) entity?	Select one	
<u>34.</u>	b.) If yes, please explain. Please provide a list of public sector clients of similar size to PEBA for which the Offeror has performed, at any time during the past three years, services substatially similar to those sought with this solicitation. List commercial clients separately from EGWP with Wrap clients.	Please label as "Tab A-1: Public Sector Client List".	
	Please provide a list of failed projects, suspensions, debarments, and significant litigation.	Please label as "Tab A-1: Failed Projects, Suspensions, Disbarments".	
	Please provide a detailed, narrative statement listing the three most recent, comparable contracts (including contact information) which you have performed.	Please label as "Tab A-1: Detailed Narrative Statement".	

II. CONTACT INFORMATION

Please identify both the primary contact, who can answer questions related to this RFP, and the account manager, who will have overall responsibility for planning, supervising and performing account services.

Primary Contact		
Name		
Title		
Address		

City	City		
State			
Zip			
	hone #		
	hone #		
	hone #		
	l Address		
L-IIIai	TAddress		
Acco	unt Manager		
Name			
Title			
Addre	ess		
City			
State			
Zip			
	hone #		
	hone #		
Cell P	hone #		
E-mai	l Address		
require	ement.	FP are mandatory. For each item, please des	cribe how the Offeror satisfies the
Min	imum Qualifications		Response
		s of providing Pharmacy Benefit	
		nistration of a retail pharmacy network, for	
		should provide detailed information to	
		siness of providing Pharmacy Benefit	
		ing a retail pharmacy network, for a	
	num of five (5) years.	ing a retail pharmacy network, for a	
the typ minim inform Manag	pe and scope outlined herein (exc num of 2,000,000 covered manag- nation to establish that they are c gement Services of the type and	narmacy Benefit Management Services of cluding discount card programs) for a ged lives. Offerors should provide detailed urrently providing Pharmacy Benefit scope outlined herein for a minimum of	
3. Offero		y URAC. Offerors should provide proof	
	rent URAC accreditation.	hanafit of at least one (1) state government	
client	or, alternatively, public sector er	benefit of at least one (1) state government mployer, of at least 250,000 lives, with	
must n	manage the prescription benefit of	and non-Medicare eligible participants; and of at least three (3) additional employer	
	nts, each including at least 25,00		
(plan p		inistration of a total drug spend volume d deductibles) of not less than two billion ear 2014.	
		iption benefit of at least one (1) state blic sector employer, of at least 300,000	
covers partici	s) with membership including bo	the numbers of lives the State Health Plan th Medicare and non-Medicare eligible scription benefit of at least three (3) cluding at least 100,000 lives.	
	or must have filled at least two man any of the last 3 years (2012,	illion (2,000,000) scripts annually in South 2013, 2014).	
	ERENCES complete the following tables w	with the requested reference information.	

III.

IV.

1. Please provide references for two clients with more than 100,000 lives for whom you provide similar prescription drug benefits administration. At least one of the references must be a statewide government sector client.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

2. Please provide references for two clients (public or private sector) with more than 25,000 lives for whom you provide similar prescription drug benefits administration.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

	Information	Reference #1	Reference #2
	provided similar prescription drug ben	efits administration.	
3.	Please provide references for two form	ner clients (public or private sector) with mo	re than 25,000 covered lives for whom you

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

4. Please provide references for two clients (public or private sector) who began utilizing your prescription drug benefit administration services within the last twelve months.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

5. Please provide references for two clients (public or private sector) for whom you administer an Indirect EGWP + Wrap program for Medicare participants.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

Request for Proposal for Pharmacy Benefit Management Services Tab A-2a: Service Description Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please provide a response to each of the following questions. If a drop down list is available, please select a response from that list. If your response for a question exceeds 1,024 characters in length, complete your response in "Tab A-2b: Questionnaire Answers" using the directions provided in Tab A-2b.

	Question	Response
I. PR	ICING AND COST CONTAINMENT	
Q-1	Describe, in detail, how you will disclose all revenue sources derived by relationships with pharmaceutical manufacturers, at mail order and at retail.	
Q-2	Provide the following data on your MAC program. a.) Please provide a copy of your proposed MAC list in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as "Tab A-2: MAC List - Commercial Plan".
	b.) Number of generic classes on MAC list c.) Number of multi-source brand drugs for which the MAC list provides substitution alternatives (all dosage forms of multi-source drug counted as one) d.) Package size basis for maximum MAC price e.) MAC drugs as a percent of total generic drugs dispensed f.) Average MAC cost as a percent of total generic drug cost g.) Average generic cost as a percent of average multi-source brand drug cost h.) Expected total generic dispensing rate using MAC program i.) Guarantee on total generic dispensing rate using MAC program j.) Expected MAC savings as a percent of plan ingredient cost (total brand and	
Q-3	generic cost) k.) Number of MAC drugs added in the past 12 months Please provide a detailed description of	
	how your organization determines which drugs are preferred versus non-preferred.	Label as "Tab A-2: Formulary Development Criteria".
Q-4	Please provide a detailed utilization management program list, including specific drug names in each program.	Label as "Tab A-2: Detailed Utilization Management Program List".
Q-5	Describe, in detail, your system of coverage review for selected medications, including the use of step therapy algorithms based on national prescribing guidelines.	
Q-6	Describe the activities involving outreach to physicians with regard to prescription drug cost containment.	
Q-7	Describe your background and experience with the following clinical programs: a. concurrent drug utilization review b. retrospective drug utilization review c. prospective drug utilization review	

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	Question	Response
	d. prior authorization	•
	e. step therapy	
Q-8	Please provide the following information	
	for each prospective/retrospective DUR	
	program you offer and include two	
	references.	
	Program #1	
	Number of programs implemented to date	
	PMPM savings associated with the	
	program	
	Risk sharing Arrangements (if any)	
	including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone) Reference #2 (name/contact/phone)	
	Program #2	
	Number of programs implemented to date	
1		
1	PMPM savings associated with the	
1	program	
1	Risk sharing Arrangements (if any)	
	including outcomes or cost savings	
	PMPM Program Costs (if any)	
1	Reference #1 (name/contact/phone) Reference #2 (name/contact/phone)	
	Program #3	
	Number of programs implemented to date	
	r eg r	
	PMPM savings associated with the	
	program	
	Risk sharing Arrangements (if any)	
	including outcomes or cost savings	
	PMPM Program Costs (if any) Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
	Program #4	
	Number of programs implemented to date	
	2001	
	PMPM savings associated with the	
	program Risk sharing Arrangements (if any)	
	including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
II. PHA	ARMACY NETWORK MANAGEMEN	
Q-9	a.) Describe, in detail, how you would	
	extend the opportunity of network	
	participation to all retail pharmacy	
	chains, independent pharmacies and	
	nursing home pharmacies operating in	
1	South Carolina as well as to any willing	
1	retail pharmacies and pharmacy chain stores located in other states.	
1	b.) Describe, in detail, the solicitation	
	materials you would use for distribution	
	to all pharmacies in South Carolina.	
1		
	c.) Provide a sample of the solicitation	
	materials you would use for distribution	Please label as "Tab A-2: Sample Pharmacy Solicitation Materials".
	to all pharmacies in South Carolina.	•
Q-10	a.) Describe how you will verify that	
V 10	pharmacies entering the network	
	maintain the necessary federal and state	
1	licenses and permits required by law.	

