**ES or Client logo**

**ES Logo if branded**

Standard Incentive Retail HD

<FirstName> <LastName>
<Address 1>
<Address 2>
<City>, <ST> <Zipcode>

# Important changes to your medication are coming <date>. We can help.

Dear <FirstName>,

Our team of pharmacists at Express Scripts wants you to know about an **important change to one or more of your medications – and how we can help.**

Throughout the year, we ask an independent panel of doctors and pharmacists to review and compare all of the medications available. When the panel finds multiple medications for the same condition that are equally safe and clinically effective, it may cause some medications to become "preferred," while others may become "nonpreferred." This helps to keep your overall benefit more affordable.

**As a result of this year's review, your medication(s) listed below will no longer be preferred, starting <date>.**

**<H1.L_MDrug_2Col_EvenDistribute>**

To make sure you continue to have access to safe, clinically effective and affordable medication, we've identified preferred alternatives that can be used in place of your current medication. While you may continue using your current medication, keep in mind, **you may pay more.** You'll pay less by switching to one of the preferred alternatives listed on the back of this letter before your current medication runs out.

**Switching to a preferred alternative is easy.** See the box on the right for how to make the switch. And on **<date>,** you can go to **express-scripts.com** to get prices for the alternatives and see if you're eligible for a 3-month supply delivered right to you.

If you have any additional questions, just call the number on your member ID card. **We're glad to help.**

Thank you.

Sincerely,

Andrew R. Behm

Andrew R. Behm, Doctor of Pharmacy
Vice President of Pharmacy Services
Express Scripts

## What do I need to do?

1. Talk with your doctor about which preferred alternative medication on the back of this letter is right for you and get a new prescription.
2. Ask your doctor to send the new prescription to Express Scripts® Pharmacy for home delivery.

   **OR**

   Fill at your local pharmacy.

# Your doctor can provide you a new prescription for one of your preferred alternative medications.

| Your current medication | Preferred alternatives |
| --- | --- |
| <<H1.L_MDrugName_1st>> | <<H1.L_MPrefDrugs_1st_VertDisp>><br><<H1.L_MPrefDrugs_1st_VertDisp>><br><<H1.L_MPrefDrugs_1st_VertDisp>><br><<H1.L_MPrefDrugs_1st_VertDisp>><br><<H1.L_MPrefDrugs_1st_VertDisp>> |

Additional preferred alternatives may be available. Other prescription plan considerations may apply. Costs for preferred alternatives may vary. If there is a clinical reason, identified by your doctor, that requires you to continue taking your current medication, your doctor can request a coverage review by visiting the Express Scripts online portal at esrx.com/PA.

*When applicable to some plans, the cost of the current medication may not be applied to your deductible or out-of-pocket maximum*.

**Express Scripts manages your prescription plan for your employer, plan sponsor, health plan or benefit fund.**

If you prefer to receive future communications by email, log in or register at **express-scripts.com** and update your account preferences.

**Note:** Controlled substances (such as pain medication) and some specialty medications may only be available in supplies of up to 30 days. Certain controlled substance prescriptions may not be faxed. For faster service, your prescriber can send a new prescription electronically or write a hard copy prescription. Please call the number on your member ID card to obtain the address for mailing controlled substance prescriptions.

EXPRESS SCRIPTS®

# Coverage for your medication is about to change.

## This is a reminder that on (Effective date) your plan will no longer cover one or more of your medications. Don't wait to make a change.

Hello X,

Our doctors and pharmacists regularly check the list of medications covered by your plan to make sure they are safe, effective, and affordable.

After (effective date) one or more of your medications will no longer be covered by your plan. This means you will pay full price for your medication if you don't move to a covered alternative.

**Your Current Medication(s)***

## ORACEA

**Rx #:** XXXXXXXXXXX

**Covered Alternatives**:**

- doxycycline hyclate
- doxycycline monohydrate
- azelaic acid
- ivermectin cream
- metronidazole topical

**Here's what you can do:**

Ask your doctor about prescribing a covered alternative.

After (effective date) you'll be able to compare medication prices with your changing coverage.

*If your doctor provided a prior approval for your medication, it may expire. You may need to talk to your doctor about getting a covered alternative approved. If there is a clinical reason identified by your doctor that requires you to continue taking your current medication, please ask your doctor to contact Express Scripts.

**Additional covered alternatives may be available. Other prescription plan considerations may apply. Costs for covered alternatives may vary. When applicable to some plans, the cost of the current medication may not be applied to your deductible or out-of-pocket maximum.

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

IS THERE A GENERIC FOR THAT?

# Six simple, money-saving words

When it comes to shopping, most consumers want to know the price of a product and will often look for the best deal before making a purchase. That's not always the case when buying prescription drugs, which means many people are paying more than they should for their medications.

One way to save money on prescriptions is to ask for a generic, which typically costs less because the manufacturer didn't have to conduct the initial research or repeat the studies that the first-to-market branded drug did. In fact, FDA-approved generics can cost up to 85% less.[1] Today, 9 in 10 prescriptions filled in the U.S. are for generic drugs.[2]

Generics fall into two categories:

- Direct chemical equivalent: a drug that has the same active ingredient as its brand-name counterpart
- Therapeutic alternative: a drug that may not be chemically equivalent to the brand, but has the same therapeutic or treatment effect

Think of it this way: direct chemical equivalents are practically identical to the branded product, while therapeutic alternatives are part of the same family.

## SAFETY FIRST

The Food & Drug Administration (FDA) requires generic drug manufacturers to adhere to strict guidelines, ensuring the safety and effectiveness of all approved generics. In 2020, the FDA approved over 750 generic drugs, including the first generic versions of commonly used brands like Daraprim®, Pradaxa®, Proventil® HFA, and Tecfidera®.[3]

Furthermore, our pharmacy benefit manager, Express Scripts, protects their supply of drugs from substandard manufacturing practices and counterfeit products. Their pharmacies only dispense medications that are manufactured according to the FDA's strict standards, which provide guidance for manufacturing, testing and quality assurance to ensure product safety.

> **"A generic medicine works in the same way and provides the same clinical benefit as its brand-name version. This standard applies to all FDA-approved generic medicines. A generic medicine is the same as a brand-name medicine in dosage, safety, effectiveness, strength, stability, and quality, as well as in the way it is taken and should be used." [4]**
> **— U.S. Food & Drug Administration**

**Here are some other six-word phrases to help keep money-saving generics top-of-mind:**

**Check it out during your checkup:** Before leaving a doctor's office with prescription in hand, be sure to ask the doctor or nurse, "Is there a generic for that?"

**Give your prescriptions a quick checkup:** Review all of your medications regularly with a doctor or pharmacist, because there may be new, lower-cost treatments available.

**Ask about generics before you fill:** When you hand over a new prescription to your pharmacist, or during refill or renewal time, ask, "Is there a generic for that?" The pharmacist can tell you and then call your doctor to discuss changing the prescription accordingly.

**Get the most from your dollars:** You can learn more about your specific generics savings opportunities by logging in at **express-scripts.com** and reviewing your prescriptions. Select **Price a Medication** from the menu under **Prescriptions**, enter your drug name and view cost and coverage information on the results page.

**Get the facts from the FDA:** Learn more about the benefits of generic drugs and the policies guiding their development from fda.gov.

[1] Source: fda.gov/drugs/generic-drugs/generic-drug-facts. Accessed July 12, 2021.
[2] Source: fda.gov/drugs/buying-using-medicine-safely/generic-drugs. Accessed July 12, 2021.
[3] 2020 Office of Generic Drugs (OGD) Annual Report. fda.gov/drugs/generic-drugs/office-generic-drugs-2020-annual-report. Accessed July 12, 2021.
[4] Generic Drug Facts. fda.gov/drugs/generic-drugs/generic-drug-facts. Accessed July 12, 2021.

EXPRESS SCRIPTS®

P.O. BOX 66773
ST. LOUIS, MO 63166-6773

<<Month DD, YYYY>>

<First Name> <Last Name>
<Address line 1>
<Address line 2>
<City>, <State> <Zip>

## A benefit coverage update: Please talk with your doctor about your prescription.

Dear <First Name>,

Express Scripts, the company managing your prescription plan, wants to let you know about an important update to your coverage. **Beginning <<Effective Date>>, the medication that you're currently taking will cost you more will no longer be covered without a trial of a preferred alternative.** A list of preferred alternatives that are covered is located on the right. The alternatives are similar, FDA-approved medications that are proven effective, preferred by your plan and covered at a lower copayment.

Preferred generics or lower-cost brand medications work just as well for most people, and they typically cost a lot less than the medication you're currently taking.

**Here are the three easy steps you should follow:**

1. **Share this letter with your doctor** and ask if one of the preferred alternatives could work for you.
2. **If a preferred alternative can work for you,** your doctor can write a new prescription to replace your current prescription for <DRUG NAME>.
3. **Fill your new prescription** so you'll have a safe, effective preferred drug and avoid paying the full cost.

If you have questions, we'd be glad to help. Please visit express-scripts.com or call Express Scripts at the number on your member ID card. And your doctor can visit the Express Scripts online portal at esrx.com/PA or call 800.417.1764 with any questions. We look forward to helping you save!

Sincerely,

Andrew R. Behm

Andrew R. Behm, Doctor of Pharmacy
Vice President of Pharmacy Services
Express Scripts

**As of <<Effective Date>>, your current medication will no longer be covered and will cost you more. Please talk with your doctor about being prescribed a preferred alternative.**

**Nonpreferred drug you currently take:** <DRUG NAME>

**Preferred alternatives**

<PREFERRED ALTERNATIVE #1>

<PREFERRED ALTERNATIVE #2>

<PREFERRED ALTERNATIVE #3>

<PREFERRED ALTERNATIVE #4>

<PREFERRED ALTERNATIVE #5>

<PREFERRED ALTERNATIVE #6>

If your doctor and you agree that the preferred alternatives are not right for you, your doctor may request a coverage review by visiting esrx.com/PA or calling 800.417.1764 on or after <<Effective Date>>.

## Questions?

We'd be glad to help.

Call the number on your member ID card.

**Express Scripts manages your prescription plan for your employer, plan sponsor, health plan or benefit fund.**

Additional covered alternatives may be available. Other prescription plan considerations may apply. Costs for covered alternatives may vary. To compare drug prices, please log in at express-scripts.com. Select "Price a Medication" from the menu under "Prescriptions," enter your current medication name and follow the instructions. When applicable to some plans, the cost of the current medication may not be applied to your deductible or out-of-pocket maximum.

# APPENDIX M

## INFORMATION SYSTEMS REQUIREMENTS DEVIATIONS AND INTERROGATORIES

# APPENDIX M
# INFORMATION SYSTEMS REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answers **for both HealthSelect PDPs and HealthSelect Medicare Rx PDP** following each question. If the responses specific to the HealthSelect PDPs are different than those of the HealthSelect Medicare Rx PDP, Respondent shall describe those differences. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal (**Appendix Q**).

## A. Deviations - Information Systems Requirements

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Information Systems Requirements*** described in RFP Sections VI.A.1. – VI.E.4.

☐ Affirm ☒ Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of any Deviation between Respondent's response and these requirements:

Respondent's requested Deviation detail:

**A.4.a. PBM shall perform quarterly retention audits to ensure all supporting documentation has been retained. The data retained should also be tested for completeness after all system upgrades.**

Cigna performs an annual assessment of company records and documentation retention to ensure the accuracy and completeness of all necessary records.

**A.5.a. ERS' data and metadata, as created, maintained and supported by PBM shall at all times remain the property of ERS, notwithstanding the fact that such records may be stored upon or within one (1) or more computer or data retention systems owned, operated, or leased by PBM. ERS is entitled to a full data model for such data.**

Express Scripts can agree that ERS retains its ownership of ERS data but cannot agree that ERS will own all metadata or other materials created or supported by the PBM since such materials contain the proprietary information of the PBM. Information containing or derived from ERS data will remain the property of ERS. Express Scripts will provide information on ERS data and how information is maintained but cannot provide a full data model for its systems due to information security obligations.

**A.6. Testing Environments. PBM shall provide testing environments for all circumstances used prior to rolling out program changes that run the logic to achieve predicted outcomes of programming prior to pushing-out a new process or enhancement/modification of an existing program.**

Confirmed with modifications. Express Scripts Control Center will be available to onboard with full support of our technology teams at the time of implementation. Designated ERS staff may register in advance to access and test the Control Center. We can also provide ERS with a live demonstration of our wide range of member website and mobile app capabilities either in person or via web conference.

**A.7. Access to ERS Data. ERS or its representatives shall have full access to all ERS data on PBM's systems. To the extent that any such data is to be maintained upon a computer system or any other data retention system that is not owned by PBM, PBM shall provide ERS with assurances from the owner of such computer facilities, satisfactory to ERS, of continued availability and security of such records at all times. ERS must be permitted to personally inspect such facilities and systems.**

Express Scripts cannot agree to full client access to our systems due to privacy and information security obligations. There are designated access points which are available to clients to access their data. In the event of an audit, Express Scripts will work with ERS or their third-party auditor to ensure appropriate access to facilities and information. Express Scripts will agree to make available ERS data through secure means but cannot provide direct access to Express Scripts or its contractors systems which will contain the information for multiple clients.

**B.9. PBM shall provide a copy of its business policies and procedures related to the file interface business process upon request by ERS.**
Confirmed. Express Scripts' policy and procedure documents contain proprietary and confidential information; certain policies are available upon request from your account team. Express Scripts expects ERS to maintain the confidentiality and proprietary nature of these policies.
To comply with CMS requirements and to support your oversight efforts, Express Scripts maintains and makes available to ERS our Medicare Part D policies and procedures documents. As new policies are updated, revised policies will be shared monthly with ERS. Additional copies of policies are available upon request and can be provided by your account team.

**B.10. ERS provides eligibility files to PBM. Upon receipt of a claim, PBM shall confirm Participant's active coverage in the applicable Program based on the most recent ERS eligibility file data sent to PBM from ERS. In the event of questions or dispute as to whether active coverage exists, PBM will be provided access to the ERS OnLine system to verify coverage, or may contact ERS.**

Confirmed with modifications. Express Scripts verifies eligibility during claims processing based on the most recent eligibility file provided by ERS; however, we do not perform follow up functions on disputed eligibility. At the retail pharmacy, the pharmacist receives a reject code and informs the member of the reason for the reject. At Express Scripts® Pharmacy, we return the prescription to the member along with an explanation, if a resolution cannot be determined.

**D.10.a. A copy of the disaster recovery plan and the disaster recovery test results. These shall include, but not be limited to: (a) the disaster recovery plans plus a description of the changes from the previous year's plans, if any; and (b) the exercise test results conducted within the last twelve (12) months of the disaster recovery and business continuity tests referencing the adequacy of these plans. The test results must include the RTO and RPO of the systems and applications which provide service to ERS. If these are part of a SOC-2 Type II report, PBM shall provide the portions of the report that refer to the normal, annual disaster recovery and business and continuity tests, plus copies of the service auditor's report. PBM shall be available for reasonable inquiry by ERS of the disaster recovery plan and tests.**
While Express Scripts agrees to provide a copy of our disaster recovery plan and test results, we do not provide RPO values. We can provide ERS with a copy of our SOC-2 Type II report as requested and contractually obligated to. We will also be available to answer reasonable inquiries regarding our disaster recovery plans and tests as requested.

**E.1. PBM shall provide a full, un-redacted copy of the most recent SOC-2 Type II report performed under SSAE18 (or equivalent report) that describes the tests performed and provides the results of those tests or any other independent external audit on the effectiveness of internal controls over operations, security, and compliance of Services to be provided throughout the Contract Term, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit. This report must also be submitted by Respondents at time of Proposal submission.**

Express Scripts performs a SOC 2 Type II assessment on an annual basis and can provide results to ERS as a contracted client. In lieu of the SOC 2 report, we are providing a copy of our HITRUST certification at this time.

**E.3. If applicable, PBM shall make its outsourcers' or subcontractors' SOC-2 Type II report under SSAE18 or any other equivalent report on the effectiveness of internal controls over operations, security, and compliance of service results available to ERS for review on an annual basis. This report must also be submitted by Respondents at time of Proposal submission.**

Upon contract award and with a signed contract, Express Scripts will work with ERS to provide these reports in a mutually agreeable manner.

## B. Interrogatories – Operations Requirements

B.1. What type of background and reference checks are completed on Respondent's staff having access to ERS' data, including Participant's confidential data, personal health information, and personal identifiable information?

- HealthSelect PDPs

All candidates for employment with Express Scripts are subject to criminal background checks, employment and education verification procedures, and drug testing.

### Initial Screening

We use one of the nation's oldest and largest background screening companies to perform employee background checks, which include the following:

- Criminal – Felony & Misdemeanor Check
- National Sex Offender database
- Federal Criminal Check
- National Criminal database
- Social Security (SS) Trace
- Education Verification
- Employment Verification
- Prohibited Parties
- Health Care Sanction Check – FACIS Level 3

### Additional Checks by Request

- Professional License
- Motor Vehicle Check
- Band 4 and 5-6 – Federal Criminal Check
- Back 5 and 6 Background – State and Federal Civil

We initiate screenings for all employees, including monthly federal watch lists and criminal history checks, as well as random drug screenings. In this manner, all employees are subject to screening on a regular basis. Onsite vendors with unescorted access to our buildings are also subject to background checks.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

In accordance with CMS regulations, we also conducts pre-employment screenings against the Office of Inspector General (OIG) and General Service Administration (GSA) exclusions lists, as well as monthly screenings thereafter. If a prospective employee's name appears, they cannot be employed by Express Scripts. If an existing employee's name appears during the monthly screenings, his or her employment will be terminated immediately. This process applies to employees, members of the Board of Directors, and contractors.

B.2. Describe any special requirements in place for technical staff that have access to confidential data.

- HealthSelect PDPs

To support our Minimum Necessary Use policy, role-based access to confidential information is employed in all areas and systems throughout Express Scripts. Access to PHI is given only to those who require it to perform specific job functions.

The business owner of the data and, in some cases, the Privacy Office must approve access to confidential data. Approval is given only on a business need-to-know basis. Mechanisms are in place to capture and track information about access that has occurred so that corrective actions or procedures can be taken if warranted. Strict authentication rules apply to all audience channels to ensure we exchange information only with callers that have the right to such information.

## Guidelines for Laptops and Handheld Devices

Due to the advent of an increasingly mobile workforce, Express Scripts has developed guidelines for employees relating to their laptops and handheld devices. Communication of these guidelines is companywide through various channels and includes the following topics:

- Steps to safeguard your laptop and handheld device
- Keeping your information secure when you take it on the road
- Privacy and security guidelines for working away from your office
- Data protection guidelines

## Technology Protections

- Encryption — In addition to the encryption methods described above, we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.
- Storage devices — Writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.
- Work at home protection — Express Scripts supports a virtual workforce and has instituted an extensive work at home program for our employees. To ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. This technology allows Express Scripts to centrally store and manage applications and data in our data center, including patient health information. No patient data is stored on the end-user workstation for the typical work-at-home employee. Centralized policies limit access to Citrix-based applications based on the employee's role or job function. Additionally, the network communication between Express Scripts' data center and an

employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.

- Copying and transport of PHI — In addition to the technology-based initiatives, Express Scripts has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Express Scripts Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

Any new initiatives require a Privacy Office review to determine if the appropriate protections are being applied to the copy and transport of data. This review occurs as part of the standard Privacy Office review of new business activities.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

B.3. Would Respondent support any kind of SSO solution? ☒ Yes ☐ No

B.3.a. If the answer to the preceding question is "yes," Respondent shall describe its Single Sign-On solution for Participants.

- HealthSelect PDPs

Single Sign-On (SSO) creates a seamless connection between the client, their members and the Express Scripts member website – allowing a member to simply click a link from their employer or Health plan website and bypass login to begin managing their prescription benefit. SSO provides the ability for users to securely access multiple applications with a single set of shared credentials that occurs behind the scenes. The SSO experience includes landing the member on the dashboard of the site which provides a one-stop shopping experience and offers members the services they expect right up front like:

- Order status with tracking
- Refilling a prescription
- Enrolling in automatic refills
- Visibility to pharmacy options and savings
- Transferring a prescription to Express Scripts PharmacySM
- Navigating to anywhere in the site

The SSO offering also allows the client to select optional deep links that drop a member onto specific applications on the site – for example, our Price a Medication tool or Order Status page allowing for an even more direct access to specific relevant information. Whichever option the client selects they are enabling their members to access their information without the burden of yet another user ID and password.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

B.4. Describe Respondent's standardized methodology for resolving issues and implementing measurable action plans for effective and efficient problem resolution (e.g., unscheduled system outages, software issues/problems, etc.)
- HealthSelect PDPs

Our Corporate Reliability program identifies and responds to technology events or service-level issues. Subsequent to any unscheduled system downtime, we initiate an issue tracking process to ensure immediate attention throughout the organization. Additionally, key business area owners across the enterprise participate in daily reliability forums to review and assess any outstanding events or issues. Discussions in the reliability forums focus on action planning for issue resolution, with emphasis placed on root cause analyses and preventive measures necessary to ensure that there are no repeat occurrences and that we capture the appropriate organizational learning. When necessary, we form a team of subject matter experts that utilizes Six Sigma methodologies to measure, analyze, improve, and monitor event solution. Finally, our operations department reviews high-impact unscheduled downtime events daily with our executive management team. This allows our operations department to trend unscheduled downtime and ensure a continuous cycle of improvement.

HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

B.5. Describe Respondent's historical periodic scheduled maintenance schedule for the past twelve (12) months.
- HealthSelect PDPs

Point-of-sale processing is available 24 hours a day, seven days a week, with the exception of scheduled maintenance activities. Express Scripts' standard system downtime is every Sunday from 2 a.m. to 6 a.m., Eastern, to facilitate implementation of software releases. Express Scripts works to minimize downtime. There is a daily batch window from 5 a.m. to 5:15 a.m., and all systems are available during this time. Although the maintenance window may vary slightly from week to week, the listed times are the maximum times for the window. Express Scripts does not track the actual weekly downtimes for scheduled maintenance.

Should a pharmacy attempt to process a claim during scheduled or unscheduled downtime, the pharmacist would be directed to call Express Scripts' Pharmacy Help Desk for information and assistance. Pharmacists are instructed by the Help Desk to hold claims until the system resumes online processing and to follow the internal procedures prepared for such occurrences. The Help Desk supplies an estimated time of recovery and asks pharmacists to contact the Help Desk to confirm system status at that time.

For any challenges that arise with non-scheduled downtime, Express Scripts maintains a process for assigning urgent tickets to support groups for immediate follow-up and resolution.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

B.5.a. Describe Respondent's non-periodic maintenance which happened outside the scheduled period the past twelve (12) months.
- HealthSelect PDPs

Express Scripts did not experience any non-periodic maintenance outside the scheduled window the past 12 months.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference

B.5.b. Describe all unscheduled outages, slowdowns, impairments, and other system events during the past twelve (12) months.
- HealthSelect PDPs

During the past 12 months there were 23 critical and 118 high technology outages.

- 15 out of 23 critical outages and 39 out of 118 high outages impacted client/member applications (Electronic claims processing, e-Service Delivery, Coverage C360, Member Website)
- The root cause of these events are a combination of configuration and process and procedures.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference

B.6. Briefly outline system changes and describe any planned or scheduled system changes and/or upgrades to Respondent's hardware, infrastructure and data centers that will be hosting ERS data and services being used between the date of Proposal submission and the following twenty-four (24) months in the table below:
- HealthSelect PDPs

| Description of System Changes and Upgrades* | Description of Software Changes* | Projected Implementation Date |
|---|---|---|
| **From an engineering perspective, we are always looking for opportunities to further mature our core adjudication platform and help improve the overall client experience. Such engineering improvements may involve tech upgrade/overhaul of various components within our platform where we may retire certain tools and technologies in favor of better, more efficient and reliable alternatives. That said, in terms of business functionality, any changes to our claims adjudication system will be driven by required updates to the National Council for Prescription Drug Programs (NCPDP) Telecommunication standard version D.0., regulatory requirements, or customer requests,** | | |

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

B.7. Upon termination of the Contract or if ERS discontinues Respondent's services during the Contract Term, how would ERS' data be extracted and how would Respondent provide Respondent's data to ERS? Respondent shall provide a detailed description of the format or structure of the extracted data.
- HealthSelect PDPs

Upon notice of termination, ERS and Express Scripts will mutually develop a run-off plan providing, among other things, for Express Scripts' provision of open home delivery refill files, standard claims data, and Prior Authorization files for the transition to the successor pharmacy benefit manager (PBM) per then-existing industry protocol, currently the D.0 format.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference

## C. Interrogatories – Data Interfaces Requirements

**File Interface Process**

C.1. Respondent shall provide a copy of Respondent's business policies and procedures related to the file interface business process.

Provided

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Express Scripts executes an API-driven business platform for use by both our internal systems and those of our clients and partners. We will provide access to Express Scripts' information, business processes, and events to authorized parties wherever they are needed through a combination of REST-based APIs and industry standard interfaces (NCPDP D.0, NCPDP SCRIPT, HL7 FHIR, etc.). Our solutions have adopted several open standards, which help maximize the integration and efficiency of our technology and processes, including XML.

C.2. What is Respondent's standard file interface protocol, and what flexibility does Respondent have with Respondent's standard approach? Provide a detailed description.
- HealthSelect PDPs

Our connectivity strategy centers on the concept of open architecture, supporting our enterprise business mindset of an unbiased approach and partnering without constraints. We don't believe in forcing our partners into a one-size-fits all model - we'll bring a curated suite of solutions to the table, while also taking the time to understand your existing connections and vendor partnerships, to implement a holistic strategy that best fits you and your members.

Our existing integration and connectivity solutions are supported through the use of API gateways, Kafka, WebSphere MQ Series, and Spring Boot. Our solutions utilize open industry standards, such as the following:

- NCPDP standards for pharmacy claim submission, CDH, billing, prior authorization, and rebate processing
- SCRIPT standards for electronic prescribing

- American National Standards Institute (ANSI) X.12 standards for eligibility roster exchanges
- HL7 FHIR for healthcare data interoperability
- WSDL for CDH and customer service capabilities
- Open API Specification (Swagger) for our REST-based APIs

In support of seamlessly weaving our data and web capabilities into your existing systems, we have adopted a "one API" and "FHIR first" strategy, meaning that we design new APIs with the intent for use by both internal and external consumers, and in the industry-wide FHIR standard whenever possible. Through our APIs, we provide our clients with access to pharmacy claims history, eligibility status, medication coverage, covered alternatives, formulary data, pharmacy network data, price a medication functionality, prior authorizations on file, accumulator balances, and more.

Additionally, we support real-time SOAP-based web services integration for some of our CDH exchanges, as well as services used by our clients' call centers, including claims inquiry and eligibility verification.

Many of our partners leverage our APIs for real-time price quotes, coverage checks, and claims inquiry. Additionally, we have existing clients who leverage our APIs to integrate pharmacy capabilities into their own mobile app to provide a seamless member experience. This includes the ability to look up medications, access pharmacy claims history, and price a medication.

While APIs provide reusable tools for rapid implementation of new interfaces using previously developed functionality, there are four key themes to our overall strategy that go beyond just APIs. This includes open architecture, industry interoperability, real-time data movement, and foundational improvements which ultimately will enable improved capabilities for Express Scripts systems, ERS' system, third party systems, or any combination thereof.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

C.3. What measures does Respondent take to ensure the security of interfaces, which would include, but not be limited to, data files, emails, print screens and email attachments that Respondent is sending/receiving to/from external sources (whether ERS or a third party)?

- HealthSelect PDPs

In addition to being in full compliance with the standards established by the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule and the HIPAA Security rule, Express Scripts' stringent corporate policies, procedures, and guidelines help ensure the practical prevention of data loss. The specific safeguards employed by Express Scripts to ensure patient confidentiality and privacy are discussed below.

## Privacy and Data Use Policies

Express Scripts has adopted policies requiring employees to safeguard protected health information (PHI) at all times. These policies address areas such as system access controls and protections, mobile end-user devices, and use of the minimum PHI necessary.

Additionally, all Express Scripts employees have been instructed on how to report any breach or violation involving PHI and have completed the mandatory HIPAA Privacy training module within their first 30 days of employment. This module covers how to recognize a HIPAA violation, when and how to report such violations, and what actions will be taken in the event of wrongdoing.

Express Scripts is committed to safeguarding our clients' and members' information through innovative processes and procedures. We have undertaken initiatives well beyond those required by the HIPAA Privacy and Security Standards to lower the practical risk of loss and currently continue to review and upgrade its technology and practices as the industry develops. Express Scripts also implements role-based access to confidential information and protection of electronic PHI, described below.

To support our Minimum Necessary Use policy, role-based access to confidential information is employed in all areas and systems throughout Express Scripts. Access to PHI is given only to those who require it to perform specific job functions.

The business owner of the data and, in some cases, the Privacy Office must approve access to confidential data. Approval is given only on a business need-to-know basis. Mechanisms are in place to capture and track information about access that has occurred so that corrective actions or procedures can be taken if warranted. Strict authentication rules apply to all audience channels to ensure we exchange information only with callers that have the right to such information.

For transmission of electronic PHI in transit between entities, Express Scripts supports the use of transport layer security (TLS), which is consistent with the HIPAA Security Rule's Addressable Implementation Standard for Transmission Security for electronic PHI. ERS must be able to support TLS or virtual private network (VPN) connectivity. Express Scripts also supports the file transfer protocol (FTP) transfer of files encrypted with an open pretty good privacy (PGP) standards-compliant encryption tool.

Express Scripts utilizes full-disk encryption for laptops, corporate desktops, and field desktops. This provides encryption below the level of the operating system, providing protection for all files and software stored on the device. Express Scripts also utilizes encryption of removable media such as CDs, DVDs, and USB drives.

## Privacy and Data Protections Training and Awareness

Express Scripts' entire workforce is required to complete corporate HIPAA training upon first hire. The training covers many aspects of privacy compliance including reviews of our policies on the Use and Disclosure of PHI, our policy on Minimum Necessary, our clean desk policy, and various scenarios related to the appropriateness of sharing confidential information.

Express Scripts' entire workforce is required to complete corporate Information Security training upon first hire. Reminders and awareness on Express Scripts' privacy, information security, and data protections policies are all included in Express Scripts' mandatory new hire Standards of Business Conduct training, mandatory annual Compliance Update training, and mandatory Compliance Update for Contingent Workers.

In addition, based on the specific job functions that a department performs, department-specific training is regularly performed. The areas that deploy department-specific training include account management, customer service, and our correspondence areas.

## Privacy and Data Protections Awareness

Express Scripts engages in extensive awareness programs to ensure our workforce fully understands their privacy, security, and data protection responsibilities. We regularly send global emails to remind workforce members of their obligations to protect confidential information. The privacy section of the Compliance and Ethics Intranet site provides extensive information concerning privacy and data protections policies and guidelines, including copies of the policies and the global compliance emails previously distributed. In addition, a campaign to promote awareness utilizing physical reminders is conducted periodically in all facilities.

## Guidelines for Laptops and Handheld Devices

Due to the advent of an increasingly mobile workforce, Express Scripts has developed guidelines for employees relating to their laptops and handheld devices. Communication of these guidelines is companywide through various channels and includes the following topics:

- Steps to safeguard your laptop and handheld device
- Keeping your information secure when you take it on the road
- Privacy and security guidelines for working away from your office
- Data protection guidelines

## Technology Protections

- Encryption — In addition to the encryption methods described above, we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.

- Storage devices — Writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.
- Work at home protection — Express Scripts supports a virtual workforce and has instituted an extensive work at home program for our employees. To ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. This technology allows Express Scripts to centrally store and manage applications and data in our data center, including patient health information. No patient data is stored on the end-user workstation for the typical work-at-home employee. Centralized policies limit access to Citrix-based applications based on the employee's role or job function. Additionally, the network communication between Express Scripts' data center and an employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.
- Copying and transport of PHI — In addition to the technology-based initiatives, Express Scripts has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Express Scripts Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

Any new initiatives require a Privacy Office review to determine if the appropriate protections are being applied to the copy and transport of data. This review occurs as part of the standard Privacy Office review of new business activities.

## Data Loss Investigation Protocols

Express Scripts is committed to protecting the confidentiality of member information. The Privacy Office maintains policies that require safeguarding of PHI and minimum necessary use of PHI, and limit use and disclosure of PHI to those purposes permitted under applicable law. In addition, employees are required to promptly report any potential unauthorized use, access, or disclosure of PHI to the Privacy Office.