	Question	Response
	b.) Describe how you will verify that	
	pharmacies entering the network	
	maintain adequate insurance for claims	
	arising out of that pharmacy.	
	c.) Describe how you will verify that	
	pharmacies entering the network will identify and notify the S.C. Public	
	Employee Benefit Authority of any	
	pharmacies which, in the opinion of the	
	Contractor, do not meet minimum	
	professional requirements or business	
	standards for inclusion in the network.	
Q-11	Describe the process used by your	
	organization to verify that network pharmacies charge the applicable	
	coinsurance or copayment to participants	
	at the point of sale.	
Q-12	Describe, in detail, your plan for	
	conducting audits of network pharmacies	
	to ensure compliance with network	
0.12	contract provisions.	
Q-13	List the elements of your various audit programs. Include frequency of the audit	
	for each element and the audit method.	
	and the dadic method.	
	Type of Audit	
	Frequency	
	Method	
	Type of Audit	
	Frequency Method	
	Type of Audit	
	Frequency	
	Method	
	Type of Audit	
	Frequency Method	
Q-14	Provide the results of your field audit	
Q I I	programs for calendar years 2012, 2013	
	and 2014.	
	2012	
	Audits completed as a percent of all	
	contracted pharmacies.	
	Pharmacies put on probation as a percent of all contracted pharmacies.	
	Pharmacies terminated as a percent of all	
	contracted pharmacies.	
	Recovery (in dollars) as a percent of total	
	book of business drug spend.	
	Audits completed as a percent of all	
	contracted pharmacies.	
	Pharmacies put on probation as a percent	
	of all contracted pharmacies.	
	Pharmacies terminated as a percent of all	
	contracted pharmacies.	
	Recovery (in dollars) as a percent of total	
	book of business drug spend. 2014	
	Audits completed as a percent of all	
	contracted pharmacies.	
	Pharmacies put on probation as a percent	
	of all contracted pharmacies.	
	Pharmacies terminated as a percent of all	
	contracted pharmacies. Recovery (in dollars) as a percent of total	
	book of business drug spend.	
Q-15	How are audit recoveries pro-rated back	
	to clients?	
	·	

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A-2a Questionnaire

	Question	Response
Q-16	a.) Describe, in detail, the contract	
	between the pharmacies and the Offeror, including the terms and conditions the	
	contract will contain.	
	b.) Please provide a sample contract	
	between the pharmacy and the Offeror.	Please label as "Tab A-2: Sample Contract".
Q-17	Will you solicit non-participating	
	pharmacies on behalf of S.C. Public Employee Benefit Authority?	
Q-18	a.) Describe how you would advise S.C.	
	Public Employee Benefit Authority on	
	your progress to obtain network participation of the largest number of	
	pharmacies covering the greatest	
	geographical area of the State.	
	b.) How frequently will you provide the	
	S.C. Public Employee Benefit Authority	Select one
	with an update of your network participation efforts?	
	AIL ORDER PHARMACY MANAGEN	MENT
Q-19	Where is the primary mail order facility location you propose for the S.C. Public	
	Employee Benefit Authority?	
Q-20	What are the days and hours of operation for this facility?	
Q-21	a.) Is this facility owned and operated by	Select one
	your organization? b.) If so, are purchase discounts passed	Select one
	along to the purchaser or kept as margin	
	by the PBM?	
Q-22	a.) Total number of mail order service centers as of December 31, 2014.	
	b.) Percent of capacity at which the mail	
	order service centers are functioning.	
Q-23	a.) What was the average daily number of	
	prescriptions filled during the period January 1, 2014 through December 31,	
	2014?	
	b.) Does this represent an increase or decrease in volume from the previous	Select one
	year?	Select one
	c.) If this represents an increase or	
	decrease from the previous year, by how much did the average daily number of	
	prescriptions change as a percent?	
Q-24	What is the estimated daily capacity of	
	the proposed facility as of December 31,	
Q-25	2014? Provide the average number of	
Q-23	clinicians/pharmacists for the following:	
	m p	
	Pharm D. Full-time	
	Part-time	
	Registered Pharmacist Full-time	
	Part-time	
	Pharmacy Technicians	
	Full-time Part-time	
	Other clinical staff	
	Full-time Part-time	
Q-26	a.) Describe your process for ordering	
	refills by mail.	
	b.) Provide a sample refill order form	Label as "Tab A-2: Sample Refill Order Form".

	Question	Response
Q-27	a.) Describe your process for ordering	
	refills by phone. b.) What percentage of fills are ordered	
	by phone?	
	c.) How far in advance can participants	
Q-28	order a refill? a.) Describe what quality controls are in	
	place to ensure accurate dispensing of	
	prescriptions. b.) How many levels of review take place	
	and who conducts the reviews?	
Q-29	Describe on-line integration, if any, with	
	retail pharmacies to ensure non- duplication and to identify potential	
	adverse interactions.	
Q-30	a.)What are your contingency plans and	
	procedures for providing backup service in the event of strike, natural disaster, or	
	backlog?	
	b.) What are your contingency plans and	
	procedures for providing backup service in the event of a total system failure?	
	•	
Q-31	a.) How often do you switch generic manufacturers for particular products?	
	b.) How are participants notified of the	
0.22	switch?	
Q-32	Provide your claim processing standards versus actual results for 2013 and 2014	
	for the following:	
	Towns of the Control	
	Turnaround time for routine prescription Claim processing standard	ons
	2013 Actual	
	2014 Actual Turnaround time for prescriptions requ	iring intervention
	Claim processing standard	ming met rention
	2013 Actual 2014 Actual	
	Prescription accuracy	
	Claim processing standard	
	2013 Actual 2014 Actual	
Q-33	Please list the top ten manufacturers of	
	generic medications for your book of	
	business by volume for calendar year 2014.	
	1. Manufacturer Name	
	2014 volume (in units) 2. Manufacturer Name	
	2014 volume (in units)	
	3. Manufacturer Name	
	2014 volume (in units) 4. Manufacturer Name	
	2014 volume (in units)	
	5. Manufacturer Name	
	2014 volume (in units) 6. Manufacturer Name	
	2014 volume (in units)	
	7. Manufacturer Name 2014 volume (in units)	
	8. Manufacturer Name	
	2014 volume (in units)	
	9. Manufacturer Name 2014 volume (in units)	
	10. Manufacturer Name	
0.27	2014 volume (in units)	
Q-34	a.) Are on-site audits performed at your mail service pharmacies?	
1	man service pharmacies:	

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	Question	Response
	b.) Describe the frequency and types of	· · · · · · · · · · · · · · · · · · ·
	audits performed.	
	c.) Is the Mail Service Pharmacy that will	
	support the S.C. Public Employee Benefit	
	Authority mail order program subjected	
	to the same audit programs as your Retail	
Q-35	Network? Please describe the process for notifying	
Q-33	customers of:	
	a.) Expiration date of their prescription	
	b.) Their next refill date and the number	
	of refills	
	c.) Prescriptions not on formulary	
0.26	d.) Generic substitution availability	
Q-36	a.) Describe your system of providing patient advisory information with	
	prescriptions filled, including next refill	
	date and the number of refills.	
	b.) What percentage of prescriptions	
	receives a patient information	
	supplement?	
	c.) Provide sample materials of your	Please label as "Tab A-2: Patient Advisory Information".
0.27	patient advisory information.	
Q-37	a.) How is the member billed (i.e. before	
1	or after the prescription is filled)?	
1	b.) How does the member know which	
1	copay applies?	
Q-38	Does the Offeror e-mail:	
	a.) Refill reminders	Select one
	b.) Savings intervention opportunity	Select one
1	messages	44.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4
IV. CP	c.) COB messages	Select one
Q-39	a.) Does your organization offer an	injectuores)
Q-39	integrated specialty program?	Select one
	b.) If yes, describe the operations of the	
	program and include elements describing	
	your case and care management abilities.	
Q-40	a.) Does your organization own a	Select one
	specialty pharmacy? b.) If yes, are purchase discounts passed	
1	along to the plan or kept as margin by the	
	PBM?	
Q-41	Please provide a copy of your proposed	
1	Specialty drug list in electronic format	
1	using MS Excel with read/write	Please label as "Tab A-2: Specialty Drug List - Commercial Plan".
1	capabilities. Include NDC-11 codes and	
Q-42	price per metric quantity. a.) Is there separate pricing for injectable	
V-72	and biotech products?	Select one
	b.) If yes, please provide a separate fee	
	schedule.	
Q-43	a.) How long has your organization had	
	this program in place?	
1	b.) How many patients do you currently	
Q-44	provide services to? Please provide a client reference for this	
Q-44	program.	
1	Organization	
	Contact Name	
	Title	
	Telephone	
Q-45	Describe the process to address	
1	exclusivity or limited distribution	
Q-46	scenario. Do you provide any of the following	
Q-40	programs?	
1	a.) a package recovery program	Select one
•	, 1	

	Question	Response
	b.) a vial/assay management program	Select one
	c.) a ready to inject program	Select one
Q-47	Do you report on compliance and	
	adherence to therapy as part of your	
	standard reporting package?	
Q-48	Please describe what you anticipate, both	
	for unit and aggregate costs, to be the top	
	ten most costly specialty drugs in the	
	next three years for your customers.	
Q-49	What is your net annual enterprise	
	forecasted specialty drug claim trend	
	factor for each of the following calendar	
	years?	
	a.) CY 2016	
	b.) CY 2017	
	c.) CY 2018	
Q-50	Please describe your company's strategy	
1	to effectively manage cost of specialty	
	drugs while ensuring access for those	
	needing those services, either solely on	
	the prescription plan and/or in	
	collaboration with the medical plan	
	vendor.	
Q-51	Please describe your company's strategy	
	to effectively manage costs associated	
	with Hepatitis C.	
V. CU	STOMER SERVICE, COMMUNICAT	IONS AND TRAINING
Q-52	Please provide sample communications	
	materials, including request letters for	
	clinical programs, switching programs	Label as "Tab A-2: Sample Communications Materials".
	and sample EOBs.	
Q-53	a.) Does the Offeror own and operate the	
	customer service department that will be	
	used to support the S.C. Public Employee	Select one
	Benefit Authority?	
	b.) If no, please explain.	
	c.) Describe the customer service unit	
	(organization, staffing and services) that	
	would handle the S.C. Public Employee	
	Benefit Authority account.	
Q-54	a.) Will the S.C. Public Employee Benefit	
	Authority customer service representative	
	team be dedicated to S.C. Public	Select one
	Employee Benefit Authority?	
	b.) If yes, define what is meant by	
	dedicated.	
Q-55	Briefly describe the training that each	
	associate receives to prepare to manage	
1	the S.C. Public Employee Benefit	
	Authority benefit? Include length of time	
	it takes to go from training to CSR.	
0.75		
Q-56	a.) Are there any scheduled changes to	Select one
	any of the CSR support platforms?	
	b.) If so, include description of old and	
	new platform along with a timeline of	
	when the changes will be implemented.	
0.57	How would the customer service unit be	
Q-57	staffed?	
0.59	What are customer service hours of	
Q-58		
Q-59	operation? What happens to after-hours calls?	
Q-59 Q-60	How do you track and monitor phone	
Q-00	service on an account-specific basis?	
Q-61	Provide your phone service standard	
V-01	versus actual results for calendar years	
1	2013 and 2014.	
1	2010 una 2017.	

	Question	Response
	Average speed to answer	
	Phone service standard	
	2013 Actual	
	2014 Actual Call abandonment rate	
	Phone service standard	
	2013 Actual	
	2014 Actual	
	Percent of calls solved without requiring Phone service standard	g a call back
	2013 Actual	
	2014 Actual	
	Percent of calls resolved on the first con	tact
	Phone service standard	
	2013 Actual 2014 Actual	
Q-62	Does your CSR system support TTY,	
`	TDY technologies?	Select one
Q-63	a.) Can your member services unit	
1	support non-English speaking members?	Select one
1	b.) If yes, please specify languages.	
Q-64	a.) Do you expect to make major changes	
1	to the service organization (e.g. moving	Select one
1	to a different location, merging units,	
1	etc)? b.) If yes, please describe the changes.	
1	5.7 2 Jes, pieuse describe the changes.	
Q-65	Please describe the process by which you	
1	notify plan participants of formulary	
Q-66	changes. a.) Provide a copy of the latest customer	
Q-50	satisfaction survey your organization has	
1	conducted.	
1	b.) How was the survey instrument	
	developed?	
	c.) Do you use an independent outside vendor to conduct the survey? If so, who?	
	vendor to conduct the survey. It so, who.	
	d.) Are survey results released to the	
1	public?	
1	e.) How are respondents to the survey selected?	
1	f.) What was the date of the last survey?	
1		
1	g.) What percentage of respondents were	
1	either very satisfied or satisfied with the services of your organization?	
1	services or your organization:	
Q-67	Are there tools available to participants	
1	who don't register on your site?	
Q-68	a.) Can you do prospective modeling for	
Q-08	patients and demonstrate their personal	
1	savings associated with changing	Select one
1	medications from their current	
1	prescriptions?	
1	b.) Does this function use existing claim history, S.C. Public Employee Benefit	
1	Authority specific plan design and	
1	pricing as a starting point?	
1	c.) If you have this capability, what have	
1	you seen for utilization patterns and changes from brand to generic	
1	medications?	
Q-69	a.) What percentage of your employer	
1	sponsored organization's employees	
1	register on your site (e.g., basis = they	
I	sign up and get a password)?	