The Privacy Office ensures all potential privacy incidents are thoroughly researched and investigated. If an issue is determined to be substantiated, the Privacy Office ensures that the appropriate corrective actions are taken to prevent future occurrences, and ensures steps are taken to mitigate any harm, to the extent possible. In addition, depending on the nature of the incident, notifications may be sent to the client, member, or regulatory authorities. Such notifications are made in accordance with applicable law and the terms of the client contract.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

C.4. Provide a full description of Respondent's business processes with regard to Respondent's managed file transfer function that shall include, but not be limited to, the following key elements:
- Support of a point-to-point VPN with ERS;
- Explanation of how Respondent will use the interface files/data that ERS will provide;
- Protocols that Respondent will use when there is a file transmission problem or a corrupted bad interface file (or like scenario) with ERS; and
- Explanation of how information reported to ERS is to be derived from the source data file.

Express Scripts is committed to protecting the privacy and security of consumers who use our internet-based offerings and continues to improve our broad and comprehensive set of controls to protect patient data confidentiality and integrity. As described below, our website addresses security across the entire transaction process, from our internal technology infrastructure and transmission across the Internet.

Internal Infrastructure

Express Scripts' Internet-accessible systems are located in a firewall-protected demilitarized zone (DMZ), which isolates them from both the internet and the internal Express Scripts network. Web application firewalls (WAFs) have also been deployed in active blocking mode to protect our internet-facing web applications. These firewalls monitor and prevent more sophisticated attacks on member data, such as structured query language (SQL) injection or cross-site scripting.

Express Scripts performs vulnerability scans on a monthly basis against the systems in the internet-facing infrastructure. In addition, our internal security experts penetration-test all Internet-facing applications at least annually. In addition, Express Scripts engages an expert, independent third party to test our network, member, and client website applications. Our centralized security event logging and monitoring program includes monitoring by a third-party security service. Through our internal team and managed security service partner, we monitor critical logs 24 hours a day, seven days a week for key security devices and appliances, including but not limited to, our WAFs, intrusion detection/prevention systems, and critical server logs.

Express Scripts has a documented software development life cycle (SDLC) process in place that includes appropriate encryption guidance, security testing, user acceptance testing, and validation testing. Security signoff is required at various stages of the SDLC process to ensure these controls are met and to provide certification and accreditation of systems.

## Transmission Across the Internet

For protection of information in transit, Express Scripts requires 128-bit secure sockets layer (SSL) connections for access to protected health information (PHI) via the client and member web applications. Express Scripts also requires that eligibility data submitted via the Internet be encrypted to protect against interception and facilitate secure email transmission of data using transport layer security (TLS) or routing via virtual private network (VPN) connection. Encryption controls are documented and managed by information technology (IT) infrastructure staff and are regularly audited. Express Scripts has documented file transfer options and procedures for sending data to third parties. Exchanging information with Express Scripts can be accomplished using different tools and is dependent on each client's individual needs and volume of data.

Our preferred encryption technology is TLS encryption (server to server), followed by IPSec VPN, then Secure Web Delivery. We will work with ERS to determine the most appropriate transaction methods.

For transmission of electronic PHI in transit between entities, Express Scripts supports the use of transport layer security (TLS), which is consistent with the HIPAA Security Rule's Addressable Implementation Standard for Transmission Security for electronic PHI. ERS must be able to support TLS or virtual private network (VPN) connectivity. Express Scripts also supports the file transfer protocol (FTP) transfer of files encrypted with an open pretty good privacy (PGP) standards-compliant encryption tool.

Express Scripts utilizes full-disk encryption for laptops, corporate desktops, and field desktops. This provides encryption below the level of the operating system, providing protection for all files and software stored on the device. Express Scripts also utilizes encryption of removable media such as CDs, DVDs, and USB drives.

## File Transmission Procedures

Express Scripts uses an automated process to send and receive files. Jobs automatically run and create a pre-edit. Once the pre-edit process starts, if there are no errors then the file is automatically loaded. If there are errors, the file is put on hold and the Operations team reviews and reaches out to client. If the client is setup with nightly batch, the file will go through the batch process for overnight loading. Claims files detect duplicates and remove those duplicates. If Eligibility files have duplicates, the system does nothing with them unless there is a change.

C.5. If Respondent supplies an interface to ERS, then Respondent shall provide a full description of the interface file that shall include, but not be limited to, complete definitions of each field of the interface file.
- HealthSelect PDPs

Confirmed. For the most up-to-date list of our APIs offered at any given time, please visit our developer portal. Note that while many APIs on the portal are available to our PBM clients, some may be specific to particular business relationships. During ERS's implementation, your account team will work with you to determine an API strategy that best meets your needs.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

C.6. **Maintenance Eligibility Transactions.** Respondent receives monthly and weekly enrollment interface files posted via ERS' SFTP sites for the Programs and updates Respondent's records accordingly (and subject to CMS approval specific to the HealthSelect Medicare Rx PDP). ERS' current eligibility file provides Respondent with additions and changes. Terminations are reflected by omission of a Participant from any file (term by omission). How will Respondent ensure that all the maintenance eligibility transactions received from ERS will be processed timely and accurately?
- HealthSelect PDPs

ERS's eligibility files will be updated in our system within one business day of receipt. An eligibility error report will be sent to ERS within four hours of receipt of the eligibility files.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

As with actives, EGWP also uses the pre-edit process. In addition to the pre-edit process, once members clear initial file transmission, they are submitted to CMS for approval in addition to meeting pre-notification requirements as needed. CMS typically approves within 24-72 hours. If a member does not have full information needed for CMS approval, they fall to the Request for Information (RFI) process. In the RFI process, Express Scripts will make multiple outreaches to the member in an attempt to validate the incomplete or incorrect information. Once obtained, that member record is resubmitted for CMS acceptance. In the unlikely event that the RFI process is unsuccessful due to lack of member response, the member will be rejected from a CMS perspective. That information is shared with ERS through the Weekly PDP Enrollment report, which is also reviewed by your Enrollment Analyst. At that time, we will partner on a plan of action for member coverage, and validating if the member is truly eligible from a CMS perspective.

C.6.a. What problems, if any, does Respondent see with the term by omission process and what steps would be taken to alleviate discrepancies?
- HealthSelect PDPs

Express Scripts does not have any problems with the term by omission process. The following is used for full file reconciliation. It is assumed that any members not on the full eligibility file no longer have pharmacy benefit coverage; those members are assigned a termination date.

- Term-by-absence logic runs automatically and is applied with each full file processed.
- Express Scripts typically applies term-by-absence logic to all groups or members. If excluding groups or members, term-by-absence never terms anyone in the specified group(s). ERS must make other arrangements to terminate the members. If including specific groups, only members in the specified groups are considered for term by absence. ERS must make other arrangements to terminate all other members.
- All active and terminated records sent are processed before Express Scripts' term-by-absence logic applies termination.
- Term-by-absence processing applies to all subscribers and dependents, unless they are in an excluded group.
- Term-by-absence logic can exclude terminating members that were manually added or had their expiration date changed within a ERS-defined number of days. This is determined during setup and can be changed at any time.
- Members terminated using term-by-absence are typically terminated with an expiration date equal to the date the file processed (current date). Other dates that can be used include: End of Current Month, End of Prior Month, or a ERS-supplied date.
- ERS can define whether existing future term dates are replaced with a term-by-absence-generated term date.
- When a member record is sent with a new effective date in the same group, the term-by-absence process applies an expiration date to the previous timeline equal to one day before the new effective date, as long as a termination date for the previous timeline is not supplied.
- When a member is sent in a new or different group, the term-by-absence process applies an expiration date to the timeline in the old group equal to one day before the effective date in the new group, if a termination date for the old group is not supplied.

Term-by-absence terminations are set up using fault tolerance at a recommended setting of 5%. When fault tolerance is used, Express Scripts' system checks to see if the number of termination transactions created by the term-by-absence utility is above tolerance percentages, compared to the total number of active records on the production system for this population. This total count includes only members whose coverage has terminated. If the total count exceeds 5% or the client's chosen percentage, then the file load job stops for future review and is not applied without approval from ERS.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

C.7. Are Respondent's computer data files encrypted using at least 256-Bit symmetric key AES encryption standards for backup media?
☒ Yes ☐ No

## D. Interrogatories – Security Practices Requirements

**Security Requirements**

D.1. Does Respondent have a full-time Information Security Officer or Chief Security Officer?
☒ Yes ☐ No

D.1.a. If the answer to the preceding question is "yes," Respondent shall describe how this role fits into Respondent's organizational chart.
- HealthSelect PDPs

We offer a robust security program supported by Noelle Eder, who serves as Executive Vice President and Global Chief Information Officer (CIO) at Cigna, our parent company. Noelle reports to Cigna President and CEO David Cordani.

James Beeson serves as our Chief Information Security Officer (CISO), reporting to Noelle. Within Noelle's organization, nearly 400 employees are dedicated to supporting security efforts, including IT regulatory compliance, digital forensics, threat and vulnerability management, supplier reviews, and performing application security assessments to ensure HIPAA compliance.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.1.b. If the answer to the preceding question is "no," Respondent shall provide a detailed description as to why not.
- HealthSelect PDPs

Not applicable.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

Not applicable.

D.2. Does Respondent have dedicated resources for information security efforts? ☒ Yes ☐ No

D.2.a. If the answer to the preceding question is "no," Respondent shall provide a detailed description as to why not.
- HealthSelect PDPs

Not applicable.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

Not applicable.

D.3. What are Respondent's minimum and maximum user ID lengths?
- HealthSelect PDPs

Not applicable. Express Scripts does not have minimum and maximum user ID requirements.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.4. What technology in the data center (servers, storage, and network infrastructure) that will provide services to ERS is shared with other data center customers?
- HealthSelect PDPs

Express Scripts uses one application portfolio to service our clients. This portfolio hardware is dedicated to Express Scripts.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.5. What kind of network security devices are running in Respondent's data center(s) (e.g., data loss prevention tools, intrusion detection systems, intrusion prevention systems)?

- HealthSelect PDPs

We deploy commercial firewalls and router Access Control Lists at all public network access points to appropriately restrict network traffic. Express Scripts does not advertise to the Internet its internal network address space and blocks all outside requests for information. Commercial network intrusion detection systems monitor inbound and outbound traffic for attack patterns and alert security personnel when appropriate.

Express Scripts conducts regular vulnerability scans against our Internet points of presence to ensure no common vulnerabilities exist. Express Scripts' Payment Card Industry auditor conducts monthly vulnerability scans.

## Isolation of Internet-Accessible Systems

Internet-accessible systems feature hardened operating systems and reside in a firewall-protected DMZ, isolated from both the Internet and Express Scripts' internal network. We also have deployed commercial host intrusion detection software on DMZ systems.

## Access Based on the "Principle of Least Privilege"

The "Principle of Least Privilege" is an important consideration in the protection of data and functionality. With this principle in mind, access to systems and applications can occur in one of two ways:

- A user starts a job for which there is a defined "role" in Express Scripts' Identity Management system. Our Human Resources system triggers the creation of a unique user ID with specific access rights approved by authorized personnel. Upon transfer to a new position or termination of employment, the Identity Management system removes access rights as appropriate.
- When providing access outside of the Identity Management processes, Express Scripts uses a request management system to initiate and track access requests, including the required owner approvals. The Identity Management system removes access rights upon termination of employment.

  The request management system also governs the modification of access privileges, which we review periodically for compliance with internal, Sarbanes-Oxley, and SOC 1 control requirements. We disable unused IDs after 90 days of inactivity and delete them after an additional 30 days.

## Strong Encryption

Express Scripts utilizes transport layer security (TLS) for encryption for web session security. Data access for all portals is authenticated and authorized. Express Scripts also utilizes risk-based authentication for client-side authentication and authorization to conduct business via the Internet.

## Other Tools

Inside our internal network, we utilize a variety of tools and methods for data protection to strengthen our Defense in Depth Security:

- Internal systems are regularly scanned using commercial tools to identify and address potential security vulnerabilities.
- Security software patches are applied on a regular basis to all platforms after evaluation, applicability, and testing, with priority given to critical and high risk items.
- Authentication and authorization controls are in place at the platform and application levels to restrict data access to authorized users.

- All data field changes are tracked and stamped with the date, time, user ID and system used to make the change.
- All Express Scripts workstations have current antivirus protection and are kept up to date with security patches.
- All CDs and DVDs sent to external parties are encrypted.
- Use of removable media is restricted to authorized users.
- All Express Scripts laptops have encrypted hard drives with pre-boot authentication.
- Data Loss Prevention software monitors outbound email communications, scans data at rest, and interrogates inbound and outbound network traffic against predefined policies.
- Independent third party Attack and Penetration Tests are performed annually, of which Executive Summaries are available upon request for active Clients.

In addition to these controls, Express Scripts relies on regular audits of our security processes and procedures as a key component of identifying and reducing risk in our environment.

HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.6. Describe in detail Respondent's practices and controls used to limit access and protect confidential and sensitive data in storage and in transit.

- HealthSelect PDPs

In addition to being in full compliance with the standards established by the HIPAA Privacy rule and the HIPAA Security rule, Express Scripts' stringent corporate policies, procedures, and guidelines help ensure the practical prevention of data loss.

The specific safeguards we employ ensure patient confidentiality and privacy are discussed below.

## Privacy and Data Use Policies

We have adopted policies requiring employees to safeguard PHI at all times. These policies address areas such as system access controls and protections, mobile end-user devices, and use of the minimum PHI necessary.

- Role-Based Access to Confidential Information
- Protection of Electronic PHI
- Training - Express Scripts' entire workforce is required to complete corporate Information Security training in addition to corporate HIPAA training upon first hire.
- Privacy and Data Protections Awareness - Express Scripts engages in extensive awareness programs to ensure our workforce fully understands their privacy, security, and data protection responsibilities.
- Guidelines for Laptops and Handheld Devices
- Steps to safeguard your laptop and handheld device
- Keeping your information secure when you take it on the road
- Privacy and security guidelines for working away from your office
- Data protection guidelines

## Technology Protections

- Encryption —we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.

- Storage devices — writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.
- Work at home protection — Express Scripts supports a virtual workforce and to ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. The network communication between our data center and an employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.
- Copying and transport of PHI — Cigna Corporation has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

## Data Loss Investigation Protocols

We are committed to protecting the confidentiality of member information. The Privacy Office maintains policies that require safeguarding of PHI and minimum necessary use of PHI, and limit use and disclosure of PHI to those purposes permitted under applicable law. In addition, employees are required to promptly report any potential unauthorized use, access, or disclosure of PHI to the Privacy Office.

The Privacy Office ensures all potential privacy incidents are thoroughly researched and investigated. If an issue is determined to be substantiated, the Privacy Office ensures that the appropriate corrective actions are taken to prevent future occurrences, and ensures steps are taken to mitigate any harm, to the extent possible. In addition, depending on the nature of the incident, notifications may be sent to the client, member, or regulatory authorities. Such notifications are made in accordance with applicable law and the terms of the client contract.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.7. Respondent shall describe how it will transmit and receive ERS' confidential and sensitive information via encrypted transmission protocols including site to site VPN, SFTP, TLS, or other industry accepted encryption methodology.

- HealthSelect PDPs

  When transmitting personal information, Express Scripts requires 128-bit transport layer security (TLS) connections for access to protected health information (PHI) available via the Client and Consumer Web Applications. Express Scripts also requires that eligibility data submitted via the Internet be encrypted to protect against interception and also facilitates secure email transmission of data using TLS or routing via virtual private network (VPN) connection. Encryption controls are documented in Express Scripts' Encryption Security Standard, managed by Information Technology (IT) Infrastructure staff, and regularly audited by Information Risk Management and Internal Audit.

  On laptops and desktops, Express Scripts utilizes full-disk encryption. Full-disk encryption protects against the loss or theft of the entire device. Express Scripts also encrypts removable media such as CDs, DVDs, and USB drives when permitted to be used. Express Scripts' policies require that employees request a policy exception if they have a business need to write to portable devices. All exceptions are managed by Information Risk Management.

To meet the requirements of the payment card industry (PCI) data security standard (DSS), Express Scripts encrypts card data that is stored in the Member Accounts Receivable databases. Additionally, all password data is encrypted in storage and transit.

## Encrypting Backups and Portable Media

All non-public data leaving Express Scripts' custody (including data on laptops, portable storage media, CD, and DVD drives; tapes, retired, or defective hard drives; employee or corporate mobile phones; and tablet computers, for example) must either be encrypted using approved methods (currently Advanced Encryption Standard [AES]-128 or above, or Triple Data Encryption Standard [DES] in cipher block chaining [CBC] mode), or cleared in compliance with current Industry guidelines, such as NIST 800-88 or Department of Defense (DoD) 5220.22-M standards.

## Email Routing and Encryption

Express Scripts supports several industry-standard solutions to secure Internet email containing PHI with business partners, all of which are fail-safe and transparent to the end-user. These secure methods ensure that email messages between Express Scripts and ERS are encrypted while in transit over the Internet using industry-standard encryption mechanisms; therefore, messages and their contents are invulnerable from being revealed to third parties. The fail-safe nature of the transmission ensures that if the encryption mechanisms are inadvertently disabled, the messages will not be transmitted and a "failure-to-send" notification will be transmitted to the sender. Neither the sender nor the recipient needs to take any action to secure their messages — the emails are automatically secured.

Our secure email options are detailed below:

- Transport layer security (TLS) — TLS between gateways, the successor to secure sockets layer (SSL), is used to secure all email messages passing over the Internet between email gateways. This method requires ERS to have an Internet email gateway that supports TLS. Most modern mail gateways include TLS support; however, it may need to be enabled or licensed.
- Internet security (IPSec) virtual private network (VPN) — IPSec VPN between VPN gateways is the standard for securing Internet Protocol traffic. This method requires ERS to have a VPN gateway that supports IPSec. This gateway could be a dedicated VPN appliance, a firewall, or a router with IPSec VPN capability.
- Secure Web Delivery — Express Scripts has developed Secure Web Delivery capabilities via PostX. This system utilizes a "send secure" option, which encrypts messages to external parties when selected by the sender.

Our preferred encryption technology is TLS encryption (server to server), followed by IPSec VPN, then Secure Web Delivery. We will work with ERS to determine the most appropriate transaction methods.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.8. Are network firewalls and other security equipment checked by independent third parties for vulnerabilities and possible exploits? ☒ Yes ☐ No

D.8.a. If the answer to the preceding question is "yes," Respondent shall state how often.

- HealthSelect PDPs

Express Scripts arranges for an annual third-party audit (SOC 1) to independently report that appropriate controls are in place and operating effectively. The audit verifies that controls provide reasonable assurance that the specified control objectives are achieved. Testing includes aspects of computer operations, physical security, access to data files and programs, and system and program development and modification. ERS can request a copy of our external audit reports through your account management team.

Additionally, our Payment Card Industry (PCI) certification is validated on an annual basis. PCI data security standards are a set of technical and administrative controls that must be in place for companies to process credit card data. We utilize a third party to assess and certify our compliance to these standards. The process includes a monthly scan of our network, an annual attack and penetration test, supporting documentation of the controls implemented, and an onsite review of our facilities.

We also have a separate formal testing process for security measures. Security is tested in the product development life cycle for all new initiatives. Use case scenarios are developed to define proper security implementation. The developed controls are tested to ensure operability and effectiveness during the design phase and then implemented into production.

We also utilize various methods to control access points to our network including:

- Commercial firewalls and router Access Control Lists at all public network access points appropriately restrict network access.
- Internal network address space is not advertised to the Internet, and all outside requests for information are blocked.
- Commercial Network Intrusion Detection Systems are in place to monitor inbound and outbound traffic for attack patterns and to alert security personnel when appropriate.
- We conduct regular vulnerability scans against its Internet points of presence to ensure no vulnerabilities exist.
- Vulnerability scans are also conducted monthly by our PCI auditor.
- Internet-accessible systems have hardened operating systems and are located in a firewall protected DMZ, meaning it is isolated from both the Internet and our internal network.
- Commercial Host Intrusion Detection Software has been deployed on the DMZ systems as an additional measure.
- An additional layer of commercial firewalls separate our Web Portal DMZ from the internal network.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

D.8.b. If the answer to the preceding question is “no,” Respondent shall provide a detailed description as to why not.

- HealthSelect PDPs

  Not applicable.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  Not applicable.

D.9. Respondent shall describe how often Respondent's firewall and router configuration standards are reviewed.

- HealthSelect PDPs

  Our Security Infrastructure Team reviews firewall and router configurations twice annually. Additionally, these items are reviewed as necessary through our Change Management Process.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No differences

D.9.a. Respondent shall provide the last date Respondent's firewall and router configuration standards were reviewed.

- HealthSelect PDPs

  June 2022

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No differences

**Security Breaches**

D.10. In the event of a security breach, describe the process to notify ERS of the breach of data related to Participants, Respondent facilities, or other types of information technology infrastructure breaches.

- HealthSelect PDPs

  We will report to ERS any confirmed security incidents involving your members' personal health information (PHI) in either electronic or paper form that we discover, regardless of whether the incident results from the acts or omissions of Express Scripts, our agents, or our subcontractors. We will report the incident either verbally or in writing to ERS within 48 hours of our discovery of the incident, or of any incident that might, upon further investigation, constitute a security incident.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.11. Respondent shall list and describe all breaches of personally-identifiable information or nonpublic personal information and all other security breaches Respondent's organization has experienced with external reporting requirements, including, but not limited to, loss of equipment that contained client information, loss of files, and unauthorized access to Respondent's networks within the last seven (7) years.

- HealthSelect PDPs

  Express Scripts complies with all federal and state privacy laws, including all aspects of the Health Insurance Portability & Accountability Act (HIPAA). Like any large healthcare organization, Express Scripts may occasionally receive complaints from clients, members, patients, or regulatory agencies alleging potentially improper use or disclosure of protected health information (PHI). We investigate all potential unauthorized disclosures and perform a risk assessment to determine whether a low probability of compromise exists. If applicable, all notifications are provided pursuant to HIPAA regulations and state data privacy breach laws. Express Scripts has experienced breaches within the last seven years, however the majority of the breaches, as defined by HIPAA, impact one individual where mail or fax was sent to an unauthorized recipient.
  As of today's date, Express Scripts has not been subject to any state or federal disciplinary actions for HIPAA violations.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

D.11.a. Describe the investments Respondent made over the past three (3) years in its technology to mitigate security breaches?

- HealthSelect PDPs

  We continually monitor and adjust our mitigation strategies against evolving and new threats. Recent examples include:

  - Enhanced use of CyberArk for administrative access control, with more robust auditing
  - Enterprise-wide, in-house phishing awareness training, in which we have significantly reduced the click rate to less than 2% from a high of 18% as well as having increased the degree of difficulty along the way
  - The implementation of Multi-Factor Authentication on our Member Website in 2022
  - A SOC 2, Type 2 Security Principle certification to our robust independent third party certifications which also includes SOC 1 Type 2; HITRUST; PCI; and multiple penetration tests

  Looking forward, we place continued focus and investment in cybersecurity to ensure our systems and ERS's patient data are protected by the latest technological advancements. Included in these projects, we deployed a focused set of security controls on our externally-facing websites that are tailored to prevent the most common attack patterns. We are also upgrading our current authentication controls for externally-facing websites to further prevent fraud and attack. Additionally, we are implementing an overarching security framework to adopt and leverage the latest, diverse, and most efficient secure cloud technologies.

  We are beginning to explore various ways we can use blockchain technology to improve the overall security, efficiency, and accuracy of various workloads. Not only are we evaluating its applicability for internal applications within the enterprise, but are always open to establishing partnerships throughout the industry, where we will be working side-by-side with our clients.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

**Backup Procedures**

D.12. Briefly describe Respondent’s backup procedures for the system(s) to be used in the services proposed to ERS.

- HealthSelect PDPs

  All claims are backed up daily and are reconciled with our primary system. We perform daily incremental backups and weekly full backups. Backups are performed using our Virtual Tape Library system over our private, internal network from our primary data center in Piscataway, NJ to our backup data center in Elk Grove Village, IL. We use a virtual tape library system, eliminating the risk of producing physical tapes.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

**Vulnerability Patching**

D.13. Respondent shall describe Respondent's processes and procedures for managing and patching known vulnerabilities.

- HealthSelect PDPs

  We scan for vulnerabilities on a continuous basis, performing weekly full network scans. Additionally, as part of our PCI certification, we have a trusted third party perform monthly network scans. We also subscribe to applicable Vendor sites for vulnerability updates. When patches are released, we test the patch and then apply according risk ranking and criticality of the vulnerability in our environment.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.13.a. Is there a patch management solution in place so that all system components and software are protected from known vulnerabilities by having the latest vendor supplied security patches installed? ☒ Yes ☐ No
If no, provide an explanation.

- HealthSelect PDPs

  Not applicable

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.13.b. How often are systems checked?

- HealthSelect PDPs

  We continuously monitor for vulnerabilities, performing weekly network scans. We also test as part of our Software Development Life Cycle (SDLC) Process, as necessary, ensuring identified issues are addressed prior to promotion to the production network.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.13.c. What was the last date Respondent's data center systems and user workstations were checked?

- HealthSelect PDPs

  June 20, 2022

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

**Security Incidents**

D.14. Respondent shall describe Respondent's processes and procedures in place for responding to low, medium and high severity information security incidents.

- HealthSelect PDPs

The following describes our process for detecting and responding to information security breaches.

## Intrusion Detection

Express Scripts uses a combination of signature-based and behavior-based intrusion detection systems (IDS). Signature-based systems are monitored 24 hours a day, seven days a week by a third-party security operations center. Suspicious activity is escalated to Express Scripts' Incident Response team, which investigates all potential security incidents. Behavior-based IDS monitors network traffic between hosts, allowing the Incident Response team to identify hosts that may be infected through anomaly detection.

## Notify Appropriate Contacts

The incident coordinator notifies:

- Information Technology (IT) management and personnel whose involvement is required for resolution of the incident. For example:
  - Security incidents must involve members of Information Risk Management.
  - Windows server incidents must involve members of Windows Servers.
  - Windows desktop incidents must involve members of PC Services.
  - Unix OS incidents must involve members of Unix Administration.

Call trees are in place for all potential impacted areas.

- Facilities Management, if the incident involves an environmental failure or disaster.
- Network Engineering, including the Network Operations Center, if the incident affects network operations.
- Our Internet Service Providers, if the incident affects them.

As appropriate, management notifies:

- Executive management
- General counsel
- Chief privacy officer
- Human Resources
- Sales and Account Management

## Assemble Incident Team

The incident coordinator assembles an incident team to perform necessary investigation and recovery operations. The composition and size of the team depends greatly on the nature of the incident.

The incident team meets with the incident coordinator in the incident command center.

The incident coordinator may reclassify the incident at any time, which may also require naming a new incident coordinator or incident team. For example, in the case of a fire, the resulting system damage must be addressed after the fire has been put out; this likely requires a different team.

## Security Incident Containment Consult with Stakeholders

The incident coordinator must ensure that IT management, infrastructure, application, business owners, and other stakeholders know the current situation, especially any actions taken in the previous step to suspend operations on affected systems and isolate network segments, for example.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference

D.14.a. What is Respondent's process to rank such incidents?

- HealthSelect PDPs

  We risk rank each incident for potential impact to our environment. As such, we respond accordingly, with Critical within seven days, High within 30 days, Medium within 60 days, and Low within 90 days.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference

D.15. Does Respondent have forensic security experts on staff or is a third party contracted in the case of a breach? ☒ Yes ☐ No

D.15.a. If the answer to the preceding question is "yes," Respondent shall describe Respondent's procedure.

- HealthSelect PDPs

  Express Scripts has both forensic security on staff and we also contract with a third party support as necessary. We engage in accordance with internal Incident Response Processes, coordinating closely with our Human Resources and Legal partners as necessary.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.16. Describe Respondent's Security Incident Management policies and procedures for the Services provided as well as internal systems.

- HealthSelect PDPs

The following describes our process for detecting and responding to information security breaches.

## Intrusion Detection

Express Scripts uses a combination of signature-based and behavior-based intrusion detection systems (IDS). Signature-based systems are monitored 24 hours a day, seven days a week by a third-party security operations center. Suspicious activity is escalated to Express Scripts' Incident Response team, which investigates all potential security incidents. Behavior-based IDS monitors network traffic between hosts, allowing the Incident Response team to identify hosts that may be infected through anomaly detection.

## Notify Appropriate Contacts

The incident coordinator notifies:

- Information Technology (IT) management and personnel whose involvement is required for resolution of the incident. For example:
  - Security incidents must involve members of Information Risk Management.
  - Windows server incidents must involve members of Windows Servers.
  - Windows desktop incidents must involve members of PC Services.
  - Unix OS incidents must involve members of Unix Administration.

Call trees are in place for all potential impacted areas.

- Facilities Management, if the incident involves an environmental failure or disaster.
- Network Engineering, including the Network Operations Center, if the incident affects network operations.
- Our Internet Service Providers, if the incident affects them.

As appropriate, management notifies:

- Executive management
- General counsel
- Chief privacy officer
- Human Resources
- Sales and Account Management

## Assemble Incident Team

The incident coordinator assembles an incident team to perform necessary investigation and recovery operations. The composition and size of the team depends greatly on the nature of the incident.

The incident team meets with the incident coordinator in the incident command center.

The incident coordinator may reclassify the incident at any time, which may also require naming a new incident coordinator or incident team. For example, in the case of a fire, the resulting system damage must be addressed after the fire has been put out; this likely requires a different team.

## Security Incident Containment Consult with Stakeholders

The incident coordinator must ensure that IT management, infrastructure, application, business owners, and other stakeholders know the current situation, especially any actions taken in the previous step to suspend operations on affected systems and isolate network segments, for example.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect 6edicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.16.a. Respondent shall provide a copy of Respondent's Security Incident Management policies and procedures.
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.
.

**Antivirus and Ransomware Protection**

D.17. What antivirus protection/programs does Respondent use?

- HealthSelect PDPs

  We use several commercially recognized products in our environment. For security reasons, we do not release product-specific information. Our process is validated each year by independent third-party assessments.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.17.a. Is antivirus software deployed on all Respondent's and Respondent's contractor systems (such as servers, workstations, laptops) commonly affected by malicious software?
☒ Yes ☐ No

D.17.b. Are all antivirus programs capable of detecting, removing and protecting against all known types of malicious software (i.e., viruses, worms, spyware, Trojans, adware and rootkits)?
☒ Yes ☐ No

D.17.c. How often are the .DAT files updated and are automatic antivirus scans enabled?

- HealthSelect PDPs

  We update daily and automatic scans are enabled.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

**Ransomware**

D.18. Respondent shall describe how it defends itself and recovers from a targeted security attack, such as a ransomware attack, where online backups and/or online backup catalogs are erased and unrecoverable.

- HealthSelect PDPs

  Our Defense in Depth approach to Security minimizes the potential for such an attack from occurring; however, we strategize to assume a worst-case scenario. Defense in Depth includes a comprehensive Information Security Program; technology Best Practices to include "detect and prevent," "identify and stop infection," "maintain gold images of configurations," and a "comprehensive backup strategy." Our backup strategies position us to recover rapidly from attacks. In addition to data replication, we employ a virtual tape library performing daily incremental backups and weekly full backups to our Virtual Tape Library system over our internal private, encrypted network. All this combined with robust user education training minimizes our risk of such attacks. The training includes comprehensive phishing tests performed by our Awareness and Education staff to continuously improve click rate results. For any targeted attack, our formal incident response process is activated and executed according to the plan. This can include system isolation in the case of a Ransomware attack, as well as engaging forensics experts (internal and external) to assess the event and take appropriate, documented action.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

**VPN**

D.19. Respondent shall describe how it will follow highly restricted access policies behind any ERS-related point-to-point VPN setup in support of this Contract.

We can support SAML 2.0 for SSO to our environment. Access requests will follow our formal request process where Role Based Controls are in place to ensure only access to what is needed to perform the job function is permitted.

**Encrypted Devices**

D.20. Are all of Respondent’s desktop, laptop computers, and portable devices encrypted to protect the data in case of theft or loss? ☒ Yes ☐ No

D.20.a. If the answer to the preceding question is “no,” Respondent shall provide a detailed description as to why not.

- HealthSelect PDPs

  N/A

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

D.20.b. Does Respondent permit the use of portable drives? ☒ Yes ☐ No

D.20.b.i. If the answer to the preceding question is "yes," how are portable drives protected?