	Question	Response
	b.) What target should S.C. Public	· · · · · · · · · · · · · · · · · · ·
	Employee Benefit Authority set for their	
	population given nearly 50% web access	
	and strong promotion?	
Q-70	a.) Describe your personalization and	
	push messaging capabilities.b.) How do these capabilities impact cost	
	or quality for your clients?	
VI. CI	AIMS PROCESSING and PAYMENT	
Q-71	Describe, in detail, your approach to	
	providing pharmacy claims processing	
	and adjudication.	
Q-72	Describe the adjudication platforms	
	(hardware, software and	
	communications) that would be used to	
	perform retail and mail order prescription claim processing	
Q-73	a.) Does the Offeror own the adjudication	
	platforms (hardware, software, and	
	communications) used to perform the	Select one
	retail and mail order prescription claims	
	processing?	
0.5:	b.) If no, please explain.	
Q-74	a.) Does the Offeror own the code that is	
	used to build all system platforms that govern the claim adjudication functions?	
	(These platforms include, but are not	
	limited to, retail and mail order	Select one
	adjudication, eligibility systems, plan	
	design systems and reporting systems.)	
	b.) If no, please explain.	
Q-75	a.) Describe your capability of separately	
	processing prescription drug claims for members enrolled in a Health Savings	
	Account qualified plan and transmitting	
	information to the Plan's medical claims	
	administrator (currently, Blue Cross Blue	
	Shield of South Carolina).	
	b.) Describe the frequency at which you	
	are able to transmit prescription drug claims data to the Plan's medical claims	
	administrator (<i>e.g.</i> real time, hourly,	
	daily, weekly, etc.)	
Q-76	a.) Describe your capability of separately	
	processing prescription drug claims for	
	members and transmitting information to	
	the Plan's medical claims administrator	
	(currently, Blue Cross Blue Shield of	
	South Carolina) in order to comply with federal requirements, including combined	
	out of pocket limits.	
	<u>k</u>	
	b.) Describe the frequency at which you	
	are able to transmit prescription drug	
	claims data to the Plan's medical claims	
	administrator (e.g. real time, hourly,	
Q-77	daily, weekly, etc.) a.) Describe the online data link between	
Q=//	each participating pharmacy and the	
	Offeror.	
	b.) Provide a list of items the online data	
	link will allow the pharmacist to review	
	prior to completion of a transaction.	
0.70	Thereign which and a feet of the control of the con	
Q-78	Identify which of the following edits are performed at the point of service:	
	a.) Ineligible participant	Select one
	b.) Ineligible drug	Select one
•		

	Question	Response
	c.) Incorrect AWP	Select one
	d.) UCR input	Select one
	e.) Duplicate Rx	Select one
	f.) Refill too soon	Select one
	g.) Incorrect dosage	Select one
	h.) Rx splitting i.) Drug interactions	Select one Select one
	i.) Over utilization	Select one Select one
	k.) Under utilization	Select one
	1.) COB	Select one
	m.) Benefit maximums for certain drug	Select one
	types	
	n.) Drug is inappropriate for the patient	Select one
	due either to age or sex	
	o.) Other (specify)	Select one
Q-79	Please describe your appeals process	
	including your brand/generic appeals	
Q-80	process. Please identify how you would propose to	
Q-00	monitor and increase member's	
	prescription compliance.	
Q-81	How would you propose to optimize the	
	mix between retail and mail order	
	prescriptions?	
Q-82	Please describe programs you have	
	implemented to expedite conversion to	
	newly released generic medications.	
0.02	Please provide examples.	
Q-83	a.) Do you have a managed injectable program? If so, please describe.	
	b.) Are you partnered with anyone?	
	c.) Does your proposed price include the	
	cost of this program?	
Q-84	How are out-of-network claims	
	processed?	
Q-85	Describe how you would notify S.C.	
	Public Employee Benefit Authority if	
	covered person fraud, provider fraud or	
	improper provider billing practices were	
Q-86	discovered. a.) Describe, in detail, how you will	
Q-00	enforce coordination of benefits at the	
	point of sale.	
	b.) Describe how you will cooperate with	
	S.C. Public Employee Benefit Authority	
	to obtain information on other health	
	insurance for covered persons.	
	. D	
	c.) Describe how you will report plan savings as a result of coordination of	
	benefits.	
Q-87	Describe how you will cooperate with the	
,	operation of the S.C. Public Employee	
	Benefit Authority appeals process for	
	disputed claims.	
Q-88	Briefly describe your organization's	
	capabilities in monitoring the costs and	
0.00	utilization of compound drugs.	
Q-89	With respect to plan design options,	
	briefly describe each of your organization's solutions to controlling the	
	costs and utilization of compound drugs.	
	costs and diffication of compound drugs.	
VIL. RE	PORTING	
Q-90	List the reports and provide examples of	
	the standard reporting package you will	Di 111 100 1 1 0 0 1 0 1 0 1 0 1 0 1 0 1
	be delivering to the S.C. Public Employee	Please label as "Tab A-2: Sample Standard Reporting Package".
	Benefit Authority.	
-	·	

	Question	Response
Q-91	Describe your online access query system	
	for analysis of individual and/or group	
	prescription drug claims data related to	
	individual claimants, prescription drug	
	information, network pharmacy information and prescriber information.	
	Offerors should describe all of the data	
	available for analysis on this system.	
	(NOTE: The highest scored Offeror's	
	online access query system may be	
	subject to demonstration prior to contract	
	award.)	
Q-92	Describe the information that will be	
	contained on the detailed claims	
	transaction file provided to the S.C.	
Q-93	Public Employee Benefit Authority. Describe the typical turnaround time for	
2,3	custom report requests.	
Q-94	Describe typically requested ad hoc	
1	reports, including turnaround time and	
	additional fees, if any.	
Q-95	a.) Will you provide normative data	
	against which the S.C. Public Employee	Select one
	Benefit Authority can benchmark its	
	plan?	
	b.) What is the source of the data and	
	what specific benchmark information will you provide?	
Q-96	What is your preferred method of data	
	transfer (CD, tape, EDI, FTP)?	
Q-97	a.) Does your organization regularly omit	
	the Social Security number from	Select one
	identification cards, benefit statements	
	and benefit drafts? b.) If yes, specify which documents do	
	not include Social Security numbers.	
	c.) If not, state why not and whether you	
	have future plans to delete the Social	
	Security number.	
	ETIREE DRUG SUBSIDY (RDS)	
Q-98	Describe, in detail, your approach to	
	providing RDS services to S.C. Public	
Q-99	Employee Benefit Authority. Describe your background and	
Q-99	experience in providing RDS services.	
IX EL	VANCIAL	
Q-100	Describe, in detail, your process of	
Q-100	releasing pharmacy payments, including	
	the timeline between requesting claims	
	reimbursement from the S.C. Public	
	Employee Benefit Authority and	
	releasing payment to pharmacies.	
v in	DIDECT ECWD - WDAD ODTIONS	
	DIRECT EGWP + WRAP OPTIONS	
	an Indirect EGWP + Wrap for Medicare	quires the Contractor to provide and maintain a CMS approved prescription drug plan in the form eligible participants. Please provide the information requested below and note that all pricing nation must be provided in Tab A-9: Financial Proposal.
Q-101	a.) Are you able to duplicate the current	
	pharmacy benefits for Medicare primary	
	participants covered by the SHP?	Select one
•		

	Question	Response
	b.) If you are not able to duplicate the current pharmacy benefits, please describe the differences between the current pharmacy benefits for Medicare primary participants covered by the SHP and the plan you are able to provide.	
Q-102	Please describe the participant out-of- pocket expense under an Indirect EGWP + Wrap plan for 90-day prescriptions filled at a retail pharmacy that is willing to accept mail order pricing.	
Q-103	Please provide a copy of your proposed MAC list for the Indirect EGWP in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as "Tab A-2: MAC List - Indirect EGWP".
Q-104	Please provide a copy of your proposed Specialty drug list for the Indirect EGWP in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as "Tab A-2: Specialty Drug List - Indirect EGWP".
Q-105	Will you provide all CMS required filings related to formulary, medication therapy management and other clinical programs on a timely basis?	Select one
Q-106	Please describe your medication therapy management program, including the process for enrollment, targeting, intervention and outcomes reporting.	
Q-107	Will you provide all CMS required filings related to certification of compliance to waste, fraud and abuse requirements?	Select one
Q-108	a.) Does your member appeals process meet all CMS Medicare Part D requirements? b.) Describe your member appeals	Select one
Q-109	a.) What is the location (city/state) of the customer service call center the Offeror will be utilizing for the Indirect EGWP? (Please note that this location cannot be offshore.) b.) Is this the same facility that will be	Select one
Q-110	used for non-Medicare participants? Please provide a sample member communications package for the Indirect EGWP + Wrap.	Please label as "Tab A-2: Indirect EGWP Sample Communications".
Q-111	Describe the transition process you will use for members who are currently using non-formulary prescription drugs, drugs requiring pre-authorization, step therapy and quantity level limits.	
Q-112	Describe the enrollment process, including when changes will be effective.	
Q-113	Describe the disenrollment process, including when changes will be effective.	
Q-114	What are your standards regarding turnaround time for issuing identification cards and accuracy?	