- HealthSelect PDPs

When transmitting personal information, Express Scripts requires 128-bit transport layer security (TLS) connections for access to protected health information (PHI) available via the Client and Consumer Web Applications. Express Scripts also requires that eligibility data submitted via the Internet be encrypted to protect against interception and also facilitates secure email transmission of data using TLS or routing via virtual private network (VPN) connection. Encryption controls are documented in Express Scripts' Encryption Security Standard, managed by Information Technology (IT) Infrastructure staff, and regularly audited by Information Risk Management and Internal Audit.

On laptops and desktops, Express Scripts utilizes full-disk encryption. Full-disk encryption protects against the loss or theft of the entire device. Express Scripts also encrypts removable media such as CDs, DVDs, and USB drives when permitted to be used. Express Scripts' policies require that employees request a policy exception if they have a business need to write to portable devices. All exceptions are managed by Information Risk Management.

To meet the requirements of the payment card industry (PCI) data security standard (DSS), Express Scripts encrypts card data that is stored in the Member Accounts Receivable databases. Additionally, all password data is encrypted in storage and transit.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

**Physical Security**

D.21. How does Respondent manage physical security of Respondent's data center?

- HealthSelect PDPs

Express Scripts leases space at our data center properties; however, we own and operate all of the systems in our data centers. Additionally, we manage entry into the data centers, where only Express Scripts employees and a few critical site facility personnel have access. QTS Realty Trust, Inc. manages our primary data center in Piscataway, New Jersey and Digital Realty Trust, L.P. manages our backup data center in Elk Grove Village, Illinois. Our co-located data centers maintain SOC 2 compliance for the environmental and physical security controls they provide.

## Physical Security Procedures

Cigna Corporations' facilities have strict identification and access protocols for employees and visitors, including:

- All persons are required to visibly display their access badges
- Facilities are monitored 24 hours a day
- Cigna Corporations' facilities commonly use closed-circuit television, video surveillance, badge access, alarm systems, and security personnel

In addition to technical controls, we maintain corporate security policies that guide our security efforts. These policies are communicated to the Cigna Corporation user community.

## ID Badges

Each employee has a responsibility to assist in maintaining the building and company security. To protect the security of Cigna Corporation personnel, information, and buildings, we issue ID badges to all employees, visitors, consultants, and temporary employees. These badges must be worn and visible at all times while in the building. All Cigna Corporation locations require ID badges for admittance into the building.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.21.a. Who gets access to Respondent's data center?

- HealthSelect PDPs

  We manage entry into the data centers, where only Express Scripts employees and a few critical site facility personnel have access.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.21.b. What are the hours of operation of Respondent's data center?

- HealthSelect PDPs

  Our Data Centers operate 24 hours a day, 365 days a year.

  HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

**Technology**

D.22. What technology is in place to manage network and server security?

- HealthSelect PDPs

  We utilize a Defense in Depth approach to security.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.22.a. Provide the name and the version of the technology used to manage the network and server security and describe the effectiveness of the technology.

- HealthSelect PDPs

  We utilize a Defense in Depth approach to security.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

**Information Security (Data Access)**

D.23. Describe how Respondent controls access to ERS' confidential data.

- HealthSelect PDPs

  In addition to being in full compliance with the standards established by the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule and the HIPAA Security rule, Express Scripts' stringent corporate policies, procedures, and guidelines help ensure the practical prevention of data loss.

  The specific safeguards employed by Express Scripts to ensure patient confidentiality and privacy are discussed below.

## Privacy and Data Use Policies

Express Scripts has adopted policies requiring employees to safeguard PHI at all times. These policies address areas such as system access controls and protections, mobile end-user devices, and use of the minimum PHI necessary.

Additionally, all Express Scripts employees have been instructed on how to report any breach or violation involving PHI and have completed the mandatory HIPAA Privacy training module within their first 30 days of employment. This module covers how to recognize a HIPAA violation, when and how to report such violations, and what actions will be taken in the event of wrongdoing.

Express Scripts is committed to safeguarding our clients' and members' information through innovative processes and procedures. We have undertaken initiatives well beyond those required by the HIPAA Privacy and Security Standards to lower the practical risk of loss and currently continue to review and upgrade its technology and practices as the industry develops. Express Scripts also implements role-based access to confidential information and protection of electronic PHI, described below.

## Role-Based Access to Confidential Information

To support our Minimum Necessary Use policy, role-based access to confidential information is employed in all areas and systems throughout Express Scripts. Access to PHI is given only to those who require it to perform specific job functions.

The business owner of the data and, in some cases, the Privacy Office must approve access to confidential data. Approval is given only on a business need-to-know basis. Mechanisms are in place to capture and track information about access that has occurred so that corrective actions or procedures can be taken if warranted. Strict authentication rules apply to all audience channels to ensure we exchange information only with callers that have the right to such information.

## Protection of Electronic PHI

For transmission of electronic PHI in transit between entities, Express Scripts supports the use of transport layer security (TLS), which is consistent with the HIPAA Security Rule's Addressable Implementation Standard for Transmission Security for electronic PHI. ERS must be able to support TLS or virtual private network (VPN) connectivity. Express Scripts also supports the file transfer protocol (FTP) transfer of files encrypted with an open pretty good privacy (PGP) standards-compliant encryption tool.

Express Scripts utilizes full-disk encryption for laptops, corporate desktops, and field desktops. This provides encryption below the level of the operating system, providing protection for all files and software stored on the device. Express Scripts also utilizes encryption of removable media such as CDs, DVDs, and USB drives.

## Privacy and Data Protections Training and Awareness

### Training

Express Scripts' entire workforce is required to complete corporate HIPAA training upon first hire. The training covers many aspects of privacy compliance including reviews of our policies on the Use and Disclosure of PHI, our policy on Minimum Necessary, our clean desk policy, and various scenarios related to the appropriateness of sharing confidential information.

Express Scripts' entire workforce is required to complete corporate Information Security training upon first hire. Reminders and awareness on Express Scripts' privacy, information security, and data protections policies are all included in Express Scripts' mandatory new hire Standards of Business Conduct training, mandatory annual Compliance Update training, and mandatory Compliance Update for Contingent Workers.

In addition, based on the specific job functions that a department performs, department-specific training is regularly performed. The areas that deploy department-specific training include account management, customer service, and our correspondence areas.

### Privacy and Data Protections Awareness

Express Scripts engages in extensive awareness programs to ensure our workforce fully understands their privacy, security, and data protection responsibilities. We regularly send global emails to remind workforce members of their obligations to protect confidential information. The privacy section of the Compliance and Ethics Intranet site provides extensive information concerning privacy and data protections policies and guidelines, including copies of the policies and the global compliance emails previously distributed. In addition, a campaign to promote awareness utilizing physical reminders is conducted periodically in all facilities.

### Guidelines for Laptops and Handheld Devices

Due to the advent of an increasingly mobile workforce, Express Scripts has developed guidelines for employees relating to their laptops and handheld devices. Communication of these guidelines is companywide through various channels and includes the following topics:

- Steps to safeguard your laptop and handheld device
- Keeping your information secure when you take it on the road
- Privacy and security guidelines for working away from your office
- Data protection guidelines

## Technology Protections

- Encryption — In addition to the encryption methods described above, we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.
- Storage devices — Writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.

- Work at home protection — Express Scripts supports a virtual workforce and has instituted an extensive work at home program for our employees. To ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. This technology allows Express Scripts to centrally store and manage applications and data in our data center, including patient health information. No patient data is stored on the end-user workstation for the typical work-at-home employee. Centralized policies limit access to Citrix-based applications based on the employee's role or job function. Additionally, the network communication between Express Scripts' data center and an employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.
- Copying and transport of PHI — In addition to the technology-based initiatives, Express Scripts has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Express Scripts Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

Any new initiatives require a Privacy Office review to determine if the appropriate protections are being applied to the copy and transport of data. This review occurs as part of the standard Privacy Office review of new business activities.

### Data Loss Investigation Protocols

Express Scripts is committed to protecting the confidentiality of member information. The Privacy Office maintains policies that require safeguarding of PHI and minimum necessary use of PHI, and limit use and disclosure of PHI to those purposes permitted under applicable law. In addition, employees are required to promptly report any potential unauthorized use, access, or disclosure of PHI to the Privacy Office.

The Privacy Office ensures all potential privacy incidents are thoroughly researched and investigated. If an issue is determined to be substantiated, the Privacy Office ensures that the appropriate corrective actions are taken to prevent future occurrences, and ensures steps are taken to mitigate any harm, to the extent possible. In addition, depending on the nature of the incident, notifications may be sent to the client, member, or regulatory authorities. Such notifications are made in accordance with applicable law and the terms of the client contract.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.24. Describe Respondent's encryption technology and the application of this technology to ensure that all client data is secured (e.g., tapes, encryption, cloud-based technology, etc.).

- HealthSelect PDPs

When transmitting personal information, Express Scripts requires 128-bit transport layer security (TLS) connections for access to protected health information (PHI) available via the Client and Consumer Web Applications. Express Scripts also requires that eligibility data submitted via the Internet be encrypted to protect against interception and also facilitates secure email transmission of data using TLS or routing via virtual private network (VPN) connection. Encryption controls are documented in Express Scripts' Encryption Security Standard, managed by Information Technology (IT) Infrastructure staff, and regularly audited by Information Risk Management and Internal Audit.

On laptops and desktops, Express Scripts utilizes full-disk encryption. Full-disk encryption protects against the loss or theft of the entire device. Express Scripts also encrypts removable media such as CDs, DVDs, and USB drives when permitted to be used. Express Scripts' policies require that employees request a policy exception if they have a business need to write to portable devices. All exceptions are managed by Information Risk Management.

To meet the requirements of the payment card industry (PCI) data security standard (DSS), Express Scripts encrypts card data that is stored in the Member Accounts Receivable databases. Additionally, all password data is encrypted in storage and transit.

## Encrypting Backups and Portable Media

All non-public data leaving Express Scripts' custody (including data on laptops, portable storage media, CD, and DVD drives; tapes, retired, or defective hard drives; employee or corporate mobile phones; and tablet computers, for example) must either be encrypted using approved methods (currently Advanced Encryption Standard [AES]-128 or above, or Triple Data Encryption Standard [DES] in cipher block chaining [CBC] mode), or cleared in compliance with current Industry guidelines, such as NIST 800-88 or Department of Defense (DoD) 5220.22-M standards.

## Email Routing and Encryption

Express Scripts supports several industry-standard solutions to secure Internet email containing PHI with business partners, all of which are fail-safe and transparent to the end-user. These secure methods ensure that email messages between Express Scripts and ERS are encrypted while in transit over the Internet using industry-standard encryption mechanisms; therefore, messages and their contents are invulnerable from being revealed to third parties. The fail-safe nature of the transmission ensures that if the encryption mechanisms are inadvertently disabled, the messages will not be transmitted and a "failure-to-send" notification will be transmitted to the sender. Neither the sender nor the recipient needs to take any action to secure their messages — the emails are automatically secured.

Our secure email options are detailed below:

- Transport layer security (TLS) — TLS between gateways, the successor to secure sockets layer (SSL), is used to secure all email messages passing over the Internet between email gateways. This method requires ERS to have an Internet email gateway that supports TLS. Most modern mail gateways include TLS support; however, it may need to be enabled or licensed.

- Internet security (IPSec) virtual private network (VPN) — IPSec VPN between VPN gateways is the standard for securing Internet Protocol traffic. This method requires ERS to have a VPN gateway that supports IPSec. This gateway could be a dedicated VPN appliance, a firewall, or a router with IPSec VPN capability.
- Secure Web Delivery — Express Scripts has developed Secure Web Delivery capabilities via PostX. This system utilizes a "send secure" option, which encrypts messages to external parties when selected by the sender.

Our preferred encryption technology is TLS encryption (server to server), followed by IPSec VPN, then Secure Web Delivery. We will work with ERS to determine the most appropriate transaction methods.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.25. Does Respondent have a formal information security program in place? ☒ Yes ☐ No

D.25.a. Respondent shall provide a copy of Respondent's formal Information Security Policy.
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

D.25.b. Respondent shall provide a full description of how it monitors compliance with Respondent's Information Security Policy.

- HealthSelect PDPs

Express Scripts engages in numerous activities to ensure compliance, including:

- Client and CMS audits — Corporate Compliance works closely with the Client Audit department to determine if any deficiencies are noted by government agencies or clients.
- Employee training — To properly communicate applicable legal compliance duties to all employees, the compliance training program covers such topics as the Health Insurance Portability and Accountability Act (HIPAA); Medicare Part D; and fraud, waste, and abuse.
- Follow-up procedures — After implementation of a corrective action plan to resolve compliance issues, follow-up reviews are conducted to verify the corrective action plan functions as intended.
- Internal compliance audits — Audits monitor compliance with pertinent policies and procedures as well as applicable legal requirements.
- Investigations — Based on available resources and the type of investigation, these are conducted either by the Ethics department or in conjunction with key business partners, including Human Resources, Legal, Finance, or Internal Audit.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

D.25.c. Are employees required to periodically confirm their compliance with Respondent's Information Security Policy, including the information security procedures and standards?
☒ Yes ☐ No

D.25.d. If the answer to the preceding question is “yes,” Respondent shall describe the policy intended to enforce periodic confirmation by employees.

- HealthSelect PDPs

  Express Scripts’ entire workforce is required to complete corporate HIPAA training upon first hire and annually thereafter. The training covers many aspects of privacy compliance including reviews of our policies on the Use and Disclosure of PHI, our policy on Minimum Necessary, our clean desk policy, and various scenarios related to the appropriateness of sharing confidential information.

  Express Scripts’ entire workforce is required to complete corporate Information Security training upon first hire and annually thereafter. Reminders and awareness on Express Scripts’ privacy, information security, and data protections policies are all included in Express Scripts’ mandatory new hire Standards of Business Conduct training, mandatory annual Compliance Update training, and mandatory Compliance Update for Contingent Workers.

  In addition, based on the specific job functions that a department performs, department-specific training is regularly performed. The areas that deploy department-specific training include account management, customer service, and our correspondence areas.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  The Compliance Department conducts and facilitates various forms of training both within and outside of the company. All Cigna employees and contractors are required to complete Code of Ethics and the Health Insurance Portability and Accountability Act (HIPAA) Privacy training within 15-days of hire and annually thereafter. This training includes information on key Cigna compliance policies, an overview of the Code of Ethics and Principles of Conduct, key healthcare laws and regulations, and HIPAA privacy and security requirements. Cigna also provides Centers for Medicare & Medicaid Services (CMS) General Compliance and Fraud, Waste, and Abuse (FWA) training to our downstream entities. The General Compliance Training includes an overview of the seven elements of an effective compliance program and how to recognize and report suspected or confirmed non-compliance. The FWA training includes information on the laws and regulations related to FWA, examples of FWA, and methods for reporting known or suspected FWA. The General Compliance and FWA training must be completed within 90 days of hire and annually thereafter. Completion of these training requirements is a condition of employment or engagement as a contractor.

D.26. Does Respondent have a user awareness campaign related to information security?
☒ Yes ☐ No

D.26.a. If the answer to the preceding question is “no,” Respondent shall enumerate and provide a detailed description as to why not.

- HealthSelect PDPs

  N/A

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

D.27. How does Respondent protect the privacy of Program-related data? Respondent shall provide a detailed description.

- HealthSelect PDPs

In addition to being in full compliance with the standards established by the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule and the HIPAA Security rule, Express Scripts' stringent corporate policies, procedures, and guidelines help ensure the practical prevention of data loss.

The specific safeguards we employ ensure patient confidentiality and privacy are discussed below.

## Privacy and Data Use Policies

We have adopted policies requiring employees to safeguard protected health information (PHI) at all times. These policies address areas such as system access controls and protections, mobile end-user devices, and use of the minimum PHI necessary.

- Role-Based Access to Confidential Information
- Protection of Electronic PHI
- Training - Express Scripts' entire workforce is required to complete corporate Information Security training in addition to corporate HIPAA training upon first hire.
- Privacy and Data Protections Awareness - Express Scripts engages in extensive awareness programs to ensure our workforce fully understands their privacy, security, and data protection responsibilities.
- Guidelines for Laptops and Handheld Devices
- Steps to safeguard your laptop and handheld device
- Keeping your information secure when you take it on the road
- Privacy and security guidelines for working away from your office
- Data protection guidelines
- Encryption —we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.
- Storage devices — writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.
- Work at home protection — Express Scripts supports a virtual workforce and to ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. The network communication between our data center and an employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.
- Copying and transport of PHI — Cigna Corporation has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

## Data Loss Investigation Protocols

We are committed to protecting the confidentiality of member information. The Privacy Office maintains policies that require safeguarding of PHI and minimum necessary use of PHI, and limit use and disclosure of PHI to those purposes permitted under applicable law. In addition, employees are required to promptly report any potential unauthorized use, access, or disclosure of PHI to the Privacy Office.

The Privacy Office ensures all potential privacy incidents are thoroughly researched and investigated. If an issue is determined to be substantiated, the Privacy Office ensures that the appropriate corrective actions are taken to prevent future occurrences, and ensures steps are taken to mitigate any harm, to the extent possible. In addition, depending on the nature of the incident, notifications may be sent to the client, member, or regulatory authorities. Such notifications are made in accordance with applicable law and the terms of the client contract.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.28. Of those identified above, outline the website security provided to ensure confidentiality of personally-identifiable information and nonpublic personal information, including what information is requested to confirm the identity of the user.

- HealthSelect PDPs

  Express Scripts is committed to protecting the privacy and security of consumers who use our Internet-based offerings and continues to improve our broad and comprehensive set of controls to protect patient data confidentiality and integrity.

  As described below, our website addresses security across the entire transaction process — from our internal technology infrastructure and transmission across the Internet.

  ### Internal Infrastructure

  Express Scripts' Internet-accessible systems are located in a firewall-protected demilitarized zone (DMZ), which isolates them from both the Internet and the internal Express Scripts network. Web application firewalls (WAFs) have also been deployed in active blocking mode to protect our Internet-facing web applications. These firewalls monitor and prevent more sophisticated attacks on member data, such as structured query language (SQL) injection or cross-site scripting.

  Express Scripts performs vulnerability scans on a monthly basis against the systems in the Internet-facing infrastructure. In addition, our internal security experts penetration-test all Internet-facing applications at least annually. Express Scripts also engages an expert, independent third party to test our network, member, and client website applications. Our centralized, security event logging and monitoring program includes monitoring by a third-party security service. Through our internal team and managed security service partner, we monitor critical logs 24 hours a day, seven days a week for key security devices and appliances, including, but not limited to, our WAFs, intrusion detection/prevention systems, and critical server logs.

  ### Transmission Across the Internet

  For protection of information in transit, Express Scripts requires 128-bit secure sockets layer (SSL) connections for access to protected health information (PHI) available via the client and member web applications. Express Scripts also requires that eligibility data submitted via the Internet be encrypted to protect against interception, and facilitates secure email transmission of data using transport layer security (TLS) or routing via virtual private network (VPN) connection. Encryption controls are documented and managed by information technology (IT) infrastructure staff and are regularly audited. Express Scripts has documented file transfer options and procedures for sending data to third parties. Exchanging information with Express Scripts can be accomplished using different tools and is dependent on each client's individual needs and volume of data.

## Member Website

Express Scripts is firmly committed to protecting the confidentiality of members' personal and medical information. When members enroll in an Express Scripts service, we request only the information required to meet their needs. Our rigorous practices and policies safeguard member information.

Members create a user name, password during the member website registration process, which requires correct knowledge of member benefit plan information and other indicative data before associating online enrollment with a member's account such as member ID, first name, last name, date of birth, ZIP code, and email address. Members must view and agree to an Internet User Agreement and a Notice of Privacy Practices. They have the option to view a Privacy Promises policy as well as complete an email preferences page. After registration, we send members a confirmation email.

We continue to improve our broad and comprehensive set of controls to protect patient data confidentiality and integrity, which include:

- User Account lockout functionality that prevents any intruder brute-force attacks after multiple failed attempts
- Members' ability to select passwords with the level of complexity that most suits each member's ability to secure and recall the password. Passwords must be at least 8 characters in length with a max length of 127 characters and you can't reuse your current password when changing. Passwords of 20 characters or less require complexity (upper/lower, special characters, etc.) Passwords of more than 20 characters do not require complexity.
- Prohibiting use of commonly used passwords to prevent a password that could be guessed
- A password strength meter, which has increased voluntary use of stronger passwords

The member website offers technical help 24 hours a day, 365 days a year for issues such as password resets for forgotten passwords. Members can reset their password by clicking on "Need help logging in?" on the homepage. The member must enter their user name. An email is sent to the user's email address containing a link to reset the password. User names and passwords can also be reset by contacting web technical support.

## Mobile App

Registered members log in to the member website and the mobile app using the same credentials. The mobile app automatically logs a member out after 15 minutes of inactivity. Members can elect to save their user name, but their password must be entered each time they log in and log in with their password or biometric identifiers (fingerprint or face). All app communications take place via https to ensure security. The only instance in which data is saved to the device occurs when the patient sets up reminders, for example for refills or dosage times. In this case, the data is encrypted with 256-bit advanced encryption standard (AES) encryption.

## Client Website

Express Scripts protects the privacy and security of member data when users access the client website. Our electronic systems are designed in accordance with regulatory requirements and company policies regarding secure and confidential access to healthcare data.

Client website utilization is protected through the following measures:

- Access is allowed only through a secure channel, such as a VPN ("strong" authentication) or with the use of SecureID tokens (two-factor authentication).
- Data is encrypted during transmission.
- User IDs and passwords are provided through an internally administered registration process.
- Access to specific functionality and data are further controlled through client website roles and variances.
- User support for the client website is provided only after a user correctly answers a unique user validation question.

Additionally, the Terms of Use agreement posted on the client website requires users to abide by processes and safeguards to appropriately protect member confidentiality.

## Privacy Policy and Terms of Use

In addition to using the best security technology available, Express Scripts' client and member websites adhere to a comprehensive Privacy Policy. To access and use our secure member website, members must acknowledge our privacy policies regarding disclosure and use of information. Additionally, our client website adheres to Terms of Use agreements posted on the website for user review.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

## E. Interrogatories – Business Resumption and Data Center Facilities Requirements

E.1. Respondent shall describe how Respondent's services provided to ERS can withstand common business and information system's continuity challenges.

We have established a comprehensive Business Continuity program that can quickly and effectively respond to crisis, emergency, or disaster events that have the potential to cause disruptions of normal business operations. The programs provide internal support and oversight that identifies potential impacts that threaten the organization. The programs utilize industry best practices and continue to improve and mature in order to meet the needs of a growing and successful company. The key foundational components of our Business Continuity program include both Business Continuity and Crisis Management. We also support other work groups whose work is related to our own Business Continuity mission, such as Disaster Recovery and Risk Management.

The Business Continuity (BC) program documents the coordination of safety, continuity, and/or recovery responses to disruptions ranging from minor to major. The BC program focuses on four key areas of recovery: People, Operations, Facilities, and Technology.

The primary emphasis of the programs includes:

- Ensuring employee safety and welfare
- Initiating emergency response
- Providing uninterrupted service to clients and members affected by an incident
- Communication with employees, clients, members, providers, and other stakeholders
- Assessment of any damage that impacts the resumption of normal business
- Recovery of business functions following a disruptive event

Business Continuity Plans are maintained in an enterprise-wide web-based business continuity management system that is available through the internet with appropriate security.

Business Continuity (BC) Governance

Business Continuity is overseen within the Enterprise Risk Management area, reporting up to the Chief Risk Officer. The Enterprise Business Continuity team is comprised of dedicated certified Continuity Planners who interact with designated employees in each of our business areas. This team oversees the entire BC planning process, which includes the annual completion/updating of the Business Impact Analysis and recovery plans, and validating/implementing approved recovery strategies. Annually, the program submits an update to our Board of Directors. We also have an established Governance and Steering committee in place to help guide and support the decisions of the Business Continuity Program.

Governance Committee

The Governance Committee provides the overarching direction and strategy for our Business Continuity program. Meeting cadence is annually and as needed when decisions are required.

Roles and Responsibilities include:

- Provide overall direction of program from an enterprise strategy level, ensuring that risks to the enterprise are appropriately remediated where possible and mitigated where necessary
- Review Critical Process/Application/Site criteria to ensure that the criteria is in line with the overall strategy of the program

## Steering Committee

The Steering Committee provides the Business Continuity program support, as necessary, using their positions within the enterprise to accomplish program goals. The Steering Committee would also ensure accountability for program objectives. Meeting/update cadence is twice annually and individually as needed to ensure that the program is on track to achieve goals set forth by the Governance Committee.

Roles and responsibilities include:

- Provide support on business continuity activities when necessary, leveraging position within the enterprise to identify and facilitate program execution
- Ensure execution of the annual documentation and testing per the Governance committee's direction
- Review testing results to ensure validity and achievement of objectives

## DISASTER RECOVERY (DR) PROGRAM OVERVIEW

The company has established a comprehensive Disaster Recovery programs which can quickly and effectively respond to unplanned events and incidents which have the potential to cause disruptions of normal IT business operations. The program provides direct internal support with oversight which identifies potential technical impacts which threaten the organization. The program utilizes industry best practices and continues to improve, evolve and mature in order to meet the needs of a growing and successful company. The key foundational components of the companies DR programs include:

1. DR Governance
2. DR Plan Management
3. Datacenter Recovery Strategy testing and Implementation

The DR program is strategically designed to:

- Mitigate or reduce risk to prevent and/or diminish the impact to business operations following a disruptive event
- Continue to meet obligations of company clients
- Comply with Health Insurance Portability and Accountability Act (HIPAA) regulations
- Comply with the Sarbanes-Oxley act of Congress
- All other compliance and regulatory requirements

The primary emphasis of the programs includes:

- Recovery of business functions and/or technology following a disruptive event

## Disaster Recovery Governance

The governance of the Disaster Recovery program is managed through policies and standards which represents the multiple controls and contractual requirements making up the compliance and regulatory oversight. Falling under the umbrella of "Enterprise Business Continuity," health of the DR program and annual assessments/tests are communicated through the "Governance" and "Steering Committees" under the BC program oversight.

## Crisis Management

In the event of a crisis, whether a man-made, natural disaster or epidemic/pandemic, our Corporate Crisis Team, led by the Global Business Continuity Officer, will gather to centralize decision making while managing the response and restoration to normal operations. The team is comprised of senior leadership across the enterprise from different critical areas, such as Human Resources, Communications, Legal, Privacy, IT, Security, Risk, and many others. Crisis Team members participate in annual mock disaster exercises.

During a crisis, the Corporate Crisis Team may take steps to ensure client and member access to benefits, including, but not limited to, policy changes, suspension of requirements, and activation of additional services as necessary.

On a daily basis, the Business Continuity Team monitors weather and events that could interrupt critical business processes and/or impact clients, members, employees or facilities. Depending on the event and the potential impact, the Business Continuity Team engages Crisis and Operational response teams as necessary to manage the event to closure.

Crisis Management playbooks are created for major events that may impact the company, members, clients or stakeholders and are stored in a library for future use. The playbooks identify tasks to coordinate and execute recovery efforts during a crisis situation. These checklists are reviewed and revised on a scheduled basis but following any event and playbook usage, lessons learned are documented and playbooks are revised accordingly.

### Crisis Communication

All client communications would be at the direction of the Corporate Crisis Team and channeled through appropriate account executives.

Crisis communications are created by Communications and additional workgroups as necessary and include:

- Communications to Employees
- Communications to Patients, Providers, Retail Pharmacies, and Clients
- Communication to Media and Stockholders
- Communications to Vendors/Service Providers

E.1.a. Respondent shall describe how ERS' data, including backups, are maintained and stored in a secure facility. Respondent shall also describe the facility where ERS' data is stored.

All claims are backed up daily and are reconciled with our primary system.

Express Scripts' primary data center is located in Piscataway, New Jersey, and our secondary recovery data center is located in Elk Grove Village, Illinois. Express Scripts leases space at our data center properties; however, we own and operate all of the systems in our data centers. Additionally, we manage entry into the data centers, where only Express Scripts employees and a few critical site facility personnel have access. QTS Realty Trust, Inc. manages our primary data center in Piscataway, New Jersey and Digital Realty Trust, L.P. manages our backup data center in Elk Grove Village, Illinois. Our co-located data centers maintain SOC 2 compliance for the environmental and physical security controls they provide.

We perform daily, incremental backups of our Production network (Piscataway) to our Secondary site (Elk Grove Village) and weekly full backups, using our electronic Vaulting Tape Library System. This is performed entirely on our internal private and encrypted network. The virtual tape library system eliminates the risk of physical tapes. All data is stored on protected databases, requiring properly authenticated access. The use of Data Loss Prevention technology monitors, and blocks, the movement of bulk data.

**Data Center Facility**

E.2. Describe who has physical access to Respondent's data center facility and how the access is monitored.

Express Scripts leases space at our data center properties; however, we own and operate all of the systems in our data centers. Additionally, we manage entry into the data centers, where only Express Scripts employees and a few critical site facility personnel have access. QTS Realty Trust, Inc. manages our primary data center in Piscataway, New Jersey and Digital Realty Trust, L.P. manages our backup data center in Elk Grove Village, Illinois. Our co-located data centers maintain SOC 2 compliance for the environmental and physical security controls they provide.

### Physical Security Procedures

Cigna Corporations' facilities have strict identification and access protocols for employees and visitors, including:

- All persons are required to visibly display their access badges
- Facilities are monitored 24 hours a day
- Cigna Corporations' facilities commonly use closed-circuit television, video surveillance, badge access, alarm systems, and security personnel

In addition to technical controls, we maintain corporate security policies that guide our security efforts. These policies are communicated to the Cigna Corporation user community.

### ID Badges

Each employee has a responsibility to assist in maintaining the building and company security. To protect the security of Cigna Corporation personnel, information, and buildings, we issue ID badges to all employees, visitors, consultants, and temporary employees. These badges must be worn and visible at all times while in the building. All Cigna Corporation locations require ID badges for admittance into the building.

E.3. State the location (city and state) where Respondent's primary data center is located.

Express Scripts' primary data center is located in Piscataway, New Jersey.

E.4. State the location (city and state) where Respondent's duplicate or backup data center is located.

**Our secondary recovery data center is located in Elk Grove Village, Illinois.**

**Backup Data Files**

E.5. Describe the facility where Respondent maintains Respondent's duplicate or backup computer data files. Respondent's description should include information regarding Respondent's environmental and access controls.

**Express Scripts' primary data center is located in Piscataway, New Jersey, and our secondary recovery data center is located in Elk Grove Village, Illinois.**

E.5.a. Are Respondent's duplicate and backup data files encrypted? ☒ Yes ☐ No

E.5.b. If the answer to the preceding question is "no," Respondent shall provide a detailed description as to why not.

**N/A**

E.6. Does Respondent use at least 256-Bit symmetric key AES encryption standards for backup media? ☒ Yes ☐ No

E.6.a. If the answer to the preceding question is "no," Respondent shall provide a detailed description as to why not.

**N/A**

**Backup System**

E.7. Provide the names and a description of the backup hardware and software systems that Respondent will use to fulfill the Contract.

**Express Scripts considers the name of our backup systems proprietary and confidential. It is our policy that all data, applications, databases, and operating system files identified via an automated change task request or manual ticket submitted will be backed up with the ability to support recovery the entire server back to its original state from the backup systems. Backups are run once every night.**

E.8. Provide Respondent's internal business service names that ERS will use as part of this Contract. Provide the linkages to these internal business service names to the associated information technology applications and information technology infrastructure which is tested annually in disaster recovery exercises, COOP exercises and tests.

**Express Scripts' client portal, the Control Center℠, is a portal that is a single point of entry for all ERS's applications, improved security and authentication features, a reporting center, and more, all developed and based on researched data for what you want and need to simplify your benefit administration.**

**Control Center URL: https://www.controlcenter.com/**

**ERS' members will have access to the member website, along with the Express Scripts mobile app, that provides ERS's members with a personalized experience every time they log in.**

**Member URL: express-scripts.com**

Disaster Recovery

The disaster recovery team has developed a testing methodology and employs a range of exercise strategies to validate enterprise recovery strategies at least annually. Disaster recovery plans for applications and systems identified through the BIA process are tested annually and during the exercise any issues and gaps are identified and either mitigated or tracked for remediation to ensure preparedness and continuity for our company. Any situation which deviates from the documented plan is either addressed during the exercise or it is tracked for remediation.
Categories of exercises that disaster recovery uses or can be involved in are outlined in the table below:

| Exercise Type | Primary Participants | Definition |
|---|---|---|
| Walkthrough | DR Plan Owner(s), SMEs | Validate process and components of documented DR Plans |
| Tabletop | DR Plan Owner(s), Supporting Area Alignments | Discuss simulation of implementing documented DR Plans & Staff Preparedness for crisis events |
| DR Exercise | DR Plan Owner(s), Technology Recovery Teams, Technical Product Owners (TPO) | Validate components of documented DR Plans by executing recovery testing of applications/components |
| Crisis Response | Site and Operational Crisis Response Teams | Validate components of documented Crisis Response Playbook which may include a Disaster Recovery scenario |

E.9. Briefly describe Respondent's data backup and recovery procedures for the system(s) to be used in the services proposed to ERS. Respondent's response must include the platform and media used for backup and record restoration processes.

The goal of the Disaster Recovery (DR) Planning program is to respond to a catastrophic event impacting a production data center. The DR technical recovery plan identifies steps to stabilize and restore the organization's critical systems and technical environment. The plan addresses recovery of critical technology facilities, technology systems, applications, supporting security software and telephony systems. The plan defines the resources, actions, tasks, equipment and data required to manage the technology recovery effort. DR Planning is a component of the overall (BCP) Business Continuity Contingency Plan, which describes how to recover and restore technology, to operation, if it is interrupted or destroyed, by an unplanned incident or event.

Data center locations are geographically disbursed to provide physical separation, continual application access, and critical data availability.

System and Application Data — The process for data backups includes:

- Full or incremental backups of member information, client and relevant data are performed daily; additionally disk replication and or virtual tape replication between the production data center and secondary recovery data center sites. Multiple generations of data backups are retained to minimize data lost in the event of a disaster through data retention requirements.
- Production servers, with the use of backup data, are fully recoverable.
- Backups are reported on and audited, allowing for any exceptions to be identified and corrected

- System and database files are replicated to the secondary recovery site, ensuring security and recoverability of the data if needed for recovery.
- Software tools such as Fast Dump Restore (FDR), EMC Avamar, EMC Data Domain, EMC Networker, Symmetrix Remote Data Facility (SRDF), and Data Facility Data Set Services (DFDSS) are used on a daily basis to backup and replicate critical data for recovery of the system infrastructure and data.

*Network* — Network architecture is designed so entire portions of the system can be shut down without impact to production. The company contracts multiple carriers and can re-route traffic to maintain connectivity. Multiple carriers also provide internet feeds, and sites are connected through redundant network links.

- As part of our overall commitment to BCP, we test each unique recovery solution at an enterprise-wide level at least annually. Specific business recovery strategies include:
  - Alternate Site: Many of our worksites have excess space and network capacity that can be used by personnel from a worksite that is affected by a disaster and/or permanent Work At Home staff in the vicinity as needed. Clinics are considered sites for the purposes of this strategy.
  - Augmented Staffing: To provide additional resources, staffing can be augmented in a number of ways such as: additional staff is/will be cross-trained to perform tasks outside of their day-to-day duties, new or temporary staff can quickly be on boarded, and/or support staff can provide additional resources for periods of increased workload (i.e. delaying managerial tasks to allow supervisors to assist with work volume).
- System Levers: Changes to processes and procedures can free up additional work resources for a set time period.
- Third Party Work Area Recovery: We maintain a 'hot site' and 'mobile trailer' recovery contract with a recognized third party recovery vendor for alternate workstations for our employees. These solutions are tested annually with live calls and data.
- Overtime: Overtime will be offered to employees and/or vendor staff to ensure work does not fall behind.
- Work at Home (WAH): We have an increasing number of staff who work from home on a full-time basis. In addition, many of our employees use work at home technology on a part-time/casual basis. These employees can work from home, using company provided technology to make their secure connections to our data centers.
- Workload Shift/Balance: The majority of our business processes are performed at multiple worksites, including Work at Home, allowing for the easy transfer of work to unaffected staff. This includes service operations load-balancing capabilities that allow calls, emails, and claims to be rerouted in the event of heavy volume or closings brought about by severe weather or emergencies.

More specifically, concerning our Pharmacy Operations/Home Delivery Distribution operations, Express Scripts' home delivery pharmacies provide complete back-up/contingency and redundant capabilities in the event of a disaster at any pharmacy site. Order routing capabilities allow the dispensing of medication at an alternate pharmacy in the national network. In the event of a failure at one home delivery pharmacy, prescription information is easily routed to other pharmacies for fulfillment without significant processing interruption. Express Scripts' dispensing process allows automatic sorting and isolation of packages by destination zip code or shipping carrier, facilitating alternate delivery methods. Express Scripts maintains relationships with several shipping carriers, reducing shipping carrier failures. The shipping carriers work closely with Express Scripts during a natural disaster such as a hurricane, flood and wildfire to determine alternate delivery or pickup locations, minimizing delivery disruptions.

Retail claims adjudication — The claims adjudication system combines data sharing and parallel computing with system clustering to share the claims workload for high performance and high availability. Recovery of claims adjudication is tested annually to ensure recovery requirements, including the Recovery Time Objective, and procedures remain current and valid.

Contact Center operations — In the event of a disruption at a Contact Center, calls can be readily routed to an alternative site. Call routing assures uninterrupted service to members in the event of a disaster at a site.

E.9.a. Describe the architecture, technology and procedures which ensure immutability of Respondent's backup files, including from internal security attacks and undetected security breaches.

Data center locations are geographically disbursed to provide physical separation, continual application access, and critical data availability.

System and Application Data — The process for data backups includes:

- Full or incremental backups of member information, client and relevant data are performed daily; additionally disk replication and or virtual tape replication between the production data center and secondary recovery data center sites. Multiple generations of data backups are retained to minimize data lost in the event of a disaster through data retention requirements.
- Production servers with the use of backup data, are fully recoverable.
- Backups are reported on and audited allowing for any exceptions to be identified and corrected
- System and database files are replicated to the secondary recovery site, ensuring security and recoverability of the data if needed for recovery.

Network — Network architecture is designed so entire portions of the system can be shut down without impact to production. The company contracts multiple carriers and can re-route traffic to maintain connectivity. Internet feeds are also provided by multiple carriers, and sites are connected through redundant network links.

The following describes our process for detecting and responding to information security breaches.

Intrusion Detection

Express Scripts uses a combination of signature-based and behavior-based intrusion detection systems (IDS). Signature-based systems are monitored 24 hours a day, seven days a week by a third-party security operations center. Suspicious activity is escalated to Express Scripts' Incident Response team, which investigates all potential security incidents. Behavior-based IDS monitors network traffic between hosts, allowing the Incident Response team to identify hosts that may be infected through anomaly detection.

## Notify Appropriate Contacts

The incident coordinator notifies:

- Information Technology (IT) management and personnel whose involvement is required for resolution of the incident. For example:
    - Security incidents must involve members of Information Risk Management.
    - Windows server incidents must involve members of Windows Servers.
    - Windows desktop incidents must involve members of PC Services.
    - Unix OS incidents must involve members of Unix Administration.
- Call trees are in place for all potential impacted areas.
    - Facilities Management, if the incident involves an environmental failure or disaster.
    - Network Engineering, including the Network Operations Center, if the incident affects network operations.
- Our Internet Service Providers, if the incident affects them.
    - As appropriate, management notifies:
    - Executive management
    - General counsel
    - Chief privacy officer
    - Human Resources
    - Sales and Account Management

## Assemble Incident Team

The incident coordinator assembles an incident team to perform necessary investigation and recovery operations. The composition and size of the team depends greatly on the nature of the incident.

The incident team meets with the incident coordinator in the incident command center.

The incident coordinator may reclassify the incident at any time, which may also require naming a new incident coordinator or incident team. For example, in the case of a fire, the resulting system damage must be addressed after the fire has been put out; this likely requires a different team.

Security Incident Containment Consult with Stakeholders

The incident coordinator must ensure that IT management, infrastructure, application, business owners, and other stakeholders know the current situation, especially any actions taken in the previous step to suspend operations on affected systems and isolate network segments, for example.

**Uptime Standards**

E.10. Does Respondent have formal Uptime Institute certification for Respondent's data center systems?
☐ Yes ☒ No

E.10.a. If the answer to the preceding question is "yes", Respondent shall provide a copy of Respondent's certification.
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

Express Scripts does not have a formal Uptime Institute certification; however, all physical infrastructure supporting the data center is architected and operated in accordance with the Uptime Institute Tier III (concurrently maintainable) standard.

E.10.b. If the answer to the preceding question is "no," does Respondent intend to obtain this certification in the next twelve (12) months?

No. Our data center is leased from a third-party co-location data center provider, and that provider does not plan to pursue formal certification within the next 12 months.

E.10.b.i. If Respondent does not have formal Uptime certification, Respondent shall confirm that all critical data center systems associated with providing power and cooling to information technology equipment maintained uptime of at least 99.982% within the last twelve (12) month period.
☒ Confirm ☐ N/A (Respondent has formal Uptime certification)

E.10.b.ii. What was Respondents uptime of Respondent's critical data center systems associated with providing network, power and cooling to information security equipment during any twelve (12) month period?

All critical data center systems which provide power and cooling to information technology equipment within the data center have delivered 100% uptime over the prior twelve months

E.11. Provide details regarding the redundant network links for internet access that Respondent has in place for Respondent's data center, including redundant last-mile connectivity and diverse physical data-center network penetrations.

Our data center has two separate internet providers on two separate lines traversing through opposite sides of the data center.

E.12. Except for scheduled change windows, what was the annual uptime of the systems and applications that will provide services to ERS during the previous twelve (12) months?

**The following table details electronic claims processing system availability, excluding scheduled maintenance windows.**

| Time Frame | Claims |
|---|---|
| June 2021 | 100.00% |
| July | 99.98% |
| August | 100.00% |
| September | 100.00% |
| October | 100.00% |
| November | 100.00% |
| December | 99.99% |
| January 2022 | 99.99% |
| February | 100.00% |
| March | 99.99% |
| April | 100.00% |
| May | 100.00% |

**The following table details Member Website and Client Website system availabilities, excluding scheduled maintenance windows.**

| Time Frame | Member Website | Client Website |
|---|---|---|
| June 2021 | 99.97% | 100% |
| July | 100.00% | 100% |
| August | 99.98% | 100% |
| September | 100.00% | 100% |
| October | 100.00% | 100% |
| November | 99.96% | 100% |
| December | 99.80% | 100% |
| January 2022 | 100.00% | 100% |
| February | 100.00% | 100% |
| March | 100.00% | 100% |
| April | 99.64% | 100% |
| May | 100.00% | 100% |

The following table details client-facing eSD and C360 system availability, excluding scheduled maintenance windows.

| Time Frame | eSD | C360 |
|---|---|---|
| June 2021 | 100% | 99.70% |
| July | 100% | 100% |
| August | 100% | 100% |
| September | 100% | 100% |
| October | 100% | 100% |
| November | 100% | 100% |
| December | 100% | 100% |
| January 2022 | 100% | 100% |
| February | 100% | 100% |
| March | 100% | 100% |
| April | 99.78% | 99.78% |
| May | 100% | 99.84% |

E.12.a. Describe how this was calculated.

System Availability calculation for the service period: Total expected uptime minutes minus total unexpected downtime minutes divided by total expected uptime minutes. Expected uptime is 24 X 7 less scheduled maintenance (every Sunday 2:00AM-6:00AM ET).

System Uptime is based on critical service errors defined as System down, operating as it is unusable or monitoring threshold breached.

E.12.b. What was the cause of the service disruptions in the last twelve (12) months?

During the past 12 months there were 17 events:

4 impacting claims adjudication

8 impacting member website

0 impacting client website

1 impacting eSD

4 impacting C360

The root causes are a combination of Configuration, Process and Procedures.

Subsequent to any unscheduled system downtime, we initiate an issue tracking process to ensure immediate attention throughout the organization. The problem management team works with key area owners to understand issue resolution, with emphasis placed on root cause analyses and preventive measures necessary to ensure that there are no repeat occurrences and that we capture the appropriate organizational learning. When necessary, we form a team of subject matter experts that utilizes Six Sigma methodologies to measure, analyze, improve, and monitor event solution.

**Disaster Recovery Plan and Test Results**

E.13. Respondent shall provide one of the following with Respondent's Proposal:

E.13.a. A copy of the disaster recovery plan and the disaster recovery test results that apply to the Programs' Services under this Contract. If a separate disaster recovery plan and disaster recovery test results apply to the HealthSelect PDPs and the HealthSelect Medicare Rx PDP, Respondent shall provide the requested documents that apply to all of the Programs. These shall include, but are not limited to: (a) the disaster recovery plans plus a description of the changes from the previous year's plans, if any; and (b) the exercise test results conducted within the last twelve (12) months of the disaster recovery and business continuity tests referencing the adequacy of these plans. Test results must include actual physical tests of all hardware and software systems which provide service to ERS – tabletop exercises are not permitted to show compliance with this requirement. Respondent must also include the Recovery Time Objective and Recovery Point Objective goals and actual RTO and RPO recovery results from the tests. If these are part of a SOC-2 Type II report, Respondent shall provide the portions of the report that refer to the normal, annual disaster recovery and business and continuity tests, plus copies of the service auditor's report. Respondent must agree to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Express Scripts does not provide RPO values; however, we have provided copies of disaster recovery plans and test results upon request.

E.13.b. Alternatively, if Respondent is not providing the information in Section E.13.a. above, Respondent must provide a summary of Respondent's latest disaster recovery tests results and a summary of Respondent's disaster recovery programs. Test results must include actual physical tests of all hardware and software systems that provide service to ERS – tabletop exercises are not permitted to show compliance with this requirement. Respondent must also include the RTO and RPO goals and actual RTO and RPO recovery results from the tests. For purposes of the RFP evaluation process, Respondent may be required to attest, by signature, that the disaster recovery tests will ensure that systems which Respondent uses to provide services to ERS will be available within X hours of outage and will experience Y hours of data loss (where X is the RTO and Y is the RPO). Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

## F. Interrogatories – SOC-2 Report Requirements

For purposes of the requirements below, if Respondent is not able to provide a SOC-2 Type II report, the report(s) shall meet the following criteria to be equivalent to a SOC-2 Type II report:

- Provide a description of controls provided by management of Respondent's organization and include the following: security, availability, processing integrity, and confidentiality and/or privacy;
- Be created by an independent third-party auditor;
- Attest that the controls are suitably designed and implemented; and
- Attest to the operating effectiveness of the controls over a minimum six-month period.

HITECH, FedRAMP or ISO 27001 certification as well as third-party audits of security controls for the services provided are acceptable. **SOC-1 reports are not equivalent reports.**

F.1. Provide a full, un-redacted copy of Respondent's most recent SOC-2 Type II report and results performed under SSAE18 or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit.

☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

Express Scripts performs a SOC 2 Type II assessment on an annual basis and can provide results to ERS as a contracted client. In lieu of the SOC 2 report, we are providing a copy of our HITRUST certification at this time.

F.2. If applicable, provide a copy of Respondent's sponsoring or parent company's most recent SOC-2 Type II report and results performed under SSAE18 or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit.

☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

Express Scripts performs a SOC 2 Type II assessment on an annual basis and can provide results to ERS upon receipt of ERS's request as a contracted client.

F.3. If any data centers, development, or data services are outsourced or subcontracted, Respondent shall provide copies of Respondent's outsourcers' or subcontractors' SOC-2 Type II report and results performed under SSAE18 or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP, including disaster recovery planning and testing, and data center facilities.

☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

We have provided our production data center and secondary data center report. For our standard subcontractors, Express Scripts assumes full responsibility of the work performed.

F.4. If Respondent, Respondent's parent or sponsoring organization, or Respondent's outsourcers or subcontractors, as applicable, conducts SOC-2 control audits with an external firm, identify the following for Respondent, Respondent's parent or sponsoring organization, and Respondent's outsourcers or subcontractors:

F.4.a. Identify if the firm is for Respondent, Respondent's parent or sponsoring organization, outsourcer or subcontractor, as applicable.

The firm listed below is for our parent company, Cigna.

F.4.b. State the name of the external firm.

PricewaterhouseCoopers LLP

F.4.c. State the address of the external firm.

6 Cardinal Way
Suite 1100
St. Louis, MO 63102

F.4.d. State the date(s) when the firm performed the audits.

November 1, 2020 through October 31, 2021

# Appendix M, Section C.1 File Interface Business Policy

Express Scripts executes an API-driven business platform for use by both our internal systems and those of our clients and partners. We will provide access to Express Scripts' information, business processes, and events to authorized parties wherever they are needed through a combination of REST-based APIs and industry standard interfaces (NCPDP D.0, NCPDP SCRIPT, HL7 FHIR, etc.). Our solutions have adopted several open standards, which help maximize the integration and efficiency of our technology and processes, including XML.

We have provided ERS with a link to our Developer Portal with additional information on our API protocols.

https://developer.express-scripts.com/api-overview

# Appendix M, Section E.10.a – Uptime Institute Certification

Per the option in the RFP, Express Scripts does not have a formal Uptime Institute certification; however, all physical infrastructure supporting the data center is architected and operated in accordance with the Uptime Institute Tier III (concurrently maintainable) standard. Our data center is leased from a third-party co-location data center provider, and that provider does not plan to pursue formal certification within the next 12 months. All critical data center systems which provide power and cooling to information technology equipment within the data center have delivered 100% uptime over the prior twelve months.

# APPENDIX N
# IMPLEMENTATION AND PROJECT MANAGEMENT REQUIREMENTS DEVIATIONS AND INTERROGATORIES

# APPENDIX N
# IMPLEMENTATION AND PROJECT MANAGEMENT REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answers **for both HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. If the responses specific to the HealthSelect PDP are different than those of the HealthSelect Medicare Rx PDP, Respondent shall describe those differences. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal (**Appendix Q**).

## A. Deviations – Implementation and Project Management Requirements

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Implementation and Project Management Requirements*** described in RFP Sections VII.A.1. – VII.B.2.

☐ Affirm ☒ Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of any Deviation between Respondent's response and these requirements:
Respondent's Requested Deviation Detail:
**A.3.a. During the Implementation Period, PBM will:**

**Acknowledge and agree that all communication materials dealing with the Implementation Period, including Participant communication materials, Call Center staff training materials, IVR, and website design are subject to ERS' review and approval.**

Confirmed, with the exception of proprietary materials such as internal training documentation.

## B. Interrogatories – Project Management Requirements

B.1. Describe how Respondent's Implementation Project Manager and Implementation Team proposes to work with the ERS Project Manager and implementation team.
**HealthSelect PDP:**
We are committed to working with ERS to facilitate a smooth transition during implementation. Our service model ensures you will have frequent, direct communication with your core implementation team, as well as close collaboration with experts in Express Scripts' operational areas as needed.

Our services are designed to be flexible to the needs of each individual client, and we will work with ERS to develop a customized project plan to accomplish your goals.

### Simplifying the Client Experience

ERS needs a PBM partner you can trust to manage the implementation process correctly and confidently, who will be a strategic partner flexible to your requirements.

Our implementation process clearly outlines client roles and responsibilities at the outset to:

- Make efficient, effective use of your staff's time
- Ensure we have the right info at the right time to implement ERS's benefits in line with your intent
- Receive appropriate, timely review and sign off of requirements to meet milestones in the project plan

We will partner with you to establish parameters for data onboarding, including file layouts, the definition of data fields, required and optional fields, processing rules, test data, and production data timelines, and method of data exchange if applicable. Then, we will work directly with your incumbent to transition the necessary files. Before receipt of test data and final file load, we will secure approval either from ERS or your incumbent, whichever is preferred. Finally, we will provide you with analytical and statistical reports to review the data and approve the output before loading the files into our production environment. Our support model will ensure that you have a clear insight into developments and milestones at the level and rate you prefer.

We have years of experience transitioning previous vendors' files to support point-of-sale deductibles, lifetime maximums, maximum out-of-pocket amounts, plan stop-loss processing, and consumer-driven health plan integration support. We will facilitate communication with your previous vendor to transfer historical records; thus, ensuring continuity of care and guaranteeing claims are not rejected for previously approved prescriptions subject to utilization management rules.

## Ensuring Predictability for Clients and Members

Above all, we understand that a successful implementation must result in a benefit that operates according to ERS's and its members' clear expectations. We've designed our implementation process to foster the most predictable healthcare experience for ERS and your members.

During the initial phase of the implementation, your seasoned implementation team will acquire important information about your current plan design, copay structure, drug formulary, retail network, and account structure. The team members will also work with you to complete a Benefit Intent Document, which captures additional important information about your current vendor.

After gathering all of the necessary, appropriate information, your implementation team will engage internal teams from across our enterprise to set up your benefit as intended. A robust project timeline will outline each task, and your implementation team will ensure project progress and keep ERS informed.

While our internal teams configure your benefit, your implementation team will ensure the transfer of your members' existing prior authorizations, open refills for home delivery and specialty prescriptions, claims history, and accumulators. We will analyze this information against our system to verify the benefit setup is accurate and validate that claims are processing correctly through our system. As needed, we will continue to reconfigure and test to ensure everything is working correctly.

We realize that transitioning your business to a new partner may seem daunting and complex. We are committed to working with ERS to create a customized implementation plan to ensure a simple, predictable, and successful transition for you and your plan participants.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.1.a. How will the individuals on the implementation team work together?
**HealthSelect PDP:**

Clients generally participate in an initial implementation kick-off meeting and three to four working sessions. Weekly status update calls are suggested to review the program and discuss any open issues. Additional meetings may be held to review program components and status. Each meeting will serve as a forum for information gathering and exchange, as well as an assessment of schedules and deliverables.

While our implementation project manager and account team will work together to ensure a smooth and successful transition, we have found that clients can help by carefully considering and confirming the following three crucial elements of the new benefit as early as possible in the implementation process:

1. Account structure and eligibility
2. Final plan design
3. Communication materials

Timely completion of the following tasks by ERS also helps to ensure a successful launch:

- Approval of:
- ID card layouts
- Final pharmacy network configuration
- Final contract
- Authority to obtain payer history files to fulfill claims processing and utilization review functions

ERS will also need to provide information regarding your relationship with the incumbent vendor after we become the benefit administrator. ERS will then inform the incumbent that, if members mistakenly send them new prescriptions, the incumbent should send the prescriptions, envelope, and check (if payment is by check) to the member.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.1.b. Which functional areas will be represented?
**HealthSelect PDP:**

As part of the implementation process, we will provide a designated implementation team, led by your two implementation project managers. Jointly, these project managers will identify critical operational, financial, and business issues related to ERS's unique requirements in both your HealthSelect PDP and HealthSelect Medicare Rx PDP and facilitate the implementation of these requirements for your pharmacy program. Your designated implementation managers will attend regularly scheduled status meetings (at least weekly) with ERS.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.1.c. If Respondent uses a specific approach or methodology, describe it.
**HealthSelect PDP:**

Your benefit is unique, and we are ready to deploy the specific customizations and enhancements required to serve your clients and members. Our implementation transition process is designed to accommodate the complexities of our clients' varying benefits, weaving together multiple operational work streams to ensure accurate, timely results.

Our proven implementation model encompasses five phases:

1. Scoping and Intent
2. Build and Configuration
3. Quality Assurance
4. Deployment
5. Go-Live Support

A high-level summary of the five phases is included below.

## Scoping and Intent

The Scoping and Intent phase formally begins with a kickoff meeting in which Evernorth provides ERS with an overview of the key aspects and milestones of the implementation. During this phase, we will work with you to clearly define the scope of your implementation program, including clarifying the requirements for each work stream. Evernorth and ERS mutually decide on a master schedule for future implementation meetings. Additional working sessions will be scheduled to capture your intent for the following areas:

- Account structure
- Benefits
- Clinical and utilization management
- Networks
- Formulary
- Eligibility
- Invoicing

## Build and Configuration

After we have defined the project scope, roles, and requirements, our internal experts begin the work of building out your program. Your implementation team will invite operational experts to weekly program-level meetings, where ERS will have an opportunity for direct insight into progress within each work stream. As needed, your team will schedule deep-dive meetings for detailed updates or discussions that need your input. The Build and Configuration phase includes:

- Defining requirements for file transitions, including claims history, prior authorizations, open refills, and accumulators
- Establishing communications and reporting requirements
- Configuring Evernorth's systems to support defined intent

Evernorth will work with ERS and your previous vendors during the implementation process to coordinate file transitions to ensure a smooth transition for you and your members as needed. Because of our many years of experience, we can work with any previous vendor to develop a mutually agreed-upon transition project plan. Other vendors in the PBM industry also use the standard layouts we use. Evernorth works closely with new clients to ensure the transfer of members' existing prior authorizations, open refills for home delivery and specialty prescriptions and claims history.

## Quality Assurance

Testing is crucial to a successful implementation. During the Quality Assurance phase, we test every unique component of your program to validate actual performance against your intent. If any discrepancy is identified, your implementation team will engage the appropriate work stream experts to remedy the issue and keep ERS informed through a transparent update process. We continue the test/solution cycle until every component works as expected. If ERS wishes to test certain aspects of your benefit in addition to our rigorous testing regimen, then ERS may do so by providing a test claims grid to your implementation team.

## Deployment

The Deployment phase begins at midnight on the effective date of your benefit. During this phase, we monitor your members' claims activity to validate that all components of your benefit are running smoothly. Your implementation team will remain on-hand in the event of any issues. As an example of our success deploying multiple complex implementations, on January 1st, our Operations Command Center, an enterprise-wide command center, stabilized all of our 355 new clients within the first two weeks of the new plan year. The Operations Command Center has consistently accomplished this for the past three years. We additionally offer designated "Red Hat" technical support resources to assist your users in adopting our systems and processes. This optional service is provided at no extra cost. This implementation phase is considered complete once we have validated your program against our proven cutover checklist, ensuring that the implementation has satisfied your high expectations.

## Go-Live Support

Finally, the Go-Live Support phase of the project spans the first-month post-go-live and can be adjusted based on your needs. Go-Live Support includes:

- Go-live meetings to address the daily status of implementation and address any concerns
- Claims monitoring
- The transition from the implementation team to the account team

Your highly-skilled implementation team is key to delivering a simple and predictable implementation process. We will meet with ERS to understand your culture and strategic requirements and identify opportunities and make recommendations to maximize efficiencies and achieve your goals. Your implementation team will monitor the joint implementation plan and provide weekly box reports and program-level logs for issues, risks, decisions, and changes. You can trust that your implementation team will handle any challenge without compromising value and effectiveness.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.1.d. How does Respondent work with the project management offices of its clients to communicate project activities (e.g., collaboration sites, meeting events, escalations, joint project monitoring tools, etc.)?

**HealthSelect PDP:**

Your designated cross-functional team will work hand-in-hand with you before, during, and after your big Day 1 after Go Live. The Express Scripts Implementation Team leads the onboarding of new clients: building relationships, gathering intent, and ensuring execution and accuracy.

Our standard go-live monitoring includes multiple daily calls and reporting for typically 2-4 weeks following the effective date, which is based upon meeting all stabilization/transition criteria. Most often, our clients choose at least daily meetings for the first two weeks post go-live. Our clients' comfort with our prior implementation results was demonstrated by reduced client meetings following the effective date. The Implementation Manager and virtual team around them are in constant communication with you and your account team, making the transition from implementation to ongoing service as seamless as possible for your entire membership. Below are a just a few examples of ongoing support.

- Our Sales & Account Management Optimization (SAMO) team continues to support our clients as an extension of the Account Team on an ongoing basis for the life of our relationship together, assisting with retention and growth, consultation, active participation and continuous improvement.
- Our Client Service Center (CSC) is a client facing group of specialists that partner closely with the Account Team to provide escalated, rapid response and resolution of member specific issues that may challenge our clients.
- The Medicare Strategist is your designated Medicare expert, assisting with CMS guidance/compliance, annual readiness, Star ratings, PBM oversight, audit, industry perspectives, CMS expectations, application and bid support.

We're excited to bring a great team and plan that showcases our experience, ensures you delivery excellence, and sets the tone for our partnership.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.1.e. How does Respondent coordinate project risks/issues with Respondent's clients (e.g., identification, communication, mitigation, tools, etc.)?

**HealthSelect PDP:**

Your implementation team uses a report card tool which communicates status, issues, risks, and mitigation steps.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.2. Describe the logistical issues and/or concerns from a project management perspective Respondent believes this project will face (e.g., location of Respondent's Implementation Project Manager(s) (offsite/onsite), resource team locations, communications, and subcontractors for printing or other outsourced services).

**HealthSelect PDP:**

In Express Scripts' experience, issues around member understanding and member inconvenience with respect to plan implementation can be most challenging. However, Express Scripts' effective implementation and member communication processes and in-depth action plans promote member understanding and convenience. This helps to mitigate implementation issues before they occur.

## Clear and Effective Member Communication

Express Scripts knows that a targeted communication plan with full customer service support is key to a successful implementation. Express Scripts will work closely with ERS to design targeted member communications that increase awareness of the new retail and home delivery pharmacy benefit and describe the specific steps to obtain maintenance prescriptions from the Express Scripts Pharmacy SM.

Our communications plan effectively informs and educates members regarding the new Express Scripts benefit program. Members receive a message announcing the new program, coverage effective date, and procedures to follow when using their new benefits. Messaging also reminds members of their Express Scripts Pharmacy benefit and includes materials that encourage the use of home delivery.

## Maximizing Member Convenience

Express Scripts' goal is to make the transition to the new benefit as simple as possible for ERS's members. In addition to our well-defined communication plan, Express Scripts enhances the members experience through:

- Online lookup of network pharmacies, drug information, and plan rules via the member website
- Fax-in capability for physicians
- Transmission of open refill files from ERS's prior vendor
- Dedicated toll-free number assigned to ERS for your members' calls
- Patient care advocate training specific to ERS's program at our Contact Center
- Convenient mobile app, which features valuable drug and pharmacy benefit information

## Working with ERS to Ensure a Smooth Transition

Express Scripts understands that the key to successfully implementing a new program and avoiding administrative challenges is to develop a clear and comprehensive understanding of ERS's unique business, service, and quality objectives prior to implementation. Express Scripts looks forward to working with ERS to assess your unique needs and develop a comprehensive implementation plan to address them.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.

☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.2.a. Provide an explanation of how these logistical issues and/or concerns are mitigated.
**HealthSelect PDP:**

In Express Scripts' experience, issues around member understanding and member inconvenience with respect to plan implementation can be most challenging. However, Express Scripts' effective implementation and member communication processes and in-depth action plans promote member understanding and convenience. This helps to mitigate implementation issues before they occur.

The following three examples illustrate breakdowns that occurred during implementation and the measures we took to rectify those situations:

- ID cards were mailed with Social Security numbers on them. As a result, we have added two new layers of quality assurance to prompt further review any time a nine-digit value is printed on the card.
- Retirees were not included on eligibility files, thus they experienced delays in receiving access to their benefits. As a result, we have added verbiage to the Eligibility Statement of Work (SOW) to specifically call out requirements around retirees and COBRA members, as well as the methods to receive eligibility for those members.
- An incorrect toll-free number was printed on member materials. As a result, all phone numbers must now be confirmed and tested prior to ID cards being printed and/or letters being mailed to ensure that the appropriate number is listed.

## Working with ERS to Ensure a Smooth Transition

Express Scripts understands that the key to successfully implementing a new program and avoiding administrative challenges is to develop a clear and comprehensive understanding of ERS's unique business, service, and quality objectives prior to implementation. Express Scripts looks forward to working with ERS to assess your unique needs and develop a comprehensive implementation plan to address them.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.3. Based on Respondent's understanding of the projects' scope, does Respondent anticipate the need to make any system and/or process changes to accommodate ERS?
**HealthSelect PDP:** ☐ Yes ☒ No
**HealthSelect Medicare Rx PDP:** ☐ Yes ☒ No

B.3.a. What are Respondent's internal processes and timelines associated with making any changes during the Implementation Period, both anticipated based on scope understanding or identified during the Implementation Period?
**HealthSelect PDP:**

Your Implementation Project Managers will work with ERS to discuss any changes identified during the implementation period and determine the timeline associated with the change. The time needed to make a change depends on the type of change being requested. Simple changes can be made in as little time as same day; while complex changes may take more time to complete.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.4. Describe how Respondent's organization proposes to coordinate the activities and transfer of information between the Implementation Team and the Account Management Team following launch of the projects.

**HealthSelect PDP:**

Our experienced implementation team is successful in transitioning the majority of our clients to their account teams within four weeks after the implementation is complete. For larger clients, that process takes closer to eight weeks. The implementation team provides ongoing support to account teams to mitigate any issues and minimize disruption, ensuring a smooth transition. During the implementation process, members of the implementation team and the account team will assist ERS to educate your staff on the specifics of working with our company. We have a full team within the organization dedicated to assisting our current clients post implementation.