	Question	Response
Q-115	Confirm that you will provide separate	
	reporting and billing for the Indirect	Select one
0.116	EGWP + Wrap enrollees.	
Q-116	a.) Please describe your preferred accounting methodology for tracking	
	direct subsidy monies received as result	
	of the S.C. Public Employee Benefit	
	Authority utilization to assure 100% pass	
	through of costs and revenue.	
	b.) Please describe your preferred	
	accounting methodology for tracking	
	catastrophic reinsurance received as a	
	result of the S.C. Public Employee	
	Benefit Authority utilization to assure	
	100% pass through of costs and revenue.	
	c.) Please describe your preferred	
	accounting methodology for tracking	
	discounts received from pharmaceutical	
	manufacturers for brand drugs in the	
	Standard Part D benefit donut hole to assure 100% pass through of costs and	
	revenue.	
Q-117	Confirm that you will mirror the current	
	clinical rules as closely as possible	Select one
	consistent with CMS regulations.	
Q-118	Confirm that you process low-income	
	premium subsidy refunds to members and the S.C. Public Employee Benefit	Select one
	Authority and low-income cost sharing	Select one
	refund requests to members.	
Q-119	Please provide a distribution of employer	
	clients by number of members in the	
	following categories for who you provide EGWP + Wrap administration services.	
	(Clients do not need to be identified.)	
	(
	Less than 1,000 members 1,000 - 4,999 members	
	5.000 - 9.999 members	
	10,000 - 49,999 members	
	50,000 - 99,999 members	
	100,000 - 499,999 members	
VI ELL	500,000 or more members GIBILITY OF PARTICIPANTS AND	COMPUTED SUPPORT
Q-120	Please describe your eligibility system	COMPORED TO RE
	that will be used to keep track of the S.C.	
	Public Employee Benefit Authority's	
	eligibility files, including:	
	System "trade name" System organization	
	System organization Date eligibility system was put in	
	place	
	Number of system upgrades since	
Q-121	inception a.) Is eligibility processing real-time with	
Q-121	the claim system?	Select one
	b.) If no, what is the delay time?	Select one
Q-122	The S.C. Public Employee Benefit	
	Authority would like direct access to the	
	Offeror's eligibility systems for review	
	and input purposes. Please describe your ability to provide The S.C. Public	
	Employee Benefit Authority with direct	
	access to the eligibility system only.	

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	Question	Response
Q-123	Offerors should state that it understands and agrees that it shall provide a secure online connection for purposes of permitting selected S.C. Public Employee Benefit Authority personnel access to make online inquiries of the Offeror's database and the ability to make limited routine changes to the Offeror's records regarding covered person eligibility.	
Q-124	a.) Offerors should state that it understands and agrees that it will be responsible for all costs associated with the installation, line test, and maintenance of the data line equipment. b.) Offerors should provide the name,	
	background and qualifications of the individual who will be the contact for S.C. Public Employee Benefit Authority's use in resolving any computer related problems.	
Q-125	Describe, in detail, all the information you will provide in your online inquiry and entry program.	
Q-126	Describe, in detail, the training you will provide to the S.C. Public Employee Benefit Authority staff on all of your customer service systems at the S.C. Public Employee Benefit Authority 's office in Columbia, South Carolina.	
Q-127	Describe, in detail, how you will maintain database backups in a manner that will eliminate disruption of service or loss of data due to system or program failures.	
Q-128	a.) Describe your disaster preparedness and recovery plans.b.) Offerors should state the maximum period of interruption in the case of an emergency.	
Q-129	Offerors shall fully describe the methods and means to be deployed in order to satisfy the requirement described in Part III, Section I, #11 of the RFP.	Please label as "Tab A-2: Data Security".
Q-130	Offerors shall fully complete the Service Provider Security Assessment Questionnaire included in Attachment Three (3) of Section IX of the RFP.	Please label as "Tab A-2: Service Provider Security Questionnaire".
Q-131	Are you able to receive eligibility data via the Internet?	Select one
Q-132	Please state if you provide a test environment (file).	
Q-133	Briefly describe how your organization will process the HIPAA 834 file layout internally (convert to proprietary file specification, dump to paper, etc.)	
Q-134	Briefly describe your process for correcting data in the event of a data tape which contains "bad data".	

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	Question	Response
Q-135	What practices and policies have you	
	implemented to ensure the confidentiality	
	of all confidential information, including	
	protected health information as defined	
	by the HIPAA privacy rule,	
	retiree/participant information, or other	
	sensitive information of S.C. Public	
	Employee Benefit Authority and its	
	retirees and/or participants?	
XII. IMI	PLEMENTATION PROGRAM (Not a	n evaluated item)
Q-136	Please discuss your procedures and	
	processes for handling the following	
	during the transition period:	
	• Transition of care	
	Employee communications regarding	
	change in administrators	
Q-137	Implementation Plan	
	• Name of the person with overall	
	responsibility for planning, supervising	
	and implementing the program for the	
	S.C. Public Employee Benefit Authority.	
	◆ Title	
	• What other duties, if any, will this person have during implementation?	
	Please include the number and size of	
	other accounts for which this person will	
	be responsible during the same time period.	
	• What percentage of this person's time	
	will be devoted to the S.C. Public	
	Employee Benefit Authority during the	
	implementation process?	
	Please provide an organizational chart	
	identifying the names, area of expertise,	
	functions, and reporting relationships of	
	key people directly responsible for	
	implementing the S.C. Public Employee	Please label as "Tab A-2: Implementation Team Organizational Chart".
	Benefit Authority's account. In	
	addition, resumes of these individuals	
	should be included.	
	Provide a detailed implementation	
	plan that clearly demonstrates the	
	Offeror's ability to meet the S.C. Public	
	Employee Benefit Authority's	
	requirements to have a fully functioning	
	program in place and operable on	
	January 1, 2016. This implementation	
	plan should include a list of specific	
	implementation tasks/transition	
	protocols and a time-table for initiation	
	and completion of such tasks, beginning	
	with the contract award and continuing	
	through the effective date of operation	
	(January 1, 2016). The implementation	Please label as "Tab A-2: Implementation Plan".
	plan should be specific about	
	requirements for information transfer as	
	well as any services or assistance	
	required from the State during	
	implementation. The implementation	
	plan should also include a	
	communications plan, which describes	
	the timeline and process for launching	
	new program materials including	
	greeting letter, ID cards, new programs,	
	etc.	
	L	

	Question	Response
Q-138	Describe the process you propose to provide a January 1, 2016 transition that is as seamless as possible for all participants.	
XIII. A	CCOUNT MANAGEMENT AND PER	RSONNEL
Q-139	Describe the organization and structure of the account service team that will support the S.C. Public Employee Benefit Authority. Include the rationale for this structure and the ways in which it is particularly responsive to the S.C. Public Employee Benefit Authority's needs and goals.	
Q-140	Name of the person with overall responsibility for planning, supervising and performing account services for the S.C. Public Employee Benefit Authority.	
	Title Where will the account manger be located?	
	What other duties, if any, does this person have? Please include the number and size of other accounts for which this person is responsible.	
	What percentage of this person's time will be devoted to the S.C. Public Employee Benefit Authority?	
	Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the S.C. Public Employee Benefit Authority. It should also document how many account executives and group services representatives will work full-time on the S.C. Public Employee Benefit Authority's account and how many will work part-time on the S.C. Public Employee Benefit Authority's account.	Please label as "Tab A-2: Account Management Team Organizational Chart".
	Describe account management support, including the mechanisms and processes in place to allow the S.C. Public Employee Benefit Authority personnel to communicate with account service representatives, hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The S.C. Public Employee Benefit Authority requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems.	Please label as "Tab A-2: Account Management Support".
Q-141	Please provide a bio of each team member, including length of time with your organization and job held while with your organization.	Please label as "Tab A-2: Account Team Biographies".
Q-142	Will this team be responsible for implementing the S.C. Public Employee Benefit Authority account?	

Tab A-2b: Additional Answers to Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Use this space to continue responses for "Tab A-2a: Service Description Questionnaire" when answers exceed 1,024 characters in length. Responses must be numbered to correspond to the question number and section number (Tab A-2a) to which it pertains.

Section #	Question #	Additional Response
5001011 !!	Question	
[

Section #	Question #	Additional Response

Tab A-3: Subcontractor Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one section of "Tab A-3: Subcontractor Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is certified by the State of South Carolina's Office of Small and Minority Business Assistance (OSMBA).

	Question	Response
Subc	ontractor 1	
SQ-1	Provide the following subcontractor information:	
	name of the subcontractor.	
	a.) Business Name	
	b.) Address	
	c.) Phone Number	
	d.) Taxpayer Identification Number	
SQ-2	e.) Point of Contact Is the subcontractor a South Carolina Certified Minority	
3Q-2	Business? If so, please submit a completed the Minority	
	Participation questionnaire located in the RFP with	
	your proposal.	
SQ-3	Provide a brief summary of the history of the	
	subcontractor's company and information about the	
	growth of the organization on a national level and within	
	the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the	
00.5	performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and	Select one
SQ-6	is ready for execution upon award. a.) Explain the process for monitoring the performance	
30-0	of the subcontractor and measuring the quality of their	
	results.	
	b.) List any services for which the subcontractor will be	
	solely responsible and describe how the subcontractor	
	will be monitored and managed.	
SQ-7	Describe any significant government action or litigation	
	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the	
	most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership	
SQ-0	structure, listing all separate legal entities in chart	
	format. Describe all major shareholders/owners (10%	
	or greater ownership) and list their percent of total	
	ownership.	
SQ-9	Does the subcontractor have contractual relationships	
	with third party administrators/organizations in which	
	the subcontractor pays service fees or other fees that	
	you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive	
	these service fees and explain the nature of the	
	relationship.	
SQ-10	What fidelity and surety insurance, general liability and	
	errors and omissions or bond coverage does the	
	subcontractor carry to protect its clients? Describe the	
	type and amount of each coverage that would protect	
	this plan. Please furnish a copy of all such policies for	
C- 1	review.	
	ontractor 2 Provide the following subcontractor information:	
SQ-1	name of the subcontractor.	
	a.) Business Name	
	b.) Address	
	c.) Phone Number	
	d.) Taxpayer Identification Number	
	e.) Point of Contact	
SQ-2	Is the subcontractor a South Carolina Certified Minority	
	Business? If so, please submit a completed the Minority	
	Participation questionnaire located in the RFP with	
	your proposal.	

	Question	Response
SQ-3	Provide a brief summary of the history of the	
	subcontractor's company and information about the	
	growth of the organization on a national level and within	
	the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the	
SQ-5	performance of the Contract? Please confirm that the Contract has been resolved and	
SQ-5	is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance	
	of the subcontractor and measuring the quality of their	
	results.	
	b.) List any services for which the subcontractor will be	
	solely responsible and describe how the subcontractor	
SQ-7	will be monitored and managed. Describe any significant government action or litigation	
J V /	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the	
	most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart	
	format. Describe all major shareholders/owners (10%	
	or greater ownership) and list their percent of total	
	ownership.	
SQ-9	Does the subcontractor have contractual relationships	
	with third party administrators/organizations in which	
	the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for?	
	If so, identify the outside organizations that receive	
	these service fees and explain the nature of the	
	relationship.	
00.10	X7 . C. 1	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the	
	subcontractor carry to protect its clients? Describe the	
	type and amount of each coverage that would protect	
	this plan. Please furnish a copy of all such policies for	
	review.	
	ontractor 3	
SQ-1	Provide the <u>following subcontractor information:</u> name of the subcontractor.	
	a.) Business Name	
	b.) Address	
	c.) Phone Number	
	d.) Taxpayer Identification Number	
SQ-2	e.) Point of Contact Is the subcontractor a South Carolina Certified Minority	
-~ -	Business? If so, please submit a completed the Minority	
	Participation questionnaire located in the RFP with	
	your proposal.	
SQ-3	Provide a brief summary of the history of the	
	subcontractor's company and information about the growth of the organization on a national level and within	
	the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the	
	performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and	Select one
SQ-6	is ready for execution upon award. a.) Explain the process for monitoring the performance	
52-0	of the subcontractor and measuring the quality of their	
	results.	
	b.) List any services for which the subcontractor will be	
	solely responsible and describe how the subcontractor	
SQ-7	will be monitored and managed. Describe any significant government action or litigation	
SQ-/	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the	
	most recent five (5) years.	
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SQ-8	Explain the subcontractor's organization's ownership	
	structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10%	
	or greater ownership) and list their percent of total	
1	ownership.	