In order to shift ownership successfully, your account team will actively participate in the implementation process, attending calls and meetings to learn specific details about your needs as a client. The partnership between the implementation team and your account team will ensure smooth, ongoing management of your account post implementation. Your account team is always available, providing additional support as needed to keep ERS's staff informed of new developments and programs.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.5. Provide a description of the proposed Implementation Team structure and internal controls to be used during the Implementation Period, including any subcontractors.

**HealthSelect PDP:**

Every level of Express Scripts is eager and focused to service your account beyond your expectations, beginning at day one of implementation. As part of the implementation process, we will provide a designated implementation team, led by your implementation program manager. Your implementation team will identify critical operational, financial, and business complexities related to ERS's unique requirements across all products and lines of business and facilitate the implementation of these unique requirements for your pharmacy program. Additionally, your implementation team is supported by a range of operational experts, all of whom have experience in transitioning plans of ERS's size and scope.

Our implementation process clearly outlines client roles and responsibilities at the outset to:

- Make efficient, effective use of your staff's time
- Ensure we have the right info at the right time to implement ERS's benefits in line with your intent
- Receive appropriate, timely review and sign-off of requirements to meet milestones in the project plan

Your client service team, including Brian Fisher, your dedicated account manager, will also participate in the implementation process to ensure smooth, ongoing management of your account after implementation. Throughout the implementation lifecycle, your client service team will be engaged and provide additional support on an ongoing basis to keep your staff fully informed. Your implementation team will remain after go-live until all stabilization criteria are met to ensure a smooth transition to your client service team. Post-implementation, your implementation team will remain engaged as an extension of the client service team through the life of our relationship together.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.6. Describe Respondent's proposed plan to achieve SE/FE readiness. SE enrollment materials must be prepared no later than the first week of April each year and FE enrollment materials must be prepared no later than the first week of October of each year of the Contract Term. See RFP Sections V.A.10. – V.A.10.d. for more information.

**HealthSelect PDP:**

Each year toward the end of June, your account team will start discussions with you regarding 1/1 plan changes and annual open enrollment. In those discussions, you will communicate your goals for the next year regarding benefit design changes, new plan offerings, vendor changes (eligibility, CDH, etc.), and any other critical information that may impact 1/1 planning. From there, once your account team understands your needs, they will create and communicate a timeline with key milestones, driven largely based on the lead time required to implement and quality check your required changes and to develop the accompanying member support plan for annual enrollment.

To inform your members about their pharmacy benefits to prepare for annual enrollment decisions, we offer the following support that is customizable based on your needs:

- Coordination with your Navigation Vendor: We partner alongside you to coordinate with your navigation vendor and ensure that they have the details on each of your pharmacy plan offerings. We will also help train the representatives at your navigation vendor to ensure they are familiar with all the tools we offer to support members in making their benefits decisions, such as checking drug coverage or finding nearby participating pharmacies.
- Open Enrollment Website: We offer an open enrollment website that provides access during open enrollment and year-round for new hires and existing members. This website will include general information about Evernorth, a benefits overview for each of ERS's pharmacy benefit plan options, members' ability to locate an in-network pharmacy, and our price a medication functionality. Our price a medication functionality will allow members to look up medications they are currently taking and see what the price would be under the different plan options. Your open enrollment website can be co-branded with ERS's logo. It will come with a custom URL, which we can then share with your navigation vendor to ensure your members have direct access to the Evernorth open enrollment website from the navigation vendor's site.
- Benefit Fair Support: If ERS wishes to host a benefit fair for their employees to educate members on their benefits and upcoming changes before annual enrollment, Evernorth provides both virtual and in-person support. With an element of customization based on ERS's needs, a digital benefit fair video can be created to discuss topics including plan design, generics, our mobile app, and more. Additional digital resources are available, including videos and comprehensive, interactive fliers. When health and travel conditions allow, Evernorth can also staff in-person events with Evernorth representatives, adhering to guidelines in place that depend on the number of attendees. Our goal is to collaborate with ERS to ensure we have the right coverage, using our proven best practices and experience with like employers.
- Integrating with your Employee Communication Campaigns: All of our support above will be coordinated in partnership with you based on your internal employee communications plan to announce plan changes and distribute employee guidebooks to your members. We aim to ensure a seamless, personalized annual enrollment experience each year, and integrating with your full employee benefits communication plan is critical to that success.

Ultimately, our annual enrollment plan is highly flexible. Your account team will collaborate with you annually to determine the approach that works best for ERS, given the expected plan changes for that year and your members' preferences.

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.7. Does Respondent have a formalized project management office?
**HealthSelect PDP:** ☒ Yes ☐ No
If the answer to the preceding question is "no", then how does Respondent structure Respondent's project management services?
**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.8. Provide the name of the tool or solution Respondent will use to manage project activities.
**HealthSelect PDP:**

Your Implementation Project Managers will manage a project plan in either Microsoft Project or Microsoft Excel.

**HealthSelect Medicare Rx PDP:**
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

B.8.a. Is the tool or solution capable of exporting to Microsoft Excel?
**HealthSelect PDP:** ☒ Yes ☐ No
**HealthSelect Medicare Rx PDP:** ☒ Yes ☐ No

# APPENDIX O

## OPERATIONAL SPECIFICATIONS AND REQUIREMENTS DEVIATIONS AND INTERROGATORIES

# APPENDIX O
# OPERATIONAL SPECIFICATIONS AND REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answers **for both HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. If the responses specific to the HealthSelect PDP are different than those of the HealthSelect Medicare Rx PDP, Respondent shall describe those differences. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal (**Appendix Q**).

## A. Deviations – Operational Specifications and Requirements

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Operational Specifications and Requirements*** described in RFP Sections VIII.A.1. – VIII.F.1.

☐ Affirm ☒ Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of any Deviation between Respondent's response and these requirements:

Respondent's requested Deviation detail:

**A.7.b. ERS retains the right to check subcontractor's background or otherwise gather information regarding subcontractors to make a determination to approve or reject the use of a submitted subcontractor. Any negative information received may result in ERS' disqualification of the subcontractor.**
Confirmed with modifications; ERS may remove any ERS-exclusive subcontractors. For subcontractors serving multiple Express Scripts clients, however, Express Scripts reserves the exclusive right to designate and approve these subcontracted entities.
**A.7.c. ERS reserves the right to request the removal of PBM's subcontractor staff deemed unsatisfactory to ERS.**
Confirmed with modifications. Express Scripts will remove any ERS-exclusive subcontractor personnel, upon your request. For subcontractor personnel serving multiple Express Scripts clients, however, Express Scripts reserves the exclusive right to terminate these subcontracted personnel. Express Scripts will work with you to resolve any issues or concerns in a mutually agreeable manner.

**B.1.e.i. This support includes but is not limited to:**
**Providing machine-readable PDP claims files and posting them to the Programs' specific dedicated websites in adherence with federal and state pricing transparency laws; and**
Express Scripts does not offer machine-readable files.

**B.4.a. PBM shall make the final MBPDs for the HealthSelect PDP available on the GBP-specific website within five (5) business days of receiving approval by ERS. PBM shall follow ADA guidelines and provide a printable version for download by Participants.**
Confirmed with modifications. Express Scripts can provide links in the Benefit Notification section of the members' website as long as documents are received with approval in time to allow 5 business days. If documents are PDF, it is up to ERS to ensure documents are ADA compliant.

**B.5. HealthSelect Medicare Rx PDP – Evidence of Coverage. PBM shall be required to provide a proposed HealthSelect Medicare Rx PDP EOC to ERS each Calendar Year as follows: Once the PDP EOC has been reviewed by ERS and all edits made, the EOC shall be submitted to CMS for approval.**
Not confirmed. EGWP plans are not required to submit materials to CMS.

**PBM shall provide the ERS Group Benefits Division its finalized CY24 PDP EOC submitted to CMS, in Word or Excel format (PDF documents will not be accepted).**
Not confirmed. Express Scripts sends the EOC to ERS in Word during the review phase. Final documents are sent via PDF.
**PBM shall inform ERS in writing once the EOC has received CMS approval and provide the final CMS-approved version of the PDP EOC to ERS.**
Not confirmed. EGWP plans are not required to submit materials to CMS.

**B.5.a. The PDP EOC shall include a copy of the HealthSelect Medicare Rx PDP Schedule of Benefits, a complete list of limitations and exclusions, including all Program provisions and the CMS-approved Participant complaint and appeal process.**
Confirmed except for the Schedule of Benefits; Express Scripts provides a Benefit Overview as part of our prenotification and welcome packages.

**B.6. EOC Approval and Delivery Requirements. PBM understands, agrees and acknowledges that the Contract between ERS and PBM shall supersede the EOC in connection with the contractual relationship between ERS and PBM. The final approved PDP EOC for CY24 shall be published and reflected in PBM's live website within three (3) business days of CMS approving the document, but no later than November 15 prior to the start of each Calendar Year. Subsequent renewal years shall have the same requirements with the PDP EOC for each Calendar Year. See the PGs (Appendix G-2).**
While Express Scripts agrees to publish the EOC in in the requested timeframe, we cannot agree to the EOC superseding the Contract between ERS and Express Scripts.

**B.8.a. As plan administrator for the GBP, ERS and the auditor may access, request, and audit documents related to the Programs and Participant records as required for purposes of administering the Programs.**
Confirmed, as outlined in Express Scripts' Standard Audit Protocol, which can be provided to ERS for review.

**B.8.c. If ERS or any of its duly authorized representatives or designees request records, data, information, report analysis rebuttals, and/or other information of PBM, PBM shall timely release all information requested. Additionally, PBM shall provide documentation related to previously identified errors which occurred during the audit time frame. All sources of revenue will be disclosed and passed through to ERS. PBM shall not withhold or reclassify any monies or other payments from manufacturers or third parties that were being passed through to ERS.**
Confirmed. Express Scripts discloses its principal sources of revenue derived from pharmaceutical manufacturers, wholesale distributors, and network pharmacies to our clients. Express Scripts agrees to pass back 100% of Rebates
and Manufacturer Administrative Fees.

**B.8.e. In the event of a disagreement between PBM and auditor regarding whether an audit finding will be considered an error for purposes of calculating audit results, ERS retains the exclusive right to make the final determination. PBM shall adhere to these determinations pursuant to ERS' directions, which may include reprocessing of PBM claims and reimbursing ERS for any applicable errors made.**
Not confirmed. All errors must be mutually agreed upon.

**B.8.f. As specified in RFP Section VIII.B.8., a separate audit engagement will be conducted for each Program. Each audit engagement will have a final audit report prepared by the auditor. Based on the final audit report, in the event that the auditor finds errors in excess of the amount designated in the Contract, PBM must reimburse ERS for the cost of the corresponding audit.**
Confirmed. Express Scripts assumes the use of a mutually agreeable auditor and will not unreasonably withhold approval.

**B.10. Fraud and Abuse. PBM shall use automated systems to detect fraud and misuse of the Programs, including, but not limited to, overpayments, wrongful or incorrect payments, falsification of eligibility, unusual or extraordinary charges, verification of enrollment and unnecessary and/or wrongful drug prescribing practices and abuses. PBM shall also conduct thorough, diligent, and timely investigations with regard to fraudulent and suspicious claims and, immediately upon discovery, notify the AD or designee of any fraudulent or suspicious activity. PBM understands that ERS may develop further policies in connection with the detection and prevention of fraud or abuse of the Programs. PBM shall comply with all applicable laws, regulations, and ERS policies and is encouraged to develop additional safeguards as allowed by law. At a minimum, PBM shall perform the following:**
**Use EOBs for the tracking of phantom billing;**
Not confirmed. Express Scripts' Fraud, Waste, and Abuse program does not use EOBs to track phantom billing; however, our robust program monitors the specific drugs and unusual concentrations of these drugs that phantom pharmacies typically target.

**Monitor the licensure of pharmacies to ensure claims of non-licensed providers are denied; and**
Not confirmed. Express Scripts reviews provider licensure during our credentialing and re-credentialing processes to ensure an active and in good standing status prior to credentialing approval. In-network providers are also contractually required to update the organization with any changes, restrictions, or impacts to their license; however, we do not proactively monitor provider licensure outside of the credentialing processes.

**B.11.a. When a pharmacist settles with or is found liable for medical malpractice, PBM will seek recoupment of benefits paid in connection with services negligently rendered by the pharmacist prior to seeking subrogation from the Participant. PBM shall incorporate a provision in PBM's contracts with pharmacists to implement this provision.**
Not confirmed. Express Scripts does not pursue malpractice recoupments.

**D.2. In the event PBM issues excess payments or payments for ineligible claims or Participants, it will:**
Confirmed with modifications. Our claims adjudication system verifies that the person is eligible for pharmacy benefit coverage so it is unlikely that there would be recovery associated with an ineligible claim or participant. Express Scripts will be financially responsible for any error that is determined to be the result of an Express Scripts issue. If the set-up error results in a client overpayment/member underpayment, we correct the claims and reimburse ERS accordingly. If the set-up error results in a member overcharge, Express Scripts corrects the claims as they should have adjudicated, which means Express Scripts

bills the client in order to reimburse the member. If the error is determined to be the result of a client-related and/or vendor-related issue, the client pays for all costs associated with the adjustment and the correction of the error. Express Scripts currently does not support member recoveries of any kind.

**D.7. PBM shall provide Participants with receipts for medications obtained by mail order. Such receipts shall include the name of the drugs dispensed, the prescribing physicians name, the date dispensed, the amount paid by the Programs for the drugs and the amounts of the deductible/coinsurance/copayment (if applicable).**
Confirmed with modification, the order processed date is provided and not the date dispensed.

**E.2.d.ii. The PBM shall submit to ERS and ERS' consulting actuary, on a monthly basis, via SFTP within a site-to-site VPN tunnel using file encryption with ERS' public key (PGP), all claims (retail, mail and Participant-submitted) processed during the previous calendar month. This data shall be used by ERS' Actuarial and Reporting Services team and the consulting actuary to analyze claims experience and reconcile the weekly invoices. The detailed claims file shall include, but not be limited to, the items listed below for each claim record: Pharmacy NABP number;**
Not confirmed. We will provide the standard pharmacy identifier, which is the NPI.

**F.1. PBM shall provide to ERS with its Proposal and to ERS' plan manager on an annual basis, a copy of the most recent SOC-1 report that was conducted in accordance with standards established by the American Institute of Certified Public Accountants on the effectiveness of internal controls related to operations and related general computer controls that are relevant to user entities' internal control over the Services to be provided for purposes of this RFP. PBM shall respond to ERS' questions as needed on any controls or testing performed to address deficiencies noted within the SOC-1 report. PBM shall provide ERS with copies of SOC-1 bridge letters as requested throughout the Contract Term. If there is not a SOC-1 engagement performed, then any other report performed by an external entity assessing how the operational control activities meet the Services to be performed under the RFP will be accepted. ERS reserves the right to request this information from Respondent's parent/sponsoring organization or outsourcers/subcontractors, if applicable. ERS also reserves the right to perform an on-site inspection.**

Confirmed upon execution of an NDA between ERS and Express Scripts. Prior to the NDA, Express Scripts cannot provide a copy of the report but will share results via a call between our organizations.

## B. Interrogatories – Firm Experience and General Information

**General Information**

B.1. Discuss the key advantages of contracting with Respondent to administer the HealthSelect PDP and HealthSelect Medicare Rx PDP and describe particular differentiators that set Respondent's organization apart from other industry competitors.

- HealthSelect PDP:

  **We know the challenges employers like ERS are facing. Post-COVID impacts on jobs, budgets, and the economy. An accelerated need for digitalization. Rising health care costs. And a demand for skilled and innovative employees. We thoughtfully crafted our proposal specifically for ERS to make the choice to work with Express Scripts an easy one.**

## Innovations

Time and time again, we have proven we are willing to take on the challenges others don't, won't, or can't on behalf of our clients and their members. We are building on our high-performing health services portfolio—combining in new ways and bringing new solutions to market that make health care more affordable, higher quality, fairer, and easier for members.

Our malleable structure gives us flexibility to quickly mobilize talent, resources, technology, and processes across all our businesses—crushing silos to solve critical industry problems.

Three important and distinct characteristics that set us apart:

1. Our connected data and pivotal insights allow us to see what others don't. Our PBM business is at the core of our health services model. This enables us to combine real-time pharmacy data with medical claims to identify opportunities to drive value for our clients. With intelligence solutions, we use advanced modeling and machine learning to uncover patterns, identify future health gaps, and calculate financial risk to drive better health. Data science forms the foundation for our entire innovation model—building a deep understanding of any given problem, so we can find the right path forward to solving it.
2. Our unbiased approach and ability to partner without constraints – Our open business model and unbiased vantage point across the industry means we can solve complex problems across a fragmented health care system in ways others can't. We have a proven track record of partnering with health plans and payers like Prime, Humana, Amazon, and others to realize greater value from the pharmacy supply chain. We amplify the impact of digital health providers with targeted access to new buyers and populations—and activating digital vendors a client may have already. Our deep industry relationships with service providers, pharmaceutical manufacturers, and health care providers work together to find new and innovative ways to solve problems.
3. Our agile innovation and our client-centric solutions – Solving today's challenges require a new vision and a new approach, period.

    - At Evernorth Labs℠, our progress accelerator, clients, members, and partners join forces with our world-class experts. In our immersive environment, we challenge industry standards, conceive big ideas, and tackle the biggest challenges in health care in new and unexpected ways.
    - Our Rapid Prototyping to Production team quickly moves ideas from concept to clickable demos in a matter of days, not months. With a grasp of customer experience, usability and performance, we can measure early-stage solutions and create a faster path to market. All of this lets us match the speed of small start-ups with a scale that can reach across the industry.

Our plans are big. New. And they're not right for everyone. But for those of you who want us to take on health care's biggest challenges with you, this is where we're going next.

## Technology

We are planning to invest over $600 million per year in technology innovation and enhancements over the next three years. We are moving healthcare forward — prioritizing the initiatives that will drive the most value for our clients, better outcomes for our members, and simpler administration for our partners across the healthcare ecosystem. We are embarking on the following multi-year initiatives, which we anticipate will provide significant value to ERS:

- *New Client Portal Transformation* — Our current client portal, Client Website, is undergoing a platform transformation. This new platform and modernized technology enables us to deliver new products and services quickly – as a response to our client and user needs. With more customization options and an expanded user profile, our users will have more control over their website experiences and content in order to access relevant information quickly. The client experience will continue to provide a single point of access to a wide array of self-serve reporting and benefit management tools, allowing ERS to manage all aspects of your benefits in one place. Major features in development include a streamlined user experience, a consolidated report center, personalized features and alerts, tailored content by market segment and program utilization, powerful data visualizations, and more.
- *Customer-Centric Pharmacy Experience* — We have taken on the challenge to redefine pharmacy as we know it and introduced a new member-facing brand and an enhanced Express Scripts® Pharmacy experience. Over the next several years, we will continue to build on our experience, with both our members and our clients in mind. We have listened to member feedback and are developing new capabilities like medication synchronization, where members receive all of their medications in a single shipment and package; increased payment options, like cash transactions and e-vouchers for manufacturer assistance; and a patient promised delivery program, where members can schedule shipment and arrival for their particular medication needs. For our clients, we are meeting you where you are — creating more opportunities for ERS to integrate Express Scripts® Pharmacy into your existing network, through tailored solutions like a customizable web experience, and coordination with virtual care providers.
- *Growing Integration with MDLIVE* — With Evernorth's acquisition of MDLIVE, we are focused on our continued development of our integration strategy across the enterprise. This new model of care delivery will deliver a connected experience with greater affordability, predictability and simplicity. By combining MDLIVE's platform and strong network for virtual providers with our comprehensive care solutions and extensive provider network, we are positioned to deliver superior support to members wherever and whenever they need it.
- *Continued Evolution of our Cloud Strategy* — We have adopted a cloud-first strategy, and are continuing to migrate legacy platforms to public cloud when there is significant opportunity increase system availability, flexibility, and agility. As we continue to deploy our cloud strategy, we are focused on an open architecture approach, developing shared APIs that will allow ERS more points of connectivity and an opportunity to integrate data into your own systems.
- *Ongoing Security Enhancements* — We place continued focus and investment in cybersecurity to ensure our systems and ERS's patient data are protected by the latest technological advancements. Included in these projects, we are deploying a focused set of security controls on our externally-facing websites that are tailored to prevent the most common attack patterns. We are also upgrading our current

authentication controls for externally-facing websites to further prevent fraud and attack. Additionally, we are implementing an overarching security framework to adopt and leverage the latest, diverse, and most efficient secure cloud technologies.

- *Piloting Blockchain Use Cases* —We are beginning to explore various ways we can use blockchain technology to improve the overall security, efficiency, and accuracy of various workloads. Not only are we evaluating its applicability for internal applications within the enterprise, but are always open to establishing partnerships throughout the industry, where we will be working side-by-side with our clients.
- *Focus on Interoperability* —Evernorth's Health Information Interoperability program turns data into actionable insights to improve affordability, predictability, and simplicity in health care. Members will have direct access to integrated health information from their entire care network in one place, on-demand. We are taking the guesswork out of managing a member's own healthcare, saving time and alleviating frustration for many, in turn, allowing for better decision making and a more purposeful approach to healthcare. Looking forward, with our data interoperability real-time intelligence coupled with richer information on member's past experiences, health conditions, behavioral patterns, and clinical touchpoints, we can partner with ERS to proactively steer members towards solutions and produce healthier outcomes sooner than ever before and continue into the future.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  As the industry leader in the EGWP market, Express Scripts has been supporting EGWP clients since the program began, implementing our first EGWP clients on 1/1/2006. We support 35% of the EGWP market – including the nation's largest EGWP at over 500,000 lives. These numbers, paired with our 94% retention rate, reflect that you are being served by experts in the market who have experience with clients of varying sizes and lines of business. We support our EGWP clients through a focus on Medicare expertise, compliance excellence, and member satisfaction.

  Express Scripts is committed to excellence in supporting your retiree population. Our commitment to service excellence has afforded us a 98% client satisfaction rating, with the highest scores awarded in enrollment and eligibility, CMS oversight and compliance, and member-related concerns. Our Medicare expertise is fostered through our commitment to government programs. Express Scripts' Government Programs department draws from a vast experience within the government programs space, with a strong focus on Medicare and an average employee tenure of 11 years. This means that ERS will be serviced by experts who have been in the space since the program began, providing unmatched insights and knowledge. Our compliance excellence is shown through our long-standing relationship with CMS. We have the lowest overall CMS findings and penalties, and our processes have been recognized by CMS as best practices. Express Scripts believes in advocating for our clients and members, evidenced by our work with the Pharmaceutical Care Management Association (PCMA) and our bold stance on opioid abuse informing the 1/1/17 CMS guidance on opioid management. We are committed to servicing both our clients and our members.

  Our 99.58% enrollment success rate at go-live, without client or member intervention, not only shows our expertise in EGWP enrollment, but also ensures members have access to care on day one, without any interruption in service. Our claims processing

system allows ERS's benefit to be supported as a single plan offering rather than supporting the benefit in two pieces (i.e., a base Medicare plan and a secondary "wrap" plan). This best-in-class process allows the plan design to meet ERS's intent and supports a streamlined member experience, driving efficiencies with member communications and other functions of the plan while allowing ERS to take advantage of the maximum amount of manufacturer reimbursement dollars, thus increasing savings. Supporting a true single claim transaction in a single claim ID provides members with a consistent, clear experience with their benefit. Eliminating the need for a COB claim provides synergies for the member that can be seen in their EOB as well as throughout the appeals and direct claims processes. This process has also afforded us a prescription drug event (PDE) acceptance rate of 99.99%, which ensures accurate claims submission and accumulator tracking in order to maximize ERS's subsidies.

B.2. Describe what position and actions Respondent took during the past year in connection with the following events:

- HealthSelect PDP:

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| Switch to OTC medications of various prescription products: | Within the past year, products that moved from Rx to OTC were already excluded from Express Script's National Preferred Formulary as they were in classes that were being tightly managed. Therefore, no additional action was required when the products moved to OTC status. |
| The continued growth of specialty drugs: | Express Scripts offers a number of specialty-focused solutions as a part of our value-based platform, SafeGuardRx. These solutions safeguard our clients' interests by combating rising drug costs and helping ensure important therapies and specialized care are available for members. Aligning with client needs, we have taken on unprecedented challenges and created greater value for plan sponsors and members. Since 2014, we have protected clients from the soaring costs of treating hepatitis C, high cholesterol, cancer, inflammatory and atopic conditions, diabetes, asthma, chronic obstructive pulmonary disease, multiple sclerosis, and rare diseases. We have also implemented programs that minimize the impact of brand-drug inflation and prevent unexpected cost spikes from impacting our plan sponsors. We saved clients $2.6B in 2021 through our specialty SafeGuardRx solutions.<br><br>Specialty trend reached 7.2 % in 2021 and we project that it will continue to grow as breakthrough therapies continue to come to market. As specialty costs put increasing pressure on the pharmacy |

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| | benefit, plan sponsors must make difficult decisions regarding coverage and cost sharing for their sickest patients. One significant component of the increases in specialty drug costs is the unit price increases from manufacturers — in particular, new therapies replacing older therapies at significantly higher prices. We are also seeing and preparing for more groundbreaking therapies, which are expected to carry an exorbitant price tag that requires aggressive manufacturer contracting and clinical outcome and utilization management. We lead the industry in taking action to address these high prices, providing patients with access to groundbreaking drugs while ensuring the sustainability of the pharmacy benefit.<br><br>Preferred Specialty Management<br><br>Specialty drug spend is predicted to grow exponentially over the next several years; it is estimated that specialty drug spend will account for more than 25% of pharmacy dollars. In addition, as more specialty drugs are approved, utilization in some traditional classes will transition to the specialty market. Preferred Specialty Management addresses this issue by reducing wasteful specialty spend and promoting clinically appropriate, cost-effective therapies.<br><br>Preferred Specialty Management enhances our existing specialty utilization management programs (Prior Authorization and Drug Quantity Management) through the use of traditional cost-containment programs such as Step Therapy. By tailoring these trend management strategies to the specialty landscape, Preferred Specialty Management allows ERS to reduce your specialty trend while improving health outcomes.<br><br>Products preferred under Preferred Specialty Management depend on your formulary and could potentially enhance any applicable rebates while improving formulary compliance. |

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| | Process<br><br>When a prescription for a targeted specialty product is presented at the pharmacy, our claims adjudication system logic ensures that a preferred specialty product is attempted before dispensing a nonpreferred product. As clinically appropriate, an automated point-of-sale review is completed to maintain member and physician satisfaction.<br><br>Medicare<br><br>Preferred Specialty Management modules for clients using one of our Medicare Part D national formularies include:<br><br>• Alpha-1 proteinase inhibitors<br>• Erythroid stimulants<br>• Hepatitis C<br>• Inflammatory conditions<br>• Multiple sclerosis<br><br>Specialty Advanced Assurance Program<br>To deliver better predictability and affordability in the specialty Rx space, we'd like to discuss the possibility of offering a forward-thinking, single financial guarantee to cover your client's specialty Rx pharmacy spend with our Specialty Advanced Assurance pilot.* Traditionally, they have been offered standalone savings, but moving forward, we can sit down with you to offer select clients, as a pilot, a simplified, integrated and predicable financial guarantee. The guarantee will continue to be re-evaluated as new strategies and solutions come to market that will drive additional savings for their plan. This will replace the standalone guarantees that they have today, and to do so, we could apply a cultivated portfolio of proven solutions – all working together - to optimize the pharmacy benefit and drive maximum value and affordability:<br>• Specialty formulary<br>• Pharmacy rebates<br>• Utilization management, inclusive of biosimilar strategies<br>• Value-based programs<br>• Copay solutions<br>• Network and channel optimization |

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| | Just like the financial assurance, additional strategies and levers would be put in place as they come to market. As a pilot, we would set up a graduated scale to the financial assurance, so the more specialty solutions they implemented, the more aggressive their guarantee.* The guarantee would not require any one of these solutions, however, the guarantee would be influenced by all of the existing strategies available today and will be influenced by future strategies. |
| Impact of biosimilars: | Each new biosimilar released in the marketplace will be unique in terms of disease, patient population, financials and interchangeability. Express Scripts tailors our strategy, product offerings, and client guidance to meet each unique biosimilar need and opportunity. We would approach any possible changes that address new-to-market biosimilars with the same care and consideration for cost and member impact as our annual changes. Pending a clinical review from the independent P&T Committee, we will review and negotiate with manufacturers to consider formulary status or possible exclusion. When working with manufacturers, Express Scripts takes exhaustive measures to obtain the best rates for our clients and to preserve member choice. A biosimilar or reference product may be excluded if a manufacturer's rates fail to provide value for our clients. |
| Implementation of relevant federal health care legislation (Ex: Medicare Part B and Part D and rebate negotiation, biosimilar coverage, Transparency in Pricing Act, the Consolidated Appropriations Act, No Surprises Act, and other relevant legislation): | The No Surprises Act section of the Consolidated Appropriations Act (CAA) establishes requirements to protect patients against balance billing for involuntary out-of-network services, as well as plan and provider requirements aimed at creating predictability and removing the customer from reimbursement disputes. Express Scripts shares the federal agencies' concern on surprise billing and desire to protect consumers from unexpected costs. We are actively seeking to protect customers from surprise medical bills and the negative financial consequences of egregious provider charges.<br><br>Express Scripts continues to evaluate the requirements of the CAA of 2021 and any additional regulatory direction to be |

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| | developed by federal regulatory agencies. We will continue to evaluate the anticipated rules and are working to address the final requirements.<br><br>As part of our ongoing commitment to share regular and ongoing communications related to current legislation/ guidance, we create and release a bi-monthly newsletter that outlines the latest Federal legislative updates and how it may apply to our regulated lines of business. This newsletter is a resource intended to provide regular communication on trending items in addition to regular touchpoints and updates provided by your assigned Market Strategist. |
| Addressing prescription drug shortages and demand during and following the COVID-19 pandemic: | Express Scripts® Pharmacy stocks all formulary products. In the unlikely event of a product shortage, our system flags that an ordered drug is out of stock. Upon notification of a shortage, we contact the prescriber to obtain a new prescription for alternate therapy. When the prescriber authorizes an alternate therapy we determine if there is a copay change. In the event the patient payment is changed, we contact the member for approval prior to dispensing. If the original order from the member included multiple prescriptions, the in-stock drugs will be filled immediately. |
| The introduction of new Alzheimer's prescription drug(s) and other new pipeline/breakthrough drugs: | |
| Formulary management of high cost/low value drugs | Our Value Assessment Committee, made up of clinicians and financial analysts, evaluates drugs having clinically effective alternatives for cost effectiveness. This is the only step in our formulary process where cost is considered. The Value Assessment Committee applies the following key concepts:<br><br>Evaluate Cost<br>Because prescription drugs within a therapy class usually have different average wholesale price costs, those cost differences are considered for formulary selection when drugs are equal in benefit. Lower-cost drugs are selected only when their clinical benefits for a substantial group of patients have been established as equal to, or better than, other agents in the |

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| | class. Formulary drugs may actually cost more than other drugs in the class when their clinical benefits are superior to the lower-cost drugs. To determine lowest net cost for each Competitive Product Category we use our Preferred Savings Grid. Our rebate program enables ERS to focus on lowest net cost through a grid structure.<br><br>Account for Market Share<br>A drug's market share is important for at least two reasons: 1) market share may impact total costs for the therapy class (for example, if drugs with high negotiated discounts are made nonformulary in favor of potentially lower-cost drugs that have little market share, costs for the therapy class may actually increase); 2) eliminating a widely used drug (for example, one with high market share) from the formulary may create unacceptable levels of disruption for patients, physicians, and network pharmacies.<br><br>Account for Market Dynamics over an Extended Time Frame<br>Patent expirations and expected introductions of new drugs within a therapy class can affect convenience, cost, and other factors that drive plan performance. A heavily prescribed, but more expensive, brand drug that is due to lose patent protection soon may remain on the formulary to ensure easier, rapid conversion when generically equivalent products are introduced. Such conversions have little potential for member and physician disruption.<br><br>The Value Assessment Committee combines all this information and develops recommendations for each of our national formularies. Each Competitive Product Category in each formulary has all the brand drugs classified by the P&T Committee as being clinically necessary, plus generic drugs and additional brand drugs needed to make the formulary clinically effective |
| Introduction of Gene therapy drugs | One of the most significant developments impacting pharmacy over the next several years will undoubtedly be the advent of |