	Question	Response
SQ-9	Does the subcontractor have contractual relationships	
ر کر ک	with third party administrators/organizations in which	
	the subcontractor pays service fees or other fees that	
	you (the Offeror) are directly or indirectly charged for?	
	If so, identify the outside organizations that receive	
	these service fees and explain the nature of the	
	relationship.	
SQ-10	What fidelity and surety insurance, general liability and	
	errors and omissions or bond coverage does the	
	subcontractor carry to protect its clients? Describe the	
	type and amount of each coverage that would protect	
	this plan. Please furnish a copy of all such policies for	
G 1	review.	
	ontractor 4	
SQ-1	Provide the following subcontractor information:	
	name of the subcontractor. a.) Business Name	
	b.) Address	
	c.) Phone Number	
	d.) Taxpayer Identification Number	
1	e.) Point of Contact	
SQ-2	Is the subcontractor a South Carolina Certified Minority	
	Business? If so, please submit a completed the Minority	
	Participation questionnaire located in the RFP with	
	your proposal.	
SQ-3	Provide a brief summary of the history of the	
	subcontractor's company and information about the	
	growth of the organization on a national level and within	
50.4	the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and	
SQ-3	is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance	
	of the subcontractor and measuring the quality of their	
	results.	
	b.) List any services for which the subcontractor will be	
	solely responsible and describe how the subcontractor	
	will be monitored and managed.	
SQ-7	Describe any significant government action or litigation	
	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the most recent five (5) years.	
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	errors and omissions or bond coverage does the	
	subcontractor carry to protect its clients? Describe the	
	type and amount of each coverage that would protect	
	this plan. Please furnish a copy of all such policies for	
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	ontractor 5	
SQ-1	Provide the following subcontractor information:	
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	b.) Address	
	c.) Phone Number	
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	e.) Point of Contact	

	Question	Response
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	your proposal.	
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	subcontractor's company and information about the	
	growth of the organization on a national level and within the State of South Carolina.	
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SQ-5	Please confirm that the Contract has been resolved and	0.1.4
	is ready for execution upon award.	Select one
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	of the subcontractor and measuring the quality of their	
	results.	
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	will be monitored and managed.	
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	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the	
	most recent five (5) years.	
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SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart	
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	or greater ownership) and list their percent of total	
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	errors and omissions or bond coverage does the	
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	type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for	
	review.	
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SQ-1	Provide the following subcontractor information:	
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	b.) Address c.) Phone Number	
	d.) Taxpayer Identification Number	
	e.) Point of Contact	
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b.) Address		a.) Business Name	
		b.) Address	

	Question	Response
	c.) Phone Number	
	d.) Taxpayer Identification Number	
	e.) Point of Contact	
SQ-2	Is the subcontractor a South Carolina Certified Minority	
	Business? If so, please submit a completed the Minority	
	Participation questionnaire located in the RFP with	
	your proposal.	
SQ-3	Provide a brief summary of the history of the	
	subcontractor's company and information about the	
	growth of the organization on a national level and within	
	the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the	
	performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and	Select one
	is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance	
	of the subcontractor and measuring the quality of their	
	results.	
	b.) List any services for which the subcontractor will be	
	solely responsible and describe how the subcontractor	
	will be monitored and managed.	
SQ-7	Describe any significant government action or litigation	
	taken or pending against the subcontractor's company or	
	any entities of the subcontractor's company during the	
	most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership	
	structure, listing all separate legal entities in chart	
	format. Describe all major shareholders/owners (10%	
	or greater ownership) and list their percent of total	
	ownership.	
SQ-9	Does the subcontractor have contractual relationships	
	with third party administrators/organizations in which	
	the subcontractor pays service fees or other fees that	
	you (the Offeror) are directly or indirectly charged for?	
	If so, identify the outside organizations that receive	
	these service fees and explain the nature of the	
	relationship.	
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SQ-10	What fidelity and surety insurance, general liability and	
	errors and omissions or bond coverage does the	
	subcontractor carry to protect its clients? Describe the	
	type and amount of each coverage that would protect	
	this plan. Please furnish a copy of all such policies for	
	review.	

Request for Proposal for Pharmacy Benefit Management Services Tab A-4: Access to Network Pharmacies - Chain Pharmacies

Instructions: The S.C. Public Employee Benefit Authority is interested in the availability of key chain pharmacies to its participant population using a broad, national network. Using the table below, provide the the requested data for each chain pharmacy included in Your proposed network of pharmacies for the commercial and/or the Medicare Part D plan.

Pharmacy Name	Chain Identification	Address Line 1 of Corporate Headquarters	Address Line 2 of Corporate Headquarters	City of Corporate Headquarters	State of Corporate Headquarters	ZIP Code of Corporate Headquarters	Number of Pharmacy Locations in SC	Number of Pharmacy Locations Nationwide	Commercial Retail Network Effective Date	Commercial Retail Network Ending Date	Commercial Retail 90 Network Effective Date	Commercial Retail 90 Network Ending Date	EGWP Retail Network Effective Date	EGWP Retail Network Ending Date	EGWP Retail 90 Network Effective Date	EGWP Retail 90 Network Ending Date
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Page 32 A-4 Access to Chain Pharmacies

Request for Proposal for Pharmacy Benefit Management Services Tab A-5: Access to Network Pharmacies - Independent Pharmacies

Instructions: The S.C. Public Employee Benefit Authority is interested in the availability of key pharmacies to its participant population using a broad, national network. Using the table below, provide the the requested data for each independent pharmacy included in Your proposed network of pharmacies for the commercial and/or the Medicare Part D plan.

Pharmacy NPI Address Line 1

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Page 33 A-5 Access to Indep Pharmacies

Tab A-6: Pharmacy Disruption based on Volume

Instructions: From Confidential Data Exhibit 1, copy and paste the Pharmacy NABP Number, Pharmacy Name, Total Number of Prescriptions, Total Number of Distinct Utilizers, Average Days Supply per Script, Total Quantity, Total Amount Paid and Average Amount Paid per Script into the table below. Then, complete each row by selecting either a "Yes" or "No" from the drop down list in column I and column J to indicate whether or not the named provider is an in-network provider. All other responses will be treated as a "No" response.

Pharmacy NABP numbers are confidential information and should be treated accordingly. Please destroy all TIN numbers within 5 business days of award of contract as described in Attachment 1: Non-Disclosure Agreement.

									of Network or No)
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
								Select one	Select one
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Page 34 A-6 Pharm Disruption_Vol

							Member of Network (Yes or No)			
Pharmacy ID	Pharmacy Name	 Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan		
							Select one	Select one		
							Select one	Select one		
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Page 35 A-6 Pharm Disruption_Vol

Tab A-7: Pharmacy Disruption based on Total Amount Paid

Instructions: From Confidential Data Exhibit 2, copy and paste the Pharmacy NABP Number, Pharmacy Name, Total Number of Prescriptions, Total Number of Distinct Utilizers, Average Days Supply per Script, Total Quantity, Total Amount Paid and Average Amount Paid per Script into the table below. Then, complete each row by selecting either a "Yes" or "No" from the drop down list in column I and column J to indicate whether or not the named provider is an in-network provider. All other responses will be treated as a "No" response.

Pharmacy NABP numbers are confidential information and should be treated accordingly. Please destroy all TIN numbers within 5 business days of award of contract as described in Attachment 1: Non-Disclosure Agreement.

								Member of Network	
								(Yes	or No)
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
								Select one	Select one
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Page 36

Manual Control

							Member of Network (Yes or No)			
Pharmacy ID	Pharmacy Name	 Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		
							Select one	Select one		

Page 37 A-7 Pharm Disruption_Paid

Tab A-8: Formulary Analysis

I. Preferred Drug List

Please provide your Preferred Drug List (PDL), including NDC-11 Code, drug name and price per metric quantity, in electronic format using <u>MS Excel with read/write capabilities</u>. Submit the MS Excel file labeled as "Tab A-8: Preferred Drug List".

II. Preferred Drug List - Indirect EGWP

Please provide your Preferred Drug List (PDL) that will be used in conjunction with the Indirect EGWP plan. The PDL should include NDC-11 Code, drug name and price per metric quantity, in electronic format using <u>MS Excel with read/write capabilities</u>. Submit the MS Excel file labeled as "Tab A-8: Preferred Drug List - Indirect EGWP".