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| | gene therapy. With the approval of Kymriah and Yescarta in 2017, Luxturna in 2018, and Zolgensma in 2019 we have entered a new era of sophisticated approaches to treating disease by actually replacing genes. It is clear these medications have significant clinical value:<br><br>• For ALL (acute lymphoblastic leukemia) patients who had failed other treatment options, 83% were cancer free within three months following treatment with Kymriah.<br>• Dramatic vision improvements have been seen almost immediately with patients receiving Luxturna.<br>• Clinical trials for hemophilia gene replacement products are showing incredible promise, with one study showing over a 95% decrease in both bleed rate and amount of factor used.<br><br>Typically, gene therapies will impart long-term results with the potential of no need for repeat dosing. While extremely effective, these novel therapies are extremely expensive with potential multimillion dollar costs per course of treatment. They can also be life-changing, highly effective treatments for conditions that have few or no treatment options available today. For those disease states with existing treatment modalities available (e.g., hemophilia), clients must consider return on investment (ROI) and time before savings is realized to cost offset, as well as quality of life considerations. Express Scripts is prepared to help plan sponsors understand these dynamics.<br>We are focused on providing appropriate clinical and financial management for gene therapies and other curative and transformative therapies coming to market. We closely monitor the pipeline and leverage our relationships across the supply chain in order to develop and deliver unique solutions for payers that address changing dynamics, assess the |

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| | value of new therapies, and effectively balance cost and care.<br>Accredo has a reputation for patient-centric and therapy-specific services, as well as long-term experience in the specialty pharmacy industry, making us well positioned to gain access to gene therapies as they are approved. Accredo has access to the majority of all specialty medications on the market, including 92% of all limited distribution drugs, those available at more than one specialty pharmacy, and 98% of all drugs in limited networks of five or more specialty pharmacies. Additionally, Accredo leads the market in exclusive distribution drug access, those available from a single specialty pharmacy, with approximately one third of all drugs in this category. We also have access to 92% of specialty drugs distributed to specialty pharmacies that have Risk Evaluation and Mitigation Strategy (REMS) requirements. Most other niche or national specialty pharmacies typically have a very small number of these drugs. Of note, Accredo was awarded access to the first true gene replacement product ever approved in the U.S. in 2018, Luxturna, as the result of our ability to meet the unique manufacturer, distribution, and patient care needs associated with this revolutionary product. This includes secure distribution processes, custom storage and shipping requirements for Luxturna, and self-monitoring refrigeration designed to keep medication at less than or equal to a negative 60 degree C temperature, with an internal power source as a risk mitigation strategy.<br>Because of the complexities and therapeutic nuances specific to genetic conditions, we believe that each gene therapy will require a custom pharmacy care model approach. Administration and related procedures, patient acuity, timing, and window of clinical efficacy may vary greatly from therapy to therapy. Additionally, achieving an optimal clinical response to some gene therapies may be highly dependent on a short window of opportunity, requiring nimble response by all parties involved. Enabling treatments during that window is more clinically |

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| | effective for the patient, and also more cost efficient for payers. Missing the opportunity for optimal treatment to prevent immediate expense could lead to worsening health and the need for more complex treatments that would cost as much, or more, over the long term.<br>Accredo's history of supporting unique requirements in rare disease areas, and the trust manufacturers have placed in us, illustrated by our broad access to these complex products, positions us well in the growing gene therapy market.<br>Given the unique aspects of each gene therapy, Express Scripts recommends that clients evaluate whether coverage under the medical or the pharmacy benefits makes the most sense — we are able to support plan sponsor needs for either coverage channel. Because many of these therapies will require administration through complex medical procedures, we expect most plan sponsors will elect coverage under the medical benefit. However, there may be instances where it is more appropriate to cover a product under the pharmacy benefit.<br>These ground-breaking treatments will require innovative thinking and collaboration among payers, pharmaceutical manufacturers, policymakers, specialty pharmacies, and PBMs. We believe gene therapies will require payment and patient care systems that are as novel as the medications themselves—that may require customization by individual product, as well as the development of unique supply chain partnerships. The models we are currently collaborating to create include payment for treatment over time and outcomes-based rebate models. We may also develop long-term monitoring programs. Ultimately, Express Scripts is committed to working with drug manufacturers to put these new medications within reach of the patients who need them, while being as fiscally responsible as possible. |
| Introduction of orphan drugs | Almost half of the medications approved by the FDA annually are Orphan Drugs. These products provide hope for an enhanced quality of life and potentially, |

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| | survival for patients diagnosed with rare diseases. Express Scripts provides pharmacy services tailored to each individual patient through condition-specific Therapeutic Resource Centers, which represent the top chronic and complex disease categories we manage, including those treated with Orphan Drugs. Patients are assigned to a Therapeutic Resource Center based on their medication history and receive specialized, patient specific support from specialize pharmacists and their extended teams to help close gaps in care, reduce unnecessary costs, and optimize patient outcomes. Via the Therapeutic Resource Centers, we promote the safe and effective use of specialty drugs; provide patients with therapeutic-centric training, education, and clinical support; provide physicians with evidence-based practice guidelines and actionable patient information; ensure coverage is consistent with plan provisions; eliminate overuse and wasteful prescribing and dispensing practices; and encourage patient compliance and persistence. Our Therapeutic Resource Center specialist pharmacists develop a clinical program for the drug that aligns with the drug itself, regardless of whether the drug has been attributed orphan status or not. There are no fees associated with the support patients taking orphan drugs receive through our Therapeutic Resource Centers. |
| Mental Health Parity and Addiction Equity Act (MHPAEA) | Under the Mental Health Parity Addiction and Equity Act (MHPAEA), each plan is ultimately responsible for formulating any required comparative analyses as part of its own compliance program. Plans and insurers are required to ensure that any nonquantitative treatment limitations (NQTLs) they adopt as part of their pharmacy benefits, such as a multi-tiered formulary design or utilization management requirement, complies with the Mental Health Parity (MHP) NQTL requirement.<br><br>However, for those clients that have adopted Express Scripts' standard formularies and/or standard utilization management programs, we can provide support and have developed more robust documentation regarding how our standard formularies and standard utilization management programs are developed and administered. The |

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| | information includes a description and analysis, conforming to the Consolidated Appropriations Act's parity analysis requirement, of how Express Scripts develops and manages all of the standard formularies and standard utilization management programs that we offer to clients. Our online Formulary Development White Paper documents the process by which our standard formularies are typically developed. The additional information provided supplements this existing, available documentation for the standard formulary and standard utilization management offerings. |

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  **Not applicable.**

B.3. Is Respondent currently a fiduciary for any other plan(s)?

- HealthSelect PDP: ☒ Yes ☐ No
  If yes, describe how Respondent acts as a fiduciary.

  **To the extent Express Scripts is acting as a fiduciary to other plans, Express Scripts discharges its fiduciary obligations by acting consistently with our agreements and with transparency, candor, diligence and good faith.**

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  **No difference.**

B.4. Fully describe how Respondent will provide actuarial personnel that shall be available to confer with the ERS staff and consulting actuaries concerning rating and other financial issues.

- HealthSelect PDP

  **In support of ERS' actuarial needs, Express Scripts is assigning a financial analyst to the account team, who has actuarial experience and access to financial experts and other actuarial resources within our Finance Department. Your financial analyst provides analytical expertise to assess ERS' program performance, including cost-effectiveness and detection/analysis of trends within the pharmacy benefit using state-of-the-art analytical tools. The financial analyst leverages this insight into plan performance and trends to identify opportunities for plan design improvements and makes recommendations for changes to ERS' programs.**

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  **No difference.**

B.5. Provide an outline for proposed client expansion within the next four (4) years and anticipated enrollment. If expansion is anticipated, what steps will Respondent take to maintain quality service to ERS and the Programs?

- HealthSelect PDP:

  Express Scripts currently serves more than 2,500 clients and more than 104 million members. Our clients range in size from less than 100 members to several million members. We anticipate that we will continue to grow over the next four years. To forecast for this growth, we maintain a rolling two-year projection for future system capacity requirements. Inputs into this process include current network performance measurements, projections of future business volumes, and analysis of future application enhancements to project systems requirements.

  We currently have ample capacity to administer ERS's program without any system impact, and can horizontally scale our system by 200% to 300% to accommodate additional volume.

  Because Express Scripts' systems are designed to dynamically scale and accommodate the demands of additional clients, we do not have a limit to the number of plans that we can support. We are able to add processing power on demand and mass storage within the ZSeries mainframe environment to expand our claims processing environment. This model permits rapid expansion when necessary, and reduces costs associated with supporting unused capacity.

  ERS's account will receive continuous attention. We proactively manage your program to achieve uninterrupted services. Account management personnel use a strategic planning procedure to address continuity. We monitor, define, document, and track ERS's program objectives and activity. This ensures accurate information is available to your primary Express Scripts contact, your core account management team, and backup personnel. Additionally, upper-level management actively participates in ERS's account proceedings to promote executive awareness and overall program stability.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  No difference.

**Firm Experience**

B.6. Provide the date Respondent's products and services were first provided by Respondent.

- Commercial PDPs: 1986
- Medicare Part D EGWP + Wrap PDPs: 2006

B.7. Provide Respondent's total enrollment as follows:

| Enrollment Type | January 1, 2021 | January 1, 2022 |
|---|---|---|
| Commercial PDPs: | 20.8 million lives | N/A |
| Medicare Part D EGWP + Wrap PDPs: | 1.5 million lives | N/A |

B.8. Respondent shall indicate the enrollment percentage that ERS will represent when compared to Respondent's total book of business if awarded these Contracts

- HealthSelect PDP: 2%
- HealthSelect Medicare Rx PDP: 6%

## C. Interrogatories – Account Management Requirements

**Account Management Team**

**Note:** Management of the Programs necessitates a senior level Account Manager or Account Executive. Therefore, within this section, the terms "Account Management Team" and "Account Executive Team" are used interchangeably.

C.1. Briefly outline Respondent's Account Management Team philosophy.

- HealthSelect PDP:

  To demonstrate Express Scripts' commitment to ERS, we will provide you with public sector resources, including a highly professional, experienced account management team, committed to meeting your specific needs through expert consultative services, strategic planning, and issue resolution. Express Scripts manages your account using a multidisciplinary, client-centered service approach. This sophisticated model applies the talents of cross-functional teams organized to serve your unique business needs.

  Our account management teams comprise key professionals supported by vast internal resources to ensure ERS and your stakeholders have access to the information you need when you need it. In partnership with the extended service team, Express Scripts' account management provides you with consistent, accessible, informed services at every level. This model of service excellence allows your account team to focus on a core set of responsibilities, while directing tasks beyond this core to experts on the extended service team. The extended service team has a deep understanding of Express Scripts' systems, operations, and processes and will work closely with ERS' account team on tasks such as plan design changes, program implementations, billing, eligibility, reporting, and communications. Centralizing these key, repeatable tasks allows your account team to execute on ERS' needs.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  Express Scripts understands the need to have streamlined support for ERS accounts. Should we be fortunate enough to have both your commercial and Employer Group Waiver Plan (EGWP) lines of business, the same account team will serve them. Understanding that Medicare is a complex space, you and your account team will receive additional designated support on the EGWP line of business. Our operational model includes Medicare specific operations within our Government Programs Medicare team. Individuals on the Government Programs Medicare team work cross functionally to broadly support operations teams that service Medicare members. ERS will be assigned an EGWP strategist to serve as ERS's main point of contact for all Medicare-related questions. Your EGWP strategist partners with you to navigate CMS guidance, identify industry trends, ensure overall compliance with your plan, and provide strategic direction for your plan.

C.2. Provide a description of the proposed Account Management Team's structure. Within the description, Respondent shall include a brief summary of the core responsibilities to be performed by its Account Management Team, whether these resources are designated or dedicated, and the locations where work will be performed.

- HealthSelect PDP:

  Express Scripts' manages plan sponsors' accounts using a unique client-centered service approach through our Client Service Team (CST) model. Compared to traditional account team models, this model drives delivery effectiveness and efficiency through a single point of accountability with direct oversight responsibility for all resources assigned to your account. ERS core team includes key specialized professionals experienced in

meeting the diverse needs and issues across the health services spectrum. Along with an account team, ERS will also receive direct support from our extended service team, experts with the experience to support complex plans and respond quickly to your changing needs.

Select members of your Client Service Team include:

- Executive Sponsor — Your Executive Sponsor, *Amy Bricker*, is the president of Express Scripts. She will maintain advanced knowledge and accountability for areas of most interest to ERS. Amy is located at Express Scripts' headquarters in St. Louis, Missouri. She is responsible for:
  - Ensuring organization-wide commitment to ERS
  - Providing strategic insight and corporate vision to ERS
  - Building and strengthening relationships with ERS
  - Serving as an advocate for ERS within Express Scripts
  - Providing strategic direction, as needed, to the Client Service Team
  - Collaborating on future products and programs to help achieve ERS long-term goals
  - Acting as a resource for executive-level intervention when necessary and appropriate
- Senior Director, Client Service Team Lead — The leader of your Client Service Team and single point of accountability will be your senior director, *Amy Daily*. Amy directs your team of experts who bring the experience to support complex plans, provide innovative solutions, and respond quickly to your changing needs. The senior director serves as the ultimate escalation point for key issues and strategic needs, providing guidance to maximize all aspects of ERS plan performance: financial, clinical, operational, strategic, and beyond. Amy's role is designated as she oversees a number of public sector clients served by her account teams. Amy provides virtual support from California.
- Senior Account Executive — Your dedicated, experienced senior account executive, *Jon Molberg*, serves as ERS's strategic partner and primary contact. Jon will collaborate with ERS during all scheduled meetings and work with ERS to formulate goals and action plans related to program enhancements, member care, drug trend management, and cost containment. He engages and coordinates with internal partners and corporate resources to maximize ERS's success. Jon is located in Texas.
- Senior Account Manager — Your dedicated senior account manager, *Brian Fisher*, will own the execution of all ERS-specific service and operational deliverables, participating in your program implementation activities to ensure a seamless transition experience. After implementation, your senior account manager will act as your primary operational point of contact to coordinate with internal partners, ensuring operational excellence and set-up quality. He will proactively monitor your service trends to allow for immediate resolution of any issues. Brian provides virtual support from Ohio.
- Senior Clinical Account Executive (CAE) — Your designated CAE, *Bryan Hammons*, manages the clinical relationship between ERS and Express Scripts. You will work closely with your CAE to develop a business plan that addresses your clinical benefit needs, including formulary intent and utilization management. To help you achieve your member health outcome goals, the CAE assists in clinical program oversight, results evaluation, and follow-up with ERS, analyzing data and delivering clinical modeling and reporting with recommendations. The CAE will work with you to define a strategic clinical plan and work with internal partners to supply information on emerging clinical trends and market events tailored to ERS needs to ensure you are prepared for future events. Bryan is located in Texas.

- Communication Specialist — Your dedicated communication specialist will be named upon contract reward. They will coordinate client and member communications and website services, as well as organizes relations management events. In doing so, team members collaborate with and provide support to account management to assist with ERS's needs, such as helping draft and edit all field alert communications as needed, ensuring proper approvals have been secured before publication, posting alerts to the Field Solution Portal and distributing field communications for all line of business field alerts via the Bundles or as an urgent priority alert.

- Actuarial Financial Analyst — Your designated actuarial financial analyst provides analytical expertise to assess ERS program performance, including cost-effectiveness and detection/analysis of trends within the pharmacy benefit using state-of-the-art analytical tools. They will leverage this insight into plan performance and trends to identify opportunities for plan design improvements and make recommendations for changes to ERS's programs. Upon implementing your program, we will assign ERS a financial analyst.

## Extended Service Team

ERS will receive focused, actionable recommendations to help you meet your healthcare goals with our consultative approach. Your designated account team collaborates with the extended service team to provide consistent, accessible, and informed services at every level. Our service excellence model allows your account team to focus on a core set of responsibilities while directing undertakings beyond this core to the extended service team. The extended service team has a deep understanding of Express Scripts's systems, operations, and processes. They will work closely with ERS's account team on plan design changes, information technology assistance, eligibility support, reporting, and communications. Centralizing these key, repeatable tasks allows your account team to execute on ERS's needs.

The extended service team includes experts in the following:

- Plan Design — Express Scripts's Benefit Operations team works closely with ERS's account team to ensure your members' unique benefit plan designs are properly configured and implemented. We administer a wide range of plan design options and offer recommendations for cost-effective benefits that your members will value.
- Contact Center — Express Scripts's Contact Center utilizes a suite of systems equipped with the most advanced technology and a staff of highly skilled, courteous patient care advocates for seamless tracking, distribution, and monitoring of calls. In alignment with our engagement model, our staff optimizes all interactions to address members' most immediate needs while informing them of actionable opportunities to improve care and reduce healthcare costs. Our state-of-the-art facilities are the key to handling member inquiries quickly and efficiently, ensuring satisfaction.
- Information Technology — Members of the Information Technology team assist with questions and issues related to adjudication, data exchange and file transfers, and the identification and pursuit of system enhancements. Information Technology relays team-scheduled system downtimes and upgrades and works with your team to meet your requests, such as file transfer method changes.
- Eligibility Support — An eligibility specialist works with Account Management during program implementation to review current technology and build an eligibility interface to meet business needs. Eligibility staff supports file loads and verification and correction of issues with eligibility information accessed online. The eligibility team provides reporting as requested by the account management team.
- Reporting Team – Express Scripts reporting team, comprised of data analysts, clinical consultants, and benefit support professionals, work closely with ERS's account team to

provide data-driven decision support, delivering accurate and actionable recommendations to improve your pharmacy plan's performance.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  In addition to the above, Express Scripts understands the need to have streamlined support for ERS accounts. Should we be fortunate enough to have both your commercial and EGWP lines of business, the same account team will serve them. Understanding that Medicare is a complex space, you and your account team will receive additional designated support on the EGWP line of business from the below experts as an extension of your account team.

  - Employer Group Waiver Plan (EGWP) Strategist — Your designated EGWP strategist will serve as ERS's main point of contact for all Medicare-related questions. Your strategist will partner with you to navigate CMS guidance, identify industry trends, ensure overall compliance with your plan, and provide strategic direction for your plan. They will also review CMS directives and guidance with an eye for your business and sharing pertinent updates with you during guidance reviews. As your consultative Medicare expert and advocate, the EGWP strategist will:
    - Support your clients' Medicare-specific questions around new guidance releases and associated impacts, engaging additional subject matter experts to address your specific needs
    - Update the status of current Medicare projects based on new CMS requirements continuously
    - Offer strategic consultation benefit design
    - Communicate industry perspectives, particularly from industry workgroup discussions and conferences

  To help support our EGWP clients, your designated EGWP strategist will work with the following team members:

- Member Experience Manager (MEM) — Responsible for reviewing and ensuring compliance with your member communication materials. Your designated MEM can also assist with drafting and reviewing ad hoc communications to ensure messaging and tone consistency throughout all member-based communications as they apply to the EGWP.
- Medicare Service Center Agents (MSCA) — Your designated MSCAs assist ERS with general member inquiries, enrollment concerns, and other day-to-day needs in conjunction with your account manager.
- Enrollment Analyst (EA) — The designated EA works with ERS to ensure that members have access to the benefit on day one. The EA will also assist with general enrollment inquiries and concerns and file setup and transmission needs.

  Locations of these individuals will be provided upon contract award.

C.3. Complete the table below to indicate how many other clients are currently, and will be in the future, assigned to the proposed Account Management Team.

| Program Type | Current Clients | Future Clients |
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| HealthSelect PDP: | Jon Molberg, Senior Account Executive - five clients | Your account executive and account manager will be dedicated to ERS. Bryan Hammons will provide service to 2 |

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| | Brian Fisher, Account Manager - nine clients<br>Bryan Hammons, Senior Clinical Account Executive - 2 clients | accounts in addition to ERS. |
| HealthSelect Medicare Rx PDP: | No difference | No difference |

C.4. Respondent shall indicate where the Program's Account Executive and Account Manager will be located and specify if the same person will act in both roles.

| Program Type | Location of Account Executive | Location of Account Manager | Dual Purpose Role (Yes/No) |
|---|---|---|---|
| HealthSelect PDP: | Jon Molberg - Frisco, TX | Brian Fisher - Independence, Ohio | No |
| HealthSelect Medicare Rx PDP: | No difference | No difference | No difference |

C.5. Include responses to the following functions and/or services. Respondent's information shall include the titles of the individuals, location where the following functions are performed; numbers of staff for each administrative function, description of the staff (including numbers of full-time equivalent employees, dedicated or designated resources) performing the Services; indicate if Services are performed by staff other than company personnel (parent company, subcontractor, etc.).

C.5.a. **HealthSelect PDP:**

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| Account Executive: | Jon Molberg has been assigned as ERS' dedicated Account Executive. He is located in Frisco, Texas. |
| Account Manager: | Brian Fisher has been assigned as ERS' dedicated Account Manager. He is located in Independence, OH. |
| Claims processing: | Express Scripts uses a single, integrated adjudication platform for our electronic claims processing. This platform was developed by Express Scripts, and we wholly own the software and source code.<br><br>When necessary, such as when a member uses an out-of-network pharmacy or a member cannot reasonably access one of our network pharmacies, the member may be asked to pay for a prescription in full and submit a direct reimbursement claim form to Express Scripts. While Express Scripts does not have one primary, centralized claims processing location, our corporate headquarters is located in St. Louis, Missouri. Express Scripts utilizes a contracted vendor, Conduent Inc., to process member-submitted claims; their data entry processing center is located in Lexington, Kentucky. We currently have 50 full-time employees supporting the direct claims operation. |

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| Customer service: | ERS will be serviced by 30 dedicated patient care advocates to support your members during the hours of 8AM EST to 5PM EST. This team will be virtually based within the United States as all of our contact centers staff work remotely. After these core hours, the calls will route to designated staff who are trained to support ERS. These agents will also be virtually based within the United States. |
| Website management: | Express Scripts performs website management in-house and does not rely on a subcontractor to perform these duties. While Express Scripts does not have one primary website management location, our corporate headquarters is located in St. Louis, Missouri. |
| Correspondence unit: | Express Scripts does not have a formal correspondence unit. Your dedicated communications specialist will work closely with ERS and your account team to ensure your communications needs are met. |
| Actuarial evaluation: | Your actuarial financial analyst will be a designated team member that provides analytical expertise to assess ERS program performance, including cost-effectiveness and detection/analysis of trends within the pharmacy benefit using state-of-the-art analytical tools. They will leverage this insight into plan performance and trends to identify opportunities for plan design improvements and make recommendations for changes to ERS's programs. Upon implementing your program, we will assign ERS a financial analyst. |
| Communication materials: | Your dedicated communications specialist will be assigned upon contract award. Express Scripts uses subcontractors for print fulfillment as listed below:<br>Command Marketing - Secaucus, New Jersey<br>FiServ - Brookfield, Wisconsin<br>Gabriel Group - Earth City, Missouri<br>RR Donnelly - Chicago, IL |
| Enrollment processing and reporting: | While Express Scripts does not have one primary eligibility location, our corporate headquarters is located in St. Louis, Missouri. We use Cognizant, a subcontractor located in Jessup, Pennsylvania, to assist with Medicare eligibility processing. |
| Grievance/complaint/appeals processes: | ERS will be serviced by 30 dedicated patient care advocates to support your members during the hours of 8AM EST to 5PM EST. This team will be virtually based within the United States as all of our contact centers staff work remotely. After these core hours, the calls will route to designated staff who are trained to support ERS. These |

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| | agents will also be virtually based within the United States.<br>The majority of members' grievances and complaints are handled during the first contact with Express Scripts' Contact Center, which is handled by your dedicated staff of patient care advocates. We do use subcontractors to perform appeals and independent peer review services, as noted below:<br>• Appeals - Medical Review Institute of America (MRI) - Salt Lake City, UT<br>• Independent Peer Review Services - MCMC - Rockville, MD |
| Clinical pharmacist: | Bryan Hammons has been assigned as ERS' senior clinical account executive. He is located in Kennedale, TX. |
| Attorney/Legal expertise: | Benton Bradshaw will service as the legal contact for ERS. He will be designated to you and is located in St. Louis, MO. |
| Regulatory Compliance: | While Express Scripts does not have one primary location for regulatory compliance, our corporate headquarters is located in St. Louis, Missouri. Our team of 275 regulated markets team members are located throughout the United States. We also have a team of 18 individuals located throughout the United States, who are the primary liaison to state officials. They are responsible for legislative and regulatory responsiveness and advocacy in the states. |
| Fraud, waste, and abuse: | While Express Scripts does not have one primary location for Fraud, Waste, and Abuse, our corporate headquarters is located in St. Louis, Missouri. This staff includes 30 professionals dedicated to fraud analytics and special investigations. Our staff of investigators and analysts has diverse skill sets and backgrounds, including experience as certified pharmacy technicians, PharmDs, certified public accountants (CPAs), certified fraud examiners, and law enforcement personnel. |
| Any support staff not listed above (specify title): | Your Executive Sponsor, Amy Bricker, is the President of Express Scripts and is located in St. Louis, Missouri. |

C.5.b. **HealthSelect Medicare Rx PDP:**

No difference.

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| Account Executive: | |
| Account Manager: | |
| Claims processing: | |
| Customer service: | |

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| Website management: | |
| Correspondence unit: | |
| Actuarial evaluation: | |
| Communication materials: | |
| Enrollment processing and reporting: | |
| Grievance/complaint/appeals processes: | |
| Clinical pharmacist: | |
| Attorney/Legal expertise: | |
| Regulatory Compliance: | |
| Fraud, waste, and abuse: | |
| Any support staff not listed above (specify title): | |

**Subcontracting**

C.6. Does Respondent propose to contract with a management or service company or otherwise subcontract for some or all of Respondent's proposed Services defined in the RFP?

- HealthSelect PDP: ☒ Yes ☐ No
- HealthSelect Medicare Rx PDP: ☒ Yes ☐ No

C.7. If applicable, provide the information below for each management or service company/subcontractor (herein, subcontractor) and specify which services are to be performed by each subcontracted entity. Any planned or proposed use of subcontractors by Respondent shall be clearly disclosed and documented in Respondent's Proposal, including specification of the services that may be performed by each subcontractor.

Respondent shall identify key personnel for each subcontractor that Respondent will use for any administrative and/or managerial functions of the Contract, which shall include a list of Respondent-related duties and length of time contracted with Respondent.

Further, Respondent shall provide complete information, prior to and, if requested by ERS, after execution of the Contract, regarding each subcontractor used by Respondent to meet the requirements of the Contract. List each in the following format:

C.7.a. **HealthSelect PDP:**

C.7.a.i. Respondent shall provide copies of any licenses, permits, and certifications that are listed as required in the table above.

☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.
Express Sripts has provided the applicable subcontracting information in Appendix I_Section A.4.d.i Subcontractors

C.7.b. **HealthSelect Medicare Rx PDP:**

C.7.b.i. Respondent shall provide copies of any licenses, permits, and certifications that are listed as required in the table above.

☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.
Express Sripts has provided the applicable subcontracting information in Appendix I_Section A.4.d.i Subcontractors

## D. Interrogatories – Administrative Requirements

**Online Capabilities**

D.1. Respondent shall describe the online access capabilities that would be available to ERS' authorized representatives to access on-demand program reports and perform queries on PDP data, including utilization, costs, etc.

- HealthSelect PDP:

  The Trend Central portal is the pathway to a wide variety of client reporting capabilities. With our flexible, web-based features, the portal gives users access to a suite of capabilities that can be used to review and evaluate plan performance data and opportunities. Based on feedback from our users, we created an online client reporting experience that is innovative and intuitive.

  Express Scripts' team of analytical experts spends a great deal of time assessing market trends, and collecting feedback and/or suggestions from our existing user community to provide the most useful and user-friendly application.

  The Trend Central interface provides our users with self-service access to a set of tools and functionality designed to address the needs of a wide variety of knowledge worker requirements. The application contains both standard and custom reporting capabilities, in addition to a variety of supplementary analytical tools to help ERS analyze their historical pharmacy benefit, identify potential opportunities, and thereby guide decision-making for plan design.

  ### Standard Report Features

  Trend Central provides an intuitive self-service method of accessing prescription claims and clinical programs performance reporting. Our years of research have helped us to create a stable of standard report templates, each designed with care to help in analyzing specific plan features. Our web-based, interactive data analysis solution enables ERS to manage performance and promptly identify emerging issues and trends.

  Using Trend Central, users gain self-service access to:

  - Generate reports that contain a subset of the client population, schedule recurring automated report generation, save reports as PDF or Excel files with the formatting preserved, and send reports to other Express Scripts Trend Central users
  - Modify member populations or groups, timeframes, and other optional claim attributes to customize the report content

  We realize there is often need for specialization. Advanced features within the tool provide a "deeper dive" and allow our support staff to specialize templates:

  - Manipulate the content and format of any report template for special reporting needs through an intuitive edit function
  - Depending on the report, drill into specific populations, create new variables or calculations, modify date ranges, apply dynamic online filtering and rankings, and conduct other variations of data editing through drag-drop functionality
  - Save, share, and reuse favorite reports, and schedule reports for recurring automated generation

Custom Report Features

Express Scripts understands the need to customize information extraction to suit specific needs. As such, Trend Central also includes an ad hoc reporting tool. Through this tool, users have the ability to create custom, tailored reports with ease. With a few simple clicks, you can quickly and easily create a report based on your specified criteria. The custom reporting tool:

- Allows users to readily choose from more than 300 prescription-drug claim data elements to learn more about costs and utilization specific to a given plan, drug, patient, prescriber, or pharmacy
- Supports the use of pre-built populations to allow users to easily construct reports that match the way ERS needs to see their data
- Quickly produces reports on demand or scheduled to run at a frequency you define

The evolution of the custom reporting feature was created with you in mind. Your time is important, as is your need for information that is relevant, timely, and easy-to-access. We have designed a tool that will appeal to experienced and new users alike.

Express Scripts' scalable, intuitive reporting tools give users the ability to easily locate the information that matters most. With simple-to-use navigation, data field descriptions, and direct access to key metrics, while we do offer various training options, the need for it is virtually eliminated. No additional installation or set-up is required.

Dashboard and Additional Features

Trend Central also includes a variety of added features. Users are given access to a tool that allows them to create and store population filters that can then be applied on demand within the standard and custom reporting tools.

The application dashboard gives direct access to hundreds of plan performance metrics and benchmarks at a glance. Users may keep apprised of developing plan trends and proactively suggest opportunities for improving overall performance and cost. All dashboard metrics are automatically updated as soon as data is available.

Through the dashboard user interface, users can:

- Gain on-demand decision support via this interactive management tool that transforms data into meaningful, actionable steps
- Quickly and easily view key metrics for a specific prescription plan and compare the data to industry benchmarks
- Explore our clinical program products and other savings opportunities
- Proactively identify trend drivers and receive guidance on the programs that best suit clients' pharmacy benefit goals and member needs
- Adjust parameters to drill into specific market segments and time frames

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference

D.1.a. How many licenses shall be made available to ERS to access Respondent's online reporting tool throughout the duration of the Contract Term?

There is no limit to the number of users that may access our online systems via risk-based authentication accounts.

**Complaint Tracking**

D.2. How long has Respondent's customer complaint tracking system been operational?

- HealthSelect PDP:

  Our customer complaint tracking system has been operational since 2014.

- HealthSelect Medicare Rx PDP:

  Our customer complaint tracking system has been operational since 2014.

D.3. Describe the functionality and reporting capabilities of Respondent's customer complaint tracking system.

- HealthSelect PDP:

  For all service-related questions, our advocates use a customer contact system. This system allows the advocate to enter call details and resolve activity online. Each time a contact is recorded, the advocate assigns a specific reason, action, or disposition code to catalog the inquiry and how the contact was resolved. The reporting system automatically logs key information such as the prescription number when placing an order for a refill. Advocates also have the ability to provide free form comments of the interaction with the member, which may be needed to further explain why the member called the Contact Center. Additionally, the customer contact system records the date and time of the call, the advocate's name, and the member's group code.

  ### Tracking System for Complaints and Grievances

  If the member's inquiry is not addressed to the member's satisfaction, the inquiry is escalated. All service-related inquiries are escalated to a supervisor and are considered complaints. Complaints are also tracked through the customer contact system. If the complaint is not addressed to the member's satisfaction, it is escalated by the call taker to a grievance and is logged into our database to allow corporate visibility to the issue. All grievances logged into the database are addressed and resolved within 30 days. We notify the member of the grievance resolution via letter.

  ### Tracking System for Appeals

  Benefit-related inquiries such as drug coverage or formulary questions are escalated to our managed care group for resolution. Escalated benefit-related inquiries may become a request for coverage or an appeal of previously denied coverage and are tracked through our system. Upon request for a coverage review or appeal, a case is opened in the system and all the case details, including applicable information provided by the physician and reasons for approval or denial, are recorded.

  ### Reporting

  We provide clients with call reporting through the Complaint Tracking Report. Complaint Tracking Reports are ERS-specific; we will work with you to develop and produce a mutually agreed upon report. Elements ERS may wish to capture in the report include member ID, call date, reason code, reason category, and call disposition. ERS's account team can generate the Complaint Tracking Report on a monthly basis.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

D.4. Does Respondent have plans within the next thirty-six (36) months to implement a new complaint tracking system?

- HealthSelect PDP: ☐ Yes ☒ No
  If yes, provide the date when Respondent plans to have this new system operational.
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  **No difference.**

D.5. Describe Respondent's problem resolution policies and procedures. Respondent's description should include, but not be limited to, Respondent's procedures for escalation of complaints and the average and target turnaround time for escalation response and resolution.

- HealthSelect PDP:

The member grievance resolution process uses the following definitions for inquiry, complaint, and grievance:

- *Inquiry* — A verbal or written communication by a member regarding benefit or service questions concerns.
- *Complaint* — A verbal or written inquiry logged by a patient care advocate regarding a service question or concern that may or may not have been resolved by the advocate. A complaint is also logged when the member requests to speak to a supervisor and the call is transferred to a resolution expert or supervisor.
- *Grievance* — A verbal or written service complaint that has not been resolved by the resolution expert to the satisfaction of the member and the call is transferred to a supervisor. The grievance will then be routed to the grievance resolution team. Members can expect to receive acknowledgement of their grievance within five business days and their grievance to be resolved within 30 days.

**All service-related issues are documented, categorized, and monitored as part of our ongoing quality-improvement processes. Operational leaders verify proper issue resolution, analyze root causes, and implement organization-wide corrective actions utilizing this data – an integral part of our continuous process improvement program.**

**Complaints and Grievances Process and Escalations**
**The following details our workflow for complaints and grievances:**

- **Any verbal or written requests regarding benefit or service questions or concerns that cannot be resolved by the advocate are logged into the system as a complaint, and the issue is escalated to a resolution expert or supervisor.**
- **The resolution team leader or supervisor works to resolve the issue to the member's satisfaction. If the issue is resolved, this status regarding the complaint is logged in the system. If the issue is not resolved to the member's satisfaction, the complaint is escalated by the supervisor to a grievance.**
- **The supervisor logs the information into our internal database, and the case is routed to the grievance resolution team to be addressed.**
- **Grievances logged into the internal database are addressed and resolved.**
- **The process ends when the member is notified of the grievance resolution via letter.**
- **As a follow-up to this process, the Contact Center receives a complaint report weekly to identify trends. In addition, the total number of inquiries, complaints, and grievances are reported to clients on a quarterly basis by type.**

## Turnaround Time

Express Scripts will initiate member issue resolution upon receipt of members' phone call. The majority of issues are resolved the first time the member calls. For email correspondence, Express Scripts will initiate and/or provide member issue resolution within 24 to 72 hours of receipt.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

Anyone attempting to follow CMS best practices knows that coverage review, determinations, appeals, and grievances continues to be an opportunity for plans. Express Scripts will promptly determine whether a request is subject to Express Scripts' grievance procedures, its coverage determination and exception and/or appeals procedures, or all. The facts surrounding an inquiry will determine whether a grievance or a coverage review request is required. Express Scripts will determine how to categorize requests on a case-by-case basis.

In enhancing our member support capabilities, our advocates are trained to help educate Medicare beneficiaries about their benefits. They focus on improving member experience, therefore, it is critical that our patient care advocate training includes careful assessment of a caller's words and tone to differentiate whether a particular call is an inquiry, complaint, grievance, or coverage determination. Advocates are trained to recognize when a caller's tone is unhappy or assertive. A caller who states "that drug is expensive" or "that is not the copay I expected" may convey their request for a coverage determination. Similarly, a caller who uses words such as "I'm not happy that …" or "I expected …" may convey the service or product they intended to receive was not provided. In these instances, an advocate will offer the caller options of a grievance or a coverage determination based on what is appropriate for the call.

All calls received are recorded and stored for training and auditing purposes. We continually update our training and internal processes with internal reviews, mock audits, and CMS program audits. For example, we changed our contact center process to actively start the coverage review process for members who are calling and appear to have some issue with access to their medications. This process has been reviewed in mock audits and validated successfully.

Through a variety of techniques and applications that allow for a multi-dimensional view of advocate performance and customer impact, we are able to successfully execute a call surveillance process to monitor compliance to an established set of criteria and provide member feedback to the business.

Should the inquiry be determined to involve a grievance, Express Scripts will initiate a case. Should the inquiry be determined to involve a coverage determination, Express Scripts will transfer the complaint to the Coverage Review Department and the appropriate coverage review case will be initiated. If a grievance addresses two or more issues, each issue shall be processed separately and simultaneously under the proper procedure by the appropriate department.

If ERS chooses to delegate appeals and/or grievances to Express Scripts, we are able to integrate with other departments and our customer service team will open a case for each identified grievance or review and are appropriately routed to the appropriate dedicated team(s): Medicare Grievance Resolution team or Coverage Review Department.

If ERS chooses to handle appeals and/or grievances without the support of Express Scripts, we will work with ERS to ensure that requests are appropriately routed to the correct entity that has responsibility to manage the request. Our representatives will refer callers to your staff as soon as they recognize that inquiry is for a Medicare service we are not delegated to manage. This is accomplished by warm transferring the caller to ERS or forwarding written requests via electronic fax. Information will be included on the fax cover sheet to indicate the date and time the request was received by Express Scripts.

For the coverage review processes, Express Scripts maintains oversight and control of processing to ensure the accurate and timely handling of requests throughout the lifecycle of a Medicare Part D redetermination request. We manage the receipt and processing of redetermination requests in accordance with all applicable CMS regulations and guidance and we make decisions for drug coverage based on clinical and administrative criteria applicable to the drug, and all available information provided with the request or received in response to our request for additional information from a physician or other prescriber. Our Appeals Team pharmacists will also review approved drug compendia to find supporting information. We manage all related written communications for enrollees, their appointed representative, physicians or other prescribers and we provide templated communications for your approval.

To ensure you have appropriate oversight of the Express Scripts handling of coverage review requests, including appeal requests, and have all necessary information related for required reporting to CMS, Express Scripts ensures the following:

- We produce CMS Annual reports for Redeterminations and Re-Openings and Grievances on a regular basis. The final CMS Annual reports for Coverage Determinations and Exceptions, Redeterminations and Re-Openings and Grievances are released to plan sponsors at least two weeks before the CMS due date.
- We provide oversight reporting to you via the Express Scripts Client Website on a daily and monthly basis so that you have appropriate oversight of us as a delegated entity of your plan. One unique reports is posted daily that details all coverage review requests Express Scripts forwarded to the plan by phone or electronic fax the previous day. In addition, Grievances reports are also posted on a daily and monthly basis and includes all cases identified and/or resolved the previous day/month.
- We provide unmatched support to you upon selection for a Coverage Determination and Appeal or Grievances audit by CMS.

D.5.a. Describe any procedures for handling customer service complaints and inquiries that were not included above, if any.

- HealthSelect PDP:

Express Scripts has a standard member escalation process in place for member service issues. However, for members who have experienced multiple serious service failures, we offer a concierge service on a limited basis.

Express Scripts internally evaluates each request individually for concierge services. An application for enrollment consideration is submitted internally to Concierge leadership. In order to be accepted, the member must have experienced numerous issues with Express Scripts® Pharmacy over the previous six months or past two fills. If we determine that a member needs the service, the member is placed in the program for a limited timeframe.

Once the member has been assigned to concierge service, he/she will receive an introductory call within 24 hours. The concierge representative will provide high-touch support by performing pharmacy transactions and/or monitoring any pharmacy activity.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

No difference.

D.5.b. Will the staff that Respondent is proposing to handle the Programs’ customer service complaints, and inquiries be designated or dedicated?

- HealthSelect PDP:

Express Scripts is proposing 30 dedicated patient care advocates to support ERS' employees.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

D.5.c. How does Respondent notify Participants of a resolution or response? Will the staff Respondent is proposing to draft the responses be designated or dedicated?

- HealthSelect PDP:

  Your dedicated patient care contact team will attempt to resolve the member's complaint via phone on at the initial contact. If the complaint is not resolved, it will be escalated further to a resolution team lead. If the complaint requires further outreach, the team lead will create a case to further track the issue and provide follow-up via a phone call.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  For Medicare Part D grievances, Express Scripts will respond to the member's grievance either verbally or in writing. Any grievance where the member request a response in writing, or the case is identified as a quality of care grievance will always be responded to in writing. All grievances responded to in writing are worked by our Medicare Part D grievance resolution team. Grievances responded to verbally are handled by our customer service staff.

**Executive Summary**

D.6. Provide an executive summary no longer than two (2) pages outlining significant features of Respondent’s Proposal. The summary should highlight Respondent’s philosophy, Respondent’s experience with similar programs and the administrative approach presented in the Proposal.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

**Master Benefit Plan Documents and Evidence of Coverage**

D.7. Respondent shall provide proposed samples of the items listed below:
- Master Benefit Plan Document for the HealthSelect PDP; and
- Evidence of Coverage for the HealthSelect Medicare Rx PDP.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

D.8. Respondent shall describe the annual process for ensuring the MBPDs and EOC are fully approved and published prior to the start of each Program/Calendar Year.

Express Scripts will work with ERS to provide you with the pharmacy benefit information you need for the Summary Plan Descriptions (SPD) developed by your medical carriers. Information we can provide ERS specific to your plan design includes details and specifications of the copayment design and descriptions of possible inclusions, exclusions, and other design features related to ERS's pharmacy benefit. Your Express Scripts account team can also review the SPD to confirm that it is consistent with ERS's plan design.

As the contract holder with CMS, Express Scripts is responsible for the creation, mailing, and delivery of all CMS-required communications.

ERS will have the opportunity to receive various template communications for your reference on an annual basis. As some documents are CMS template, not all are customizable. However, ERS will have the opportunity to customize certain documents with the assistance of your designated Member Experience Manager (MEM). The process for creation and annual review of customizable documents includes direct support from ERS's MEM as well. Express Scripts will notify ERS on the timing of other large CMS-required mailings to provide ERS advanced notice should such a mailing increase call volume. Please note that some CMS-required mailings trigger on an as-needed, member-level basis, and as such, proactive notification is not always possible to ensure that CMS-required turnaround times are met. However, as stated above, ERS will have access to templates of various communications to ensure familiarity. Additionally, should there be a need to send an ad-hoc communication, your MEM can work with ERS to craft the message to ensure CMS compliance, as well as consistency of messaging and tone when compared to other plan documents.
With regard to the Summary Plan Description, Express Scripts does not create the Summary Plan Description for ERS; rather ERS creates its own Summary Plan Descriptions, as they often include other benefits that Express Scripts does not provide. Your Express Scripts MEM will be happy to review the EGWP portion of the Summary Plan Description for ERS upon client request.

D.9. Respondent shall provide electronic mock-ups pf the proposed GBP-specific ID cards for the Programs.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

## E. Interrogatories – Customer Service Requirements

**Customer Service Unit**

E.1. Does Respondent expect to make major changes to its Customer Service Unit or customer service facilities within the next four (4) years (e.g., moving to a different location, reorganizing or merging units, etc.)?

- HealthSelect PDP: ☐ Yes ☒ No
  If yes, explain and indicate timeframe.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.2 Respondent will describe how Respondent's Customer Service Unit be staffed.

- HealthSelect PDP:

  Express Scripts is proposing a dedicated contact center staff of 30 patient care advocates to handle ERS' call volume. These advocates and pharmacist has access to comprehensive member-specific and plan-specific information through Express Scripts' customer service system. This system includes a personalized electronic record that details the member's health and financial savings opportunities based on available pharmacy, medical, and lab data.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.3. Describe the manner in which the Customer Service Unit may be accessed (e.g., web chat, telephone, email, mobile app, etc.) and the hours of operation for each.

- HealthSelect PDP:

  Members can access the Customer Service Unit through a variety of ways, all of which are available 24 hours a day, 365 days a year.
  ERS's members will call one dedicated, toll-free member service number for all of their retail, home delivery, and specialty pharmacy needs. Leveraging sophisticated telephone system technology, our Contact Centers effectively manage your call volume. Calls from members with specialty pharmacy questions are routed to our specialty pharmacy for enhanced clinical care. Members also have the ability to contact our specialty pharmacy directly through a separate toll-free number, which is also printed on the member ID card.

  Through the member website, members are offered a number of different channels to contact us, including:

  - *Live Chat* – This is the fastest and easiest way to reach a Patient Care Advocate. Our advocates are available 24-7 and should be available to chat in seven seconds. (Not available for Medicare members at this time.)
  - *Contact a member service representative* — Members have the ability to leave secure online messages for our member service representatives. Most inquiries are answered within 24 to 48 hours, either by email or, when necessary, by telephone.
  - *Contact a specialist pharmacist* — This function provides members with a convenient and confidential way to ask our staff of registered pharmacists about prescriptions. Most inquiries are answered within 24 to 48 hours, either by email or, when necessary, by telephone.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

E.4 How does Respondent monitor Participant first call resolution and inquiries that do not get resolved during the initial call?

- HealthSelect PDP:

  Our customer service platform provides our patient care advocates with the tools to resolve calls quickly and accurately the first time the member calls, improving client and member satisfaction while also allowing us to capture, track, and record member interactions. Express Scripts' first call resolution rate in 2021 was 96.6%.

  If an issue cannot be resolved due to the need for further research or follow up from Express Scripts, our Patient Care Advocates contact a Resolution Team Lead (or Supervisor) who can create a case to follow up and will contact the caller to provide a resolution within a specified time frame. If the issue involves the need for further information from a third party, such as the member's doctor, our Patient Care Advocates will reach out to the appropriate parties to initiate the process. This proactive process, which is governed by specific policies and procedures, employs sophisticated reporting mechanisms and eliminates service issues before they occur. Members will then receive automated messaging via their preferred method of contact advising them of the outcome.

  The Customer Contact System allows the patient care advocate to assign a specific reason, action, or disposition code to classify the member inquiry and the resolution. All service-related issues are documented, categorized, and monitored as part of our ongoing quality-improvement processes. For example, the reporting system automatically logs key information, such as the prescription number, when placing a refill order. Advocates also have the ability to provide free-form comments related to the member interaction to further explain why the member contacted Express Scripts.

  Advantages of our Customer Contact System include:

  - *Key process quality indicators* — Indicators identify opportunities for improvement through analysis of information entered into the Customer Contact System.
  - *Personalization* — Consistent messaging speaks to ERS's plan in a manner that members can comprehend and utilize effectively.
  - *Rapid screen access* — Pre-populated patient information includes the member number and prescription number based on the unique telephone number for the patient that is stored within our system.
  - *Scripting and messaging capabilities* — These capabilities support accurate communication while also incorporating historical data to enhance patient decision-making.

  Our quality manager, along with operational leaders, monitors service issues, verifies proper issue resolution, analyzes root causes, and implements organization-wide corrective actions. This process is an integral part of our continuous process improvement program.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.4.a. To what metric does Respondent adhere to regarding Participant first call resolution to ensure Participant inquiries will not require a subsequent call for the same issue (e.g., drug copay, benefit navigation, etc.) within a seven (7) day timespan?

Express Scripts defines the first call resolution rate as those calls that were resolved and the member did not call back within five calendar days for the same reason. The first call resolution rate is confirmed by the indication that a member has not called back within five calendar days. The majority of the remaining calls for which the member called back within five days are resolved during the second contact with Express Scripts. If a member has a complex issue that takes additional time to research, Express Scripts' patient care advocates maintain regular contact with the member until the issue is resolved. Our goal for first call resolution is 95%. In 2021, our first call resolution rate was 96.6%.

E.5. Describe Respondent's procedure for managing written inquiries and current standard response time.

- HealthSelect PDP:

  Our patient care advocates are entrusted with all written inquiries through the Contact Center and are immediately logged into our customer contact system. Express Scripts responds to the majority of written inquiries sooner, but we guarantee that annually: 95% or more of written inquiries will be responded to within five (5) business days and that 100% of written inquiries will be responded to within ten (10) business days.

  ## Email Inquiries

  All email inquiries received by the Contact Center are also captured in our customer contact system. Express Scripts' e-patient care advocates are responsible for providing responses to inquiries within five (5) business days.

  In 2021, we responded to 99.9% of written and email inquiries within five business days. Our corporate standard is to respond to 95% of member correspondence received by mail or email within five business days of receipt.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  In 2021, we responded to 99.9% of written and email inquiries within five business days. Our corporate standard is to respond to 95% of member correspondence received by mail or email within five business days of receipt.

E.6. Describe the related training received by each employee category (i.e., claim processors, customer service representatives, supervisors, and other management staff).

- HealthSelect PDP:

  Customer service is central to the success of our programs. Our model is founded on the premise that an exceptional service experience opens the door for effecting positive member behavior change. We strive to keep employees engaged, so we ensure that we provide a workplace culture in which employees are recognized and rewarded for behaviors that build trusting relationships and deliver platinum-level service to members. Our interactions with members deliver a superior customer service experience that empowers the member to make more informed decisions and to achieve healthier results.

## Initial Training Program and Requirements

We ensure superior patient care advocate performance through training, coaching, just-in-time access to electronic knowledge management tools, and positive reinforcement of desired behaviors. Individual modules that advocates complete include the following:

### New Hire Training

Patient care advocates complete a ten-week new hire program that is outcome-focused to provide service beyond the transaction. Learning is progressive and organized in two phases from basic to complex. In the first phase, advocates participate in ten days of formal classroom instruction with hands-on practice learning basic call scenarios followed by eight days of taking calls in a controlled environment with personalized coaching. This is followed by three weeks of working independently before returning to the classroom for two weeks of additional instruction for more complex scenarios. The second phase of training also includes a week of call-taking in a controlled environment before advancing to work independently. During this time, advocates become fully versed in accessing our online reference tools which provide real-time detail on the nuances of plan designs. Within seconds, advocates can access member-specific and client-specific information by leveraging electronic performance support systems via our online knowledge management toolset. Advocates also receive substantial training and coaching in-service skills including: call courtesy, problem-solving, patient sensitivity, and patient advocacy. Their ongoing performance is monitored, tracked, and evaluated.

### Ongoing Training

As new knowledge or skills are required, we offer additional training to support our patient care advocates. Existing advocates receive approximately 25 hours annually of ongoing training to review new clients, programs, products, and procedures. In addition to this ongoing training, advocates receive coaching on quality behaviors required by Express Scripts. The quality behaviors include communication skills, business practices, and regulatory compliance.

In addition to the New Hire program, we support over 90 specialized client-specific training programs. To support Patient Care Advocates as new knowledge is required, we deliver additional training through various media; i.e. team huddles, LMS eLearning modules, attestations, criterion-based knowledge assessments, and electronic communications.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  In addition to the training outlined above in the HealthSelect PDP response, our designated Contact Center team that supports ERS’s Medicare Part D beneficiaries receives an additional 30 hours of extensive training to understand the nuances of Medicare Part D, including:
  - Fraud, waste, and abuse training
  - Medicare Part D compliance training
  - Medicare product training
    - Deciphering government communications
    - Managing straddle claims, coverage gaps, true out of pocket costs, and client benefits

Advocates receive ongoing training as necessary to ensure they are aware of all Centers for Medicare & Medicaid Services (CMS) changes.

E.7. Identify any dedicated staff units to be assigned to ERS or that Respondent plans to assign to this account.

- HealthSelect PDP:

  Express Scripts is providing ERS with a dedicated senior account executive, senior account manager, and communications specialist. We are also proposing a dedicated patient care advocate team.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.8. Are Customer Service Representatives separated from the claim processing unit, or do claim processors have customer service responsibilities?

- HealthSelect PDP:

  The role of our patient care advocates is distinct from claims processing. Patient care advocates do not have the ability to approve or process claims. However, in instances when a patient refers to being out of medicine or close to having an interruption of therapy, the advocate can use various operating procedures to assist the patient. Patient care advocates are empowered to offer short-term local supplies and to expedite prescriptions through Express Scripts Pharmacy.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.9. Do Respondent's Customer Service Representatives have the authority to approve claims?

- HealthSelect PDP:

  No. Patient care advocates do not have the ability to approve or process claims. Patient care advocates are empowered to offer short-term local supplies and to expedite prescriptions through Express Scripts Pharmacy.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.9.a. If any of the responses to Section E.9. above was yes, Respondent shall provide examples of approvals that Customer Service Representatives can make.

  Not applicable.

- HealthSelect PDP:

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

**Customer Service Unit**

E.10. Describe Respondent's IVR system and discuss the following.

- HealthSelect PDP:

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|---|---|
| Services available: | Some of the information members can obtain through the IVRU include:<br><br>• *Home Delivery Refills and Renewals* — For placing a prescription refill order using the prescription number. Members may also order early and pend the prescription request. The system also allows a prescription to be renewed and sends a fax to the patient's doctor for permission to renew that prescription. The system provides an order cost to the member, requests payment, confirms the shipping address, and processes the order. The member receives a confirmation number indicating that the order is in process.<br>• *Participating Retail Pharmacy Locator* — For locating participating retail pharmacy names, locations, and phone numbers. The system uses "locator logic" so that a member, after providing a ZIP code, not only receives information regarding the pharmacies located within that ZIP code, but also those within adjacent ZIP codes if desired.<br>• *Home Delivery Status* — For checking the status of a new, faxed, or refill home delivery prescription. To use this option, the member may provide either a prescription number or their member ID number. The system looks back 28 days and tells the caller of the expected shipping date of those orders beginning with the most recent.<br>• *Drug Coverage and Pricing* — To define whether a particular medication is covered and its cost at both home delivery and retail. The system identifies savings opportunities when a generic equivalent is available. The member may provide either a prescription number or a member ID to initiate the process. Members should also know the medication name, dose, and form.<br>• *Order Supplies* — For ordering home delivery forms, envelopes, and direct reimbursement claim forms. The member provides the member number, selects the item(s), selects the method of delivery, and then confirms the delivery address.<br>• *Balance and Payment* — Allows members to check balance due, make payments by credit card, sign up for automatic payment using a credit card or electronic checking, and update credit card information.<br>• *Statement of Benefits or Explanation of Benefits* — For requesting a record of claims information |

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| | for home delivery and retail to view prescription drug costs accrued during the course of a year.<br>• *Eligibility*— For members to check the status of their own and their dependents' eligibility.<br><br>The following provides an example of Express Scripts' Interactive Services:<br><br>• Members may access the names and locations of participating pharmacies by providing their ZIP code.<br>  ○ The caller will hear the names and locations of 12 pharmacies that participate in their network within their ZIP code. If there are less than 12 participating pharmacies in that ZIP code, the caller is asked if they would like to know the names and locations of participating pharmacies in neighboring towns. The member can continue requesting the names of pharmacies until 12 have been named.<br>• Members may request a refill by providing the prescription number. Upon ordering that refill, the member will be told the number of refills remaining.<br>  ○ The caller provides the prescription number for the medication they would like to order. The system, upon accepting that prescription number, then tells the caller the number of refills remaining after this order. The system provides the cost of the order, prompts the member for payment, and confirms the member's shipping address.<br>• Members may request the status of a specific prescription order by providing that prescription number or member ID number.<br>  ○ If the caller provides a specific prescription number, he/she will be told the shipping date of that prescription and the other items in that order. Members may also check the status of orders by providing their member ID. The system looks back 28 days and speaks the most recent order first. Our new Order Status application can also provide status on new orders and fax orders. |
| Implementation date: | Express Scripts has been working with IVR-based self-service technology for 30+ years. |

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| Historical upgrades and dates: | Express Scripts has been working with IVR based self-service technology for 30+ years. During that time it has been completely transformed and modernized through more than five different generations. |
| Future upgrades (with scheduled dates) being considered: | Express Scripts is constantly monitoring the technology landscape to see how we can improve our patient experience. Upgrades to our system are ongoing; most recently, we enhanced our system to provide a conversational experience leveraging AI-based technology. |
| System down times over the last twelve (12) months other than for routine maintenance: | Our product is built with local high availability and is geographically redundant. It operates 24/7 without the need for scheduled outages for routine maintenance. The IVR has had zero down time in the past 12 months. |
| Customization capabilities: | To personalize the customer service experience, ERS may customize your greeting on our Express Scripts Voice Router (ESVR) application. For example, you can work with your implementation project manager or account manager to include custom messaging that states, "Thank you for calling Express Scripts, serving ERS," which would then route to our automated IVR system. Custom messaging is available at no additional cost. Also, Express Scripts can remove IVR options not applicable to ERS's benefit; for example, we can remove the "locate pharmacy" option for mail-only clients. |
| Participant (Caller) Authentication Process (how a vendor would authenticate/validate the caller via the IVR prior to providing an specific information): | The IVR system will attempt to authenticate a caller prior to transferring them to a patient care advocate. The IVR may ask for information like the member's name, date of birth, zip code, prescription number, or member ID to authenticate the caller. When the caller is authenticated through the IVRU, the patient's electronic file displays for the patient care advocate to see that they have been authenticated. From there, the patient care advocate must ask for the caller's full name to ensure that they are speaking to the correct member. If they have not been authenticated through the IVRU, then they will need to verbally authenticate with the patient care advocate as described below.<br>Express Scripts' standard procedures, which are followed by our Contact Center teams, provide a high degree of attention to caller authentication and appropriate disclosure of PHI. The protection of member and dependent PHI is taken very seriously. Prior to disclosing an individual's PHI to an inbound caller, Express Scripts requires callers to clearly establish their identity. A caller may need to provide information such as name, member number, prescription number, medication name, patient address, ZIP code, or date of birth.<br><br>Prior to disclosing an individual's PHI to a family member or caregiver, Express Scripts requires inbound callers to clearly establish that they are involved in the individual's care. The caller must provide specific information about the individual, including the individual's name, member number, and prior knowledge of the prescription in question, consisting of either: i) a prescription number, or |

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| | ii) drug name and, in some cases, drug strength. A caller providing this information will be able to act on behalf of the individual, but only with regard to the prescription associated with the prescription number or drug name provided. If an individual has requested confidential communication (pursuant to sect. 164.522 of HIPAA Privacy Standards), Express Scripts takes specific steps to ensure that the individual's PHI and information concerning the confidential address to which the individual has directed communications will be disclosed only to the individual or the individual's personal representative.<br>When responding to written requests for an individual's PHI, Express Scripts requires specific documentation establishing the requestor's right to the receive the information, such as, power of attorney, Patient Authorization Form, Deceased Patient Authorization & Death Certificate, or subpoena. The document required applies both to family members or third parties. Requests forwarded with a power of attorney or a subpoena are forwarded to the Privacy Office's Custodian of Records, who validates each request before fulfilling. |

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  No difference.

E.11. Describe Respondent's Call Center telecommunications system, technologies, and capabilities (to include reporting) in detail.

- HealthSelect PDP:

  Express Scripts' Contact Centers are equipped with the most current telephonic equipment and management tools. We continue to invest in technologies and processes to provide superior quality service to members, including:

  - *Aspect eWorkforce Management* — This tool models required staffing levels based on historical call patterns, while accounting for average absenteeism on given days and shifts, scheduled breaks, lunch hours, and training, as well as special projects to which an advocate may be assigned.

  - *Cogito* - Our call center technology listens to the exchange between your member and our PCA and evaluates for immediate opportunities to improve that exchange with specific focus on improving empathy, speed of dialogue, ability to listen, silence, tone/sentiment of discussion, etc. and provides real time guidance on THAT call to improve the at the moment' experience. Essentially, putting a coach in the ear of every PCA for every member conversation real time.
  - *Contact Center Platform* — This platform includes our customer service platform and the Customer Contact System. These are browser-based applications for retrieval and entry of information for our advocates.
  - *Genesys Intelligent Call Routing* — This technology allows us to virtualize our Contact Centers and extend resources to multiple locations around the country, providing

our Contact Centers with the capability to dynamically route calls to available advocates. We also have intelligence to redirect calls for members that may have called the wrong number and target the correct agent skills to avoid transfers.

- *Intradiem* — Provides real-time adherence coaching to patient care advocates in the form of pop-up messages.
- *IVRU Applications Including Speech Recognition* — These applications provide members with the latest speech recognition technology that allows members to speak using natural language to access a particular service rather than utilizing a touch-tone menu.
- *Language Line and Telecommunications Device for the Deaf/Teletypewriter (TDD-TYY) Services* — These services allow foreign language–speaking and hearing-impaired members to communicate with advocates and pharmacists.
- *Outbound Voice Messaging* — This technology is designed to enhance a member's home delivery experience and proactively alert members to pertinent information regarding a specific prescription order or benefit. Outbound Voice Messaging campaigns include scenarios where we need to notify members that it's time to refill their prescription, that there's a delay or inability to fill the prescription order, or that benefit-related opportunities are available.
- *Verint Quality Call Monitoring* — This real-time call-monitoring system and feedback tool provides the technological capability to listen to an advocate and view the online screens that the advocate accessed during the call.

### Reporting

Account teams can access and provide clients with call reporting details such as the Top 5 Call Reasons and a detailed report that specifically contains complaint tracking. This report captures the top complaints received by patient care advocates and details complaints by member ID, call date, dispensing date for the prescription, reason code, reason category, disposition of the call, and turnaround time in days for resolution of the member's complaint. Your account team has the ability to generate these reports on a monthly basis.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

  In addition to the technology and reporting above, for Medicare we provide grievance reporting. Daily reporting (including all cases opened and closed the previous day) and monthly reporting (including all cases opened and closed the previous month) is available to clients who delegate Medicare Grievance Resolution to Express Scripts.

E.12. Does Respondent currently provide any automated customer service support using voice response for routine questions?

- HealthSelect PDP: Yes.
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

E.13. Does Respondent provide access to automated, interactive data systems that would provide Participants with information?

- HealthSelect PDP: Yes.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. **No difference.**

E.13.a. If yes, fully describe the self-service functionality.

- HealthSelect PDP:

  Some of the information members can obtain through the IVRU include:

  - *Home Delivery Refills and Renewals* — For placing a prescription refill order using the prescription number. Members may also order early and pend the prescription request. The system also allows a prescription to be renewed and sends a fax to the patient's doctor for permission to renew that prescription. The system provides an order cost to the member, requests payment, confirms the shipping address, and processes the order. The member receives a confirmation number indicating that the order is in process.
  - *Participating Retail Pharmacy Locator* — For locating participating retail pharmacy names, locations, and phone numbers. The system uses "locator logic" so that a member, after providing a ZIP code, not only receives information regarding the pharmacies located within that ZIP code, but also those within adjacent ZIP codes if desired.
  - *Home Delivery Status* — For checking the status of a new, faxed, or refill home delivery prescription. To use this option, the member may provide either a prescription number or their member ID number. The system looks back 28 days and tells the caller of the expected shipping date of those orders beginning with the most recent.
  - *Drug Coverage and Pricing* — To define whether a particular medication is covered and its cost at both home delivery and retail. The system identifies savings opportunities when a generic equivalent is available. The member may provide either a prescription number or a member ID to initiate the process. Members should also know the medication name, dose, and form.
  - *Order Supplies* — For ordering home delivery forms, envelopes, and direct reimbursement claim forms. The member provides the member number, selects the item(s), selects the method of delivery, and then confirms the delivery address.
  - *Balance and Payment* — Allows members to check balance due, make payments by credit card, sign up for automatic payment using a credit card or electronic checking, and update credit card information.
  - *Statement of Benefits or Explanation of Benefits* — For requesting a record of claims information for home delivery and retail to view prescription drug costs accrued during the course of a year.
  - *Eligibility* — For members to check the status of their own and their dependents' eligibility.

  The following provides an example of Express Scripts' Interactive Services:

  - *Members may access the names and locations of participating pharmacies by providing their ZIP code.*
  - *The caller will hear the names and locations of 12 pharmacies that participate in their network within their ZIP code. If there are less than 12 participating pharmacies in that ZIP code, the caller is asked if they would like to know the names and locations of participating pharmacies in neighboring towns. The member can continue requesting the names of pharmacies until 12 have been named.*

- *Members may request a refill by providing the prescription number. Upon ordering that refill, the member will be told the number of refills remaining.*
- *The caller provides the prescription number for the medication they would like to order. The system, upon accepting that prescription number, then tells the caller the number of refills remaining after this order. The system provides the cost of the order, prompts the member for payment, and confirms the member's shipping address.*
- *Members may request the status of a specific prescription order by providing that prescription number or member ID number.*
- *If the caller provides a specific prescription number, he/she will be told the shipping date of that prescription and the other items in that order. Members may also check the status of orders by providing their member ID. The system looks back 28 days and speaks the most recent order first. Our new Order Status application can also provide status on new orders and fax orders.*

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

E.13.b. If no, does Respondent have future plans for this type of service?

- HealthSelect PDP: N/A

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. N/A

E.14. How does Respondent's Customer Service Team and system support Participants with disabilities?

- HealthSelect PDP:

  We recognize that a large percentage of our clients' members have unique and specific needs. We have extensive experience in providing prescription drug benefits to those with special requirements, including seniors and physically challenged members, and have developed a number of services and with this in mind. Assisted services include:

  - Brochures printed in large type, to provide as requested
  - Prescription labels printed in Braille
  - Telecommunications device for the deaf/teletypewriter (TDD-TYY) capabilities and other special-needs communication services and products that allow members to communicate with patient care advocates and pharmacists; TDD-TTY devices are available via a toll-free number
  - Our patient care advocates can review and provide accurate explanations related to eligibility, benefits, and claims processing systems when members are unable to read member materials, invoices, or other communications
  - A device designed to help our visually impaired members, ScripTalk, allows users to have information spoken to them straight from their prescription bottles. Trained team members at the Express Scripts® Pharmacy affix radio frequency identification (RFID) labels onto the bottles, allowing ScripTalk the ability to read the information aloud when a patient places the bottle on the device. This technology also helps patients who have caregivers assisting with taking their medication.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

E.15. Describe how overflow and after-hours calls are handled.

- HealthSelect PDP:

  Express Scripts' Contact Center network is available 24 hours a day, 365 days a year; therefore there are no after hours calls. Regarding overflow, we invest in several technologies to ensure our Contact Centers are appropriately staffed. These technologies include:

  - *Aspect eWorkforce Management* — This tool models required staffing levels based on historical call patterns, while accounting for average absenteeism on given days and shifts, scheduled breaks, lunch hours, and training, as well as special projects to which an advocate may be assigned.
  - *Genesys Intelligent Call Routing* — This technology allows us to virtualize our Contact Centers and extend resources to multiple locations around the country, providing our Contact Centers with the capability to dynamically route calls to available advocates. We also have intelligence to redirect calls for members that may have called the wrong number and target the correct agent skills to avoid transfers.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

E.16. Does Respondent record all telephone calls?

- HealthSelect PDP: ☒ Yes ☐ No

  If yes, how long are these recordings stored?

  We retain member calls for one year.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  We retain member calls for one year. In addition, we retain ERS's Medicare Part D open enrollment calls for 11 years.

E.16.a. Can Respondent send recordings of calls via secured email to ERS if requested?

- HealthSelect PDP: ☒ Yes ☐ No

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  No difference.

E.17. Does Respondent have the ability to monitor live customer service calls?

- HealthSelect PDP: ☒ Yes ☐ No

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  No difference.

E.18. How are patterns of customer service inquiries monitored, tracked and the subsequent data used to improve customer service and claims processing activities?

- HealthSelect PDP:

  Express Scripts recognizes that the quality of our customer service is reflected in the ability of our patient care advocates to optimize every member interaction while lowering your healthcare costs. Our model is founded on the principle that an exceptional service

experience opens the door for changing member behavior. To deliver maximum value with every encounter, we make significant investments in call recording and monitoring, as well as advocate coaching.
Express Scripts uses a state-of-the-art call-recording system to digitally record 100% of the voice portion of incoming calls to our advocates. Callers are notified of the recording prior to the connection to the advocate. The system also captures the actual screen video on a significant sample of the calls, providing the ability to listen to the call and view how the advocate navigated the screens in the service delivery system.
Our Speech Analytics system transcribes approximately 20% of recorded calls, allowing our dedicated speech analysts to mine spoken words and phrases, categorize calls, and identify opportunities for improvement. This technology is also available to all front-line supervisors, enabling them to search for specific types of calls and deliver targeted coaching.
There are varied initiatives underway to drive process and performance improvements. There are monthly initiatives lead by the pharmacy practice and quality teams to continue focus on clinical topics under regulatory compliance and process improvements related to order processing. In addition, the contact center has implemented a new process improvement team, including front line supervisors and agents, that focus on simplifying or clarifying internal procedures to improve the overall member experience. Lastly, we are implementing systems that are more intuitive and user friendly for our front line agents that are geared to help them to better navigate the steps within a call flow and order process. These are only a few of the ongoing efforts under way to improve overall quality and ultimately the patient experience.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

  No difference.

E.19. How does Respondent ensure that its Customer Service Representatives are providing timely and accurate information?

- HealthSelect PDP:

  Through the customer service platform, patient care advocates have access to a wealth of information that is unique to each member for both retail and Express Scripts® Pharmacy, detailing the member’s health and financial savings opportunities based on available pharmacy, medical, and lab data and associated algorithms. Information available in the customer service platform includes:

  - Applicable clinical programs and coverage rules, including authorization history
  - Benefit design
  - Claims history and status
  - Drug information, including coverage
  - Explanation of benefits (EOB) reports
  - ID card eligibility and status
  - Images of letters and other communications sent by Express Scripts
  - Patient medical profiles
  - Pharmacy locations

  Advocates present members with the benefits and potential savings opportunities they may gain by utilizing our home delivery pharmacy.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  **No difference.**

E.20. Does Respondent's customer service inquiry system allow representatives to record comments so that another Customer Service Representative can review previous notes in order to assist Participants? ☒ Yes ☐ No

E.21. Respondent shall describe its extensive experience in providing optimal participant service with a dedicated Customer Service Unit model.

**Express Scripts has vast experience in effectively operating dedicated contact center teams. Currently, we manage five fully dedicated teams. Each dedicated team undergoes extensive training to understand client specific benefits, nuances, and culture. In addition to the patient care advocates undergoing extensive training, these advocates are grouped together by leadership to ensure that their team lead is familiar with the ins and outs of the client that their team is servicing.**

**Express Scripts uses eWorkforce Management software to accurately forecast call volume to ensure that each dedicated team has the appropriate dedicated staffing. Our modeling takes into account call history, membership and benefit changes, peak calling periods, and interval level staffing requires based on absenteeism, breaks, and lunches. This modeling allows us to plan in advance to ensure performance targets are met and to quickly adapt any staffing changes that are needed.**

E.22. Respondent shall describe how it will ensure that Respondent's Customer Service Unit will be functional for the HealthSelect Medicare Rx PFP prior to October 1, 2023 and for the HealthSelect PDP by December 1, 2023.

**Express Scripts can support your open enrollment as long as we have received new or updated plan designs by the mutually agreed upon date. Members will have access to our patient care advocates 24 hours a day, seven days a week. Advocates can access and provide your members with the following information:**

- **Participating retail pharmacy locations**
- **Drug-specific coverage**
- **Drug-specific copayment**
- **Instructions on how to begin home delivery**

**ERS is responsible for distributing member communication materials containing the toll-free customer service number along with an accurate description of new plan design or plan changes. Benefit designs need to be finalized by Express Scripts and ERS by the agreed upon implementation timeframe. Benefit Operations will need to have all the client benefit information in order to build Open Enrollment Groups. After ERS supplies Express Scripts with the appropriate plan information, we enter it into our system to make available for our patient care advocates to reference.**

E.23. How many licensed pharmacists are employed in Respondent's Customer Service Unit who will be performing any services in connection with the Programs?

- HealthSelect PDP: **142**
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. **No difference.**

**Customer Service Representatives**

E.24. Describe Respondent's quality and assurance program as it relates to CSR's (including process of monitoring timeliness of responses and real-time calls).

- HealthSelect PDP:

  Quality monitoring at Express Scripts encompasses a surveillance process to ensure compliance to an established set of criteria and provide member feedback to the business. The process at Express Scripts is achieved through a variety of techniques and applications that allows for a multi-dimensional view of agent performance and customer impact:

  - Call monitoring and trend analysis
  - Test calls (secret shopper)
  - Video and audio recordings for coaching

  From the use of Speech Analytics to the more traditional call monitoring, the varied formats and applications allow us better line of sight and provide exceptional intelligence into the customer perspective, allowing us to pivot, as necessary, to drive improvements.

  Our program evaluates core behavioral competencies as well as the overall member experience and is designed to reinforce behaviors we want to see repeated and reinforce our service culture of being all in for our patients.

  The monitoring program is only as successful as the complementary coaching methodology in place to reinforce expectations and deliver feedback. Because we realize how critical coaching is in the development of our employees, one dimension of our process focuses solely on how to facilitate an effective coaching session and drive improvements to obtain positive customer outcomes.

  Call Recording and Live Call Monitoring

  Express Scripts uses a state-of-the-art call-recording system to digitally record 100% of the voice portion of incoming calls to our patient care advocates. Callers are notified of the recording prior to the connection to the advocate. The system also captures the actual screen video on a significant sample of the calls, providing the ability to listen to the call, view how the advocate navigated the screens in the service delivery system, and provide coaching based on the observation.

  Our speech analytics system transcribes approximately 20% of recorded calls, allowing our dedicated speech analysts to mine spoken words and phrases, categorize calls, and identify opportunities for improvement. This technology is also available to all front-line supervisors, enabling them to search for specific types of calls and deliver targeted coaching.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. **No difference.**

E.25. How will Respondent assist bilingual Participants? Response shall include, but not be limited to, if calls are handled by a CSR or subcontractor, the languages where language translation services are available, and any increase in response time for bilingual Participants vs. non-bilingual Participants.

- HealthSelect PDP:

  Translation services are available to members 24 hours a day, 365 days a year. Express Scripts advocates can set up three-way conference calls with members and Language Line representatives to address members' requests.

  To assist those members who do not speak English, Express Scripts subscribes to the Language Line, which provides translation services for more than 200 foreign languages, including the major languages of Asia, Africa, Europe, and South America. These languages represent approximately 98.6% of all customer requests from the 6,809 languages spoken in the world today. Experienced professionals staffing this line have the skills necessary to understand and accurately interpret the nuances of both language and culture.

  In addition, we have a designated team of in-house bilingual representatives that support the Contact Center and specialize in providing service to Spanish-speaking members. These agents assist Spanish-speaking members in Spanish, removing the third party and creating a more seamless member experience.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

E.26. Describe Respondent's customer satisfaction survey process, including: how satisfaction surveys are typically sent out (mail, email, phone, etc.), how Respondent determines quantity/sample size of survey, and frequency of surveys.

- HealthSelect PDP:

  Express Scripts regularly conducts member satisfaction surveys, allowing members to provide feedback and suggestions related to their pharmacy benefit. Our book of business surveys are conducted on a weekly basis, while client-specific surveys are conducted on a quarterly basis to ensure an accurate sample size.
  An independent research firm conducts telephone interviews with a random selection of members who have utilized their prescription-drug benefit within the previous month. Members rate their experience with specific services, including the Contact Center, Express Scripts® Pharmacy, and our retail pharmacy network, as well as their overall satisfaction with Express Scripts. Additionally, separate surveys are conducted with members who use our Accredo® specialty pharmacy to allow members the opportunity to rate their experience specific to the specialty services provided.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  No difference.

E.27. Respondent shall submit sample surveys for the HealthSelect PDP and the HealthSelect Medicare Rx PDP with their RFP response.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

E.28. Describe Respondent's ability to make immediate/emergency enrollment updates by phone or email upon request from ERS.

- HealthSelect PDP:
  Through our web-based eService Delivery product, ERS can update eligibility online in real time. Additionally, emergency eligibility updates can be made by Express Scripts by calling our Client Support Center for assistance.

- HealthSelect Medicare Rx PDP:
  Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. ERS can make real-time enrollment updates by using our online eService Delivery tool and its capability, eSD enroll. For an Employer Group Waiver Plan (EGWP) plan, all submissions are subject to Centers for Medicare & Medicaid Services (CMS) approval. ERS can also make enrollment updates via file, or by contacting your designated Medicare Service Center Agent (MSCA) team.

E.29. Does Respondent offer an employer portal that would allow ERS to make immediate/emergency enrollment updates on demand? If so, describe the functionality of Respondent's employer portal.

- HealthSelect PDP:

Yes. Express Scripts supports real-time eligibility changes through eService Delivery, our user-friendly, point-and-click, browser-based application accessible to clients through the client website.

Key benefits of utilizing eService Delivery for eligibility information include:

- Access to member eligibility and plan information in an easy-to-read format
- Secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant system that establishes individual levels of access for all users by restricting access to only the information pertinent to perform specific tasks
- Ease of use through flexible search functions, navigational aids, and detailed online help
- Ability to immediately add or update members and dependents, avoiding member delays in filling prescriptions
- Comprehensive training and technical support

The following are some of the eligibility data elements clients can update using eService Delivery:

- Effective dates
- Termination dates
- Dependent information (additions and deletions)
- Member record information (for example, address, phone, email, name changes)
- Member status code (for example, member-only, spouse-only coverage to full family coverage)
- Termination of eligibility
- Reinstatement of eligibility

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  ERS can make real-time enrollment updates by using our online eService Delivery tool and its capability, eSD enroll. For an Employer Group Waiver Plan (EGWP) plan, all submissions are subject to Centers for Medicare & Medicaid Services (CMS) approval. ERS can also make enrollment updates via file, or by contacting your designated Medicare Service Center Agent (MSCA) team.

E.30. Describe the hours that Respondent's staff is available to handle immediate/emergency updates.

- HealthSelect PDP:
  Our Client Service Center is available through a toll-free number, Monday through Friday, from 8 a.m. to 8 p.m., Eastern. However, ERS can make immediate/emergency updates through eService Delivery 24 hours a day, seven days a week.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
  No difference.

## F. Interrogatories – Claims Processing Requirements

F.1. Provide a detailed description of Respondent's claims processing procedures, including processing of electronic claims and Participant submitted paper claims.

- HealthSelect PDP:

Electronic claims adjudication includes the steps outlined below:

1. For retail prescriptions, the pharmacy uses the information on the member's benefit ID card. Network pharmacies use a switching company or have direct connection to our claims adjudication system. For home delivery prescriptions, the member submits the prescription to the Express Scripts Pharmacy℠.

2. The pharmacist submits the required information to Express Scripts based on the current National Council for Prescription Drug Programs(NCPDP) Telecommunication Standard and our payer sheets. Depending on ERS's plan design, other fields may be required with claim submission. Our claims adjudication system verifies that the person is eligible for pharmacy benefit coverage and then applies benefit design and concurrent drug utilization review (DUR) edits to the claim.

3. Our claims adjudication system checks the current prescription against the member's claim history to identify possible clinical concerns and also completes checks for state or federal-mandated dispensing requirements. Member claim histories include all claims processed through Express Scripts and may include any claims history records that were integrated into our system from a prior pharmacy benefit manager. We add information for each new claim to the member's online pharmacy claims history.

4. Calculated benefit information is returned to the pharmacist, including information on the applicable copayment, deductible due from the member, and clinical messaging. If the claim rejects, our system provides the pharmacy with the appropriate National Council for Prescription Drug Programs (NCPDP) error code and additional messaging, as appropriate. This information is available online for review.

5. For retail prescriptions, the retail pharmacist collects appropriate payment from the member, as determined by the online message from Express Scripts, and dispenses the drug to the member along with a receipt. For home delivery prescriptions, the payment is deducted from the member's credit card or debit card. If the member has mailed in the payment, we verify the correct payment has been included with the prescription order. The prescription is then mailed to the member along with a receipt.

### Paper Claims Process

When necessary, such as when a member uses an out-of-network pharmacy or a member cannot reasonably access one of our network pharmacies, the member may be asked to pay for a prescription in full and submit a direct reimbursement claim form to Express Scripts.
The direct claim adjudication process — also known as the paper claim adjudication process — begins when claims are received, imaged, stamped with the date received, sorted, and batched at our claims processing facility. The process concludes with the member receiving either reimbursement or documentation as to why a claim was rejected.
A step-by-step description of the direct claims adjudication process is detailed below.

#### Direct Claims Processing Flow

- Members submit direct claims to Express Scripts via mail, fax, or electronically via the Prescription Drug Reimbursement Form (recommended).
- The mail room dates, sorts, and prepares claims for the scanning process.
- Claims are scanned and assigned a document control number.
- Data entry operators key each claim into our claims processing system.
- The claims processing system verifies the member's eligibility and reviews the claim against all applicable edits.
- If the claim passes all applicable edits, a check and explanation of payment (EOP) are mailed to the member.
- If the claim does not pass all applicable edits, a rejection letter is mailed to the member.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

## Medicare Claims Processing

Electronic claims adjudication includes the steps outlined below for Medicare claims.

1. For retail prescriptions, the member submits a pharmacy benefit ID card and prescription. Network pharmacies use a switching company or have direct connection to our claims adjudication system. For home delivery prescriptions, the member submits the prescription to the Express Scripts Pharmacy℠.

2. If the beneficiary has no card, the pharmacy submits an E1 eligibility transaction to the Transaction Facilitator, which returns all payers on file for the beneficiary. The pharmacy uses the data returned to route the claim to Express Scripts.

3. The pharmacist submits the required information to Express Scripts. We check for the four elements of prescription data: prescription bin number, prescription processor control, prescription group, and prescription ID. Depending on ERS's plan design, other fields may be required with claim submission. Our claims adjudication system verifies that the person is eligible for pharmacy benefit coverage and then applies benefit design and concurrent drug utilization review (DUR) edits to the claim. Express Scripts also applies claim edits as required by the Centers for Medicare & Medicaid Services (CMS) programs, such as Precluded Provider, and the Office of Inspector General Sanctioned (OIGS) Provider list for all Medicare Advantage plans.

4. When calculating the member obligation for Medicare Advantage Prescription Drug (MAPD) benefits and Prescription Drug Plans (PDP) benefits, the claim adjudication system validates the member's accumulated true out-of-pocket (TrOOP), total drug spend (TDS), or maximum out-of-pocket (MOOP), depending on ERS's Centers for Medicare & Medicaid Services (CMS)-approved benefit design and member's eligibility. The TrOOP, TDS, or MOOP accumulated balance could include amounts from previous plans.

5. Calculated benefit information is returned to the pharmacist, including information on the applicable copayment, deductible due from the beneficiary, and clinical messaging. If the claim rejects, our system provides the pharmacy with the appropriate National Council for Prescription Drug Programs (NCPDP) error code and the rejection reason, and sends notification to the pharmacy to distribute the beneficiary right of appeals notice. Please note that this notification is only for MAPD and PDP plans and is not applicable for Medicare Advantage Part C plans that do not offer prescription drug coverage. This information is available online for review.

6. If a beneficiary has Supplemental Coverage to Medicare, coordination of benefits (COB) claims are sent to supplemental payer(s) after the Medicare claims and routed through the Transaction Facilitator (if submitted properly by the pharmacist). The Transaction Facilitator creates NCPDP transactions from the COB responses and sends them to Express Scripts to be used to update TrOOP balances.

7. For retail prescriptions, the retail pharmacist collects appropriate payment from the beneficiary, as determined by the online messages from Express Scripts and Supplemental Payers, and dispenses the drug to the beneficiary along with a receipt.

8. For home delivery prescriptions, the payment is deducted from the beneficiary's credit card or debit card. If the beneficiary has mailed in the payment, we verify the correct payment has been included with the prescription order. We then mail the prescription to the beneficiary along with a receipt.

## Paper Claims Process

Express Scripts recognizes and supports the requirement to accommodate use of out-of-network pharmacies for members who cannot be reasonably expected to obtain covered Medicare Part D drugs at a network pharmacy. Medicare is an "any willing provider" benefit, and we extend the contract terms to all pharmacies. That affords ERS a broad network that should minimize the need for utilization outside of the network. However, in cases where the use of an out-of-network pharmacy is required, Express Scripts accommodates this need through a direct claims process. Because an out-of-network pharmacy is not set up with pricing in our systems, there is no way to adjudicate those claims at the point of sale. If there is a significant utilization of out-of-network pharmacies, we will work with you to negotiate terms with those pharmacies to minimize the burden on the members. While Express Scripts is offering ERS several options in constructing the pharmacy network, we want to balance choice and access to the cost savings/financial management needs ERS requires with your benefit. Please note that there is an inverse relationship between the size of the network and the likelihood that a member will need to use an out-of-network pharmacy. Therefore, we will work with you to design the optimal network to support your members' needs.

When necessary, such as when a member uses an out-of-network pharmacy or a member cannot reasonably access one of our network pharmacies, the member may be asked to pay for a prescription in full and submit a direct reimbursement claim form to Express Scripts.

The direct claim adjudication process — also known as the paper claim adjudication process — begins when claims are received, imaged, stamped with the date received, sorted, and batched at our claims processing facility. The process concludes with the member receiving either reimbursement or documentation as to why a claim was rejected.

A step-by-step description of the direct claims adjudication process is detailed below.

### Direct Claims Processing Flow

- Members submit direct claims to Express Scripts via mail, fax, or via the Prescription Drug Reimbursement Form (recommended).
- The mail room dates, sorts, and prepares claims for the scanning process.
- Claims are scanned and assigned a document control number.
- Data entry operators key each claim into our claims processing system.
- The claims processing system verifies the member's eligibility and reviews the claim against all applicable edits.
- If the claim passes all applicable edits, a check and explanation of payment (EOP) are mailed to the member.
- If the claim does not pass all applicable edits, a rejection letter is mailed to the member.

F.1.a. Respondent shall provide the average turnaround time for:

- New Prior Authorization Approval

Electronic Prior Authorization (ePA) is Express Scripts' preferred channel for the submission of prior authorizations. Over 66% of ePAs are approved in real-time, within minutes. Express Scripts manages more than 8,000 unique sets of prior authorization criteria, which allows 98% of prior authorizations to be completed through ePA.

Express Scripts still accepts prior authorization requests over the phone. This process can result in a decision within minutes if all information is available to make the determination at the time of the call. Express Scripts immediately communicates the decision, then mails written documentation, if required, to the prescriber and member. If information needed to render a determination is not available at the time of the call or if the prior authorization request comes in via fax, web, or letter, then our goal is an average turnaround time of 48 hours, or sooner if required by law or ERS contract.

For Medicare, Express Scripts handles authorization requests via phone, fax, web, and letter. All initiated requests that have enough information to complete the coverage determination must be completed within 72 hours for standard requests and in 24 hours for urgent requests.

- Renewal of Prior Authorization
  Express Scripts' timelines are the same for new prior authorizations and renewing therapies.
- Appeal of a denied claim, prior authorization, or approval of a medication for a tier change (e.g., waive brand penalty)

- The chart below illustrates the turnaround time for urgent and non-urgent claims.

| Type of Request | Pre-Service Claims | | Post-Service Claims |
|---|---|---|---|
| | Non-Urgent | Urgent | Non-Urgent |
| Initial Determination Decision | No later than 15 days from the receipt of the claim | As soon as possible; no later than 72 hours from receipt of the claim | No later than 30 days from the receipt of the claim |
| Deadline to Appeal an Adverse Benefit Determination | Within 180 days following receipt of a notification of an adverse benefit determination | Within 180 days following receipt of a notification of adverse benefit determination | Within 180 days following receipt of a notification of an adverse benefit determination |
| First Level Appeal Decision | No later than 15 days from receipt of the appeal | As soon as possible and no later than 72 hours from receipt of the appeal | No later than 30 days from the receipt of the appeal |
| Deadline to Appeal a First Level Appeal Decision | Within 90 days following receipt of a notification of an adverse benefit determination | May not be applicable* | Within 90 days following receipt of a notification of an adverse benefit determination |

| | | | |
|---|---|---|---|
| Second Level Appeal Decision | No later than 15 days from receipt of the appeal | May not be applicable* | No later than 30 days from the receipt of the appeal |

- *Total appeals timeframe is limited to 72 hours, preventing the ability to support two levels of urgent appeals.
-
- For Medicare, all coverage determination, exception, and redetermination requests are processed according to the Centers for Medicare & Medicaid Services (CMS)-required turnaround-timeframes as stated within the Prescription Drug Benefit Manual, Chapter 18.

  - Primary Appeal

  The number of days allowed to respond to an appeal varies, depending on the type of appeal. The table below provides information regarding time frames and formats for standard and urgent appeal decisions and notifications. The timeframe represents the time a request will remain open while collecting information from the patient, prescriber, medical literature, or specialty consultants. Once Express Scripts receives all required information, the goal is to make a benefit determination as soon as possible, and therefore determinations are frequently made in a shorter time period than the standard guidelines.

| Type of Appeal | Decision Timeframe<br>Decisions are completed ASAP from receipt of request and no later than: |
|---|---|
| Standard Pre-Service | 15 days |
| Standard Post-Service | 30 days |
| Urgent* | 72 hours |

- *If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

  - Secondary (Tertiary) Appeal

- The chart below illustrates the turnaround time for urgent and non-urgent claims.

| Type of Request | Pre-Service Claims | | Post-Service Claims |
|---|---|---|---|
| | Non-Urgent | Urgent | Non-Urgent |
| Second Level Appeal Decision | No later than 15 days from receipt of the appeal | May not be applicable* | No later than 30 days from the receipt of the appeal |

- *Total appeals timeframe is limited to 72 hours, preventing the ability to support two levels of urgent appeals.
- For Medicare, all coverage determination, exception, and redetermination requests are processed according to the Centers for Medicare & Medicaid Services (CMS)-required turnaround-timeframes as stated within the Prescription Drug Benefit Manual, Chapter 18.

F.2. Are there situations where Respondent would accept a paper claim Universal Claim Form from a pharmacy for processing?

- HealthSelect PDP: Yes.
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

F.3. How does Respondent process/pay compound drug claims submitted by network pharmacies?

HealthSelect PDP: The following outlines the processes for adjudicating compound claims for network pharmacies:

**1.** The pharmacist flags the claim as a compound in the claims adjudication system via the National Council for Prescription Drug Programs (NCPDP) compound segment.

**2.** The pharmacist submits each compound ingredient (up to 25) as follows:

- Dosage description code
- Dispensing form indicator (for example, liquid or ointment)
- Ingredient component count
- Product ID qualifier (national drug code [NDC])
- Ingredient quantity
- Ingredient cost

**3.** Express Scripts' adjudication system calculates the total ingredient cost based on the price of the individual ingredients submitted.

**4.** Pharmacies receive a dispensing fee based on the ingredients submitted and at a rate specified in their contract, plus a professional service fee based on the complexity of the compound that is consistent with current NCPDP standards.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. While Express Scripts pays for all compounds and ingredients per the plan sponsor's benefit design and formulary, non-Medicare Part D eligible drugs are excluded from prescription drug event (PDE) submissions when part of a compound. This allows the plan to cover compounds with ingredients that are non-Medicare D eligible but not submit them on the PDE.

F.3.a. How does Respondent process/pay compound drug claims submitted by non-network pharmacies?

- HealthSelect PDP: For out of network pharmacies, compound claims reject with NCPDP Reject of 40 (Pharmacy Not Contracted with Plan on Date of Service).
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

F.4. What safeguards exist to prevent one group's claims experience from being charged to another?

HealthSelect PDP: We require an Rx Group number as well as a Group Level ID on the pharmacy claim as outlined in our Payer Sheets to process with a BIN/PCN. Our system is capable of setting up benefit elements at a high level to apply to an entire line of business or at lower, more specific levels, such as group level. Different elements of the benefit can be configured at different levels as needed.

The reason for this requirement is to prevent one group's experience from being charged to another group. When setting the group up, a Client Benefit Manager (CBM) record is created, which is a record of each grouping of individuals who share the same benefit plan design or who have common reporting characteristics. The CBM records exist in our claims adjudication system. This file contains all of the data required to identify each covered group, the particular payment method, copayment set, pointers to the plan, and fee files. The parameters and pointers that make up the CBM records govern specific network rules, physician restrictions, and utilization review options. The key to the CBM record is the group number, which is a 15-digit numerical field. Plan parameters are maintained in fields on the CBM, which drive our claims processing and related systems.

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- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

F.5. Discuss the measures Respondent employs to protect Participant identity information (i.e., social security number, credit card information).

HealthSelect PDP: In addition to being in full compliance with the standards established by the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule and the HIPAA Security rule, Express Scripts' stringent corporate policies, procedures, and guidelines help ensure the practical prevention of data loss.

The specific safeguards we employ ensure patient confidentiality and privacy are discussed below.

# Privacy and Data Use Policies

We have adopted policies requiring employees to safeguard protected health information (PHI) at all times. These policies address areas such as system access controls and protections, mobile end-user devices, and use of the minimum PHI necessary.

- Role-Based Access to Confidential Information
- Protection of Electronic PHI

# Privacy and Data Protections

- *Training* - Express Scripts' entire workforce is required to complete corporate Information Security training in addition to corporate HIPAA training upon first hire.
- *Privacy and Data Protections Awareness* - Express Scripts engages in extensive awareness programs to ensure our workforce fully understands their privacy, security, and data protection responsibilities.
- *Guidelines for Laptops and Handheld Devices*
  - Steps to safeguard your laptop and handheld device
  - Keeping your information secure when you take it on the road
  - Privacy and security guidelines for working away from your office
  - Data protection guidelines

# Technology Protections

- *Encryption* —we comply with the requirements of the payment card industry (PCI) data security standard (DSS) by encrypting card data that is stored in Member Accounts Receivable databases.

- *Storage devices* — writing to peripheral storage devices is prohibited and prevented unless a policy exception is approved. In cases where permission is granted, removable media is encrypted.
- *Work at home protection* — Express Scripts supports a virtual workforce and to ensure a secure environment for these employees, Express Scripts utilizes a delivery platform based on Citrix Presentation Server™ technology. The network communication between our data center and an employee's home workstation is encrypted using VPN technology, adding another layer of protection and security for data transmission.
- *Copying and transport of PHI* — Cigna Corporation has instituted a corporate-wide effort to examine the processes by which PHI is copied and transported on a daily basis. The Privacy Office has assessed all departments to identify, evaluate, and certify the processes for replication and transport of data, including paper copies, CD transfers, mailing of disks, email, and others.

# Data Loss Investigation Protocols

We are committed to protecting the confidentiality of member information. The Privacy Office maintains policies that require safeguarding of PHI and minimum necessary use of PHI, and limit use and disclosure of PHI to those purposes permitted under applicable law. In addition, employees are required to promptly report any potential unauthorized use, access, or disclosure of PHI to the Privacy Office.
The Privacy Office ensures all potential privacy incidents are thoroughly researched and investigated. If an issue is determined to be substantiated, the Privacy Office ensures that the appropriate corrective actions are taken to prevent future occurrences, and ensures steps are taken to mitigate any harm, to the extent possible. In addition, depending on the nature of the incident, notifications may be sent to the client, member, or regulatory authorities. Such notifications are made in accordance with applicable law and the terms of the client contract.

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- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

F.6. Does Respondent offer any programs or financial arrangements that would be available to the Programs' Participants that would offer lower cost or no cost options in the event that multiple or expensive medications may create an economic hardship on the Participants?

If so, describe the programs/arrangements available.

HealthSelect PDP: Express Scripts offers the SaveOnSP program in conjunction with a third party vendor. Within the SaveOnSP program, the Affordable Care Act state benchmarks are utilized to classify certain specialty products as non-essential health benefits, removing them from the accumulator. The plan will then implement higher member cost shares on the targeted drugs to fully utilize the manufacturer copay assistance amount available, resulting in savings for the member and the plan. After all funds are applied, the member's final remaining responsibility will be zero.

SaveOnSP targets drugs in more than 20 specialty categories, including:

- Oncology
- Inflammatory conditions
- Multiple sclerosis
- Blood cell deficiency
- Hepatitis C
- Hereditary angioedema
- Pulmonary arterial hypertension
- Cystic Fibrosis
- Hemophilia
- Asthma & Allergy

Express Scripts is working to make available the SaveOnSP program for ERS's self-funded commercial line of business, and will provide additional details for the open network offering. Currently we offer this very valuale service for exclusive specialty programs and limited networks. The SaveOnSP program cannot be implemented in conjunction with the Variable Copay program.

## Copay Assistance Program

Accredo® understands that patient out-of-pocket cost is the most common — and critical — barrier to specialty medication adherence. We work with patients to identify and address the need for financial assistance. Our Contact Center and Patient Access teams are knowledgeable in available financial assistance sources for patients based on diagnosis, prescribed specialty medication, or both. Accredo assists more than one-third of our patients in receiving financial assistance from manufacturers and foundations. We currently work with hundreds of copayment programs and continually strive to find more ways to assist our patients.

For example, we began to work specifically on proactive copayment assistance for oncology patients in 2014. Accredo now maintains a specialized team of advocates that works directly with foundations and programs