III. Formulary Analysis

From Confidential Data Exhibit 3, copy and paste the NDC11 Code, Drug Name, Total Days of Therapy and Rx Count into the table below. The data contains a list of the top 250 drugs utilized by Plan participants during calendar year 2014. In column F, select the formulary tier applicable for each drug assuming the standard plan, or current program. In column G, select the formulary tier applicable for each drug under the Indirect EGWP with Wrap plan.

			Formulary Tier			
NDC-11	Drug Name	Total Days of Therapy	Rx Count	Standard Plan	Indirect EGWP + Wrap Plan	
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				Formulary Tier		
NDC-11	Drug Name	Total Days of Therapy	Rx Count	Standard Plan	Indirect EGWP + Wrap Plan	
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Tab A-9: Performance Guarantees

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: As part of the effort toward continuous improvement in the services provided to participants, the S.C. Public Employee Benefit Authority would like to implement performance standards with contractors. These standards and accompanying guarantees may be negotiated. Offeror's shall propose guarantees using the following S.C. Public Employee Benefit Authority specific definitions and measurements outline. The Offeror shall provide their organization's Proposed Amount at Risk for PG-2 through PG-17.

Offerors will report results on all performance measurements quarterly per the requirements set forth below. Performance results will also be audited annually by the S.C. Public Employee Benefit Authority's contract auditor.

	Performance Indicator	Reporting Measurement (subject to audit by the S.C. Public Employee Benefit Authority and/or contract auditors)	Standard/Goal	Proposed Amount at Risk
PG-1	Final Implementation Plan	The Final Implementation Plan, as described in Q-137 of Tab-A-2 Questionnaire will be submitted to the S.C. Public Employee Benefit Authority.	On or before May 15, 2015.	\$5,000 per day for each day or partial day during which the Contractor is not in compliance with the FIP.
PG-2	Average Speed to Answer	a.) The dedicated toll-fee customer service phone line will answer calls within the time specified. Measurement will be from the initial ring.	Within an average of 30 seconds or less	
		b.) The dedicated toll-free customer service phone line shall provide an opt out option to speak with a live customer service representative at any time during the call. For those Participants who require assistance, a live customer service representative will answer calls within the time specified. Measurement shall be from the point at which the caller requests live assistance via the IVR.	Within an average of 30 seconds or less	
PG-3	Call Abandonment Rate	The call abandonment rate of the dedicated toll- fee customer service phone line will not exceed the specified rate.	3% or less	
PG-4	Paper Claims	a.) For the commercial pharmacy plan, the Contractor will respond (mail a check or reject notice) to reimbursement paper claims within the guidelines specified.	97% or greater within 5 business days 100% within 14 business days	
		b.) For the EGWP with Wrap plan, the Contractor will respond (mail a check or reject notice) to reimbursement paper claims within the guidelines specified.	100% within 15 business days	
PG-5	Participant Overall Satisfaction Rate	a) The Contractor will conduct telephonic surveys to gauge participant satisfaction on a monthly basis. (See Part III, Section C, #15 of the RFP). The overall satisfaction rate will meet or exceed the specified goal.	95% or greater	\$5,000 per month for each month that the Contractor fails to meet a 95% overall satisfaction rates.
		b) The Contractor will mail participant satisfaction surveys on a annual basis. (See Part III, Section C, #16 of the RFP). The overall satisfaction rate will meet or exceed the specified goal.	95% or greater	
PG-6	Automated Claim System Availability Rate	The automated claims system will be available 24 hours a day, 7 days per week.	99.5% or greater	
PG-7	Dispensing Accuracy Rate	Mail Order prescriptions will be dispensed accurately at the specified rate.	99.9% or greater	
PG-8	Financial Accuracy Rate	The financial accuracy rate for all prescriptions dispensed at both retail and mail order pharmacies will be greater than or equal to the specified rate.	99.9% or greater	
PG-9	Mail Order Dispensing Turnaround Time	a.) The Contractor shall dispense all non- protocol prescriptions under the mail service program within the time specified.	average of 2 business days following receipt	
		b.) The Contractor shall dispense all protocol within the time specified.	average of 4 business days following receipt	

		Reporting Measurement		
	Performance Indicator	(subject to audit by the S.C. Public Employee	Standard/Goal	Proposed Amount at Risk
		Benefit Authority and/or contract auditors)		
PG-10	Eligibility Transactions	a.) Processable maintenance eligibility		
		transactions will be processed within the time specified.	within 2 business days	
		b.) For emergencies (retiree is at the retail		
		pharmacy and system shows they are not	same business day if requested during	
		eligible), eligibility transactions will be	normal business hours; otherwise,	
		processed within the time specified.	within 24 hours	
PG-11	ID Card for the Indirect	All maintenance ID cards will be mailed within		
	EGWP + Wrap	the time specified following receipt of a	99.0% within 4 business days	
PG-12	participants Standard Reporting	processable eligibility tape.		
PG-12	Package	a.) Standard monthly management/utilization reports will be delivered to the S.C. Public	within 30 business days following the	
	1 dekage	Employee Benefit Authority by close of	month's end	
		business within the time specified.		
		b.) Standard quarterly management/utilization		
		reports will be delivered to the S.C. Public	within 45 business days following the	
		Employee Benefit Authority by close of	quarter's end	
		business within the time specified.		
		c.) Standard semi-annual management/utilization reports will be delivered	within 45 business days following the	
		to the S.C. Public Employee Benefit Authority	second quarter's end	
		by close of business within the time specified.	second quarter s cha	
		d.) Standard annual management/utilization		
		reports will be delivered to the S.C. Public	within 45 business days following the	
		Employee Benefit Authority by close of	Plan Year's end	
DC 12	A . D .	business within the time specified.	000 6 1 11 11 11 11	
PG-13	Access Rate	The Contractor shall establish and maintain a network of participating pharmacies to provide	98% of primary eligible participants will have at least one participating pharmacy	
		service under the retail pharmacy plan.	within 5 miles of their home ZIP code	
		r	where any retail pharmacy exists within	
			5 miles of their home ZIP Code.	
PG-14	Decline in Participating	<u>Unless Contractor and S.C. Public Employee</u>		
	Pharmacies	Benefit Authority mutually agree to limit the		
		retail network in order to meet cost or quality objectives during the contract period,		
		the network of participating pharmacies should	5.0% or less	
		not decrease in size by more than the specified		
		percentage on an annual basis.		
PG-15	Final Reconciliation	The Contractor will calculate and submit final	On or before the tenth workday	
		cost reports to client for client's review under	following the date client completes Step	
		Step 6 of Final Reconciliation of the current Retiree Drug Subsidy claim.	5 of Final Reconciliation	
PG-16	Notices of Creditable	Annually, the Contractor will use eligibility files		
	and Non-Creditable	furnished by client to mail personal notices to	100% of mailings: 11 b 1	
	Coverage	Medicare Plan participants notifying them of	100% of mailings will be made on or	
		creditable or non-creditable prescription drug	before October 31st of each year.	
ng :-		coverage.		
PG-17	Monthly Cost Reports	The Contractor will submit monthly cost reports	On or before the fifth workday following	
		for client's review and submission of RDS payment request.	the date of client's request for the cost	
		F7	report. On or before the 21st calendar day of the month following the	
			reporting month.	
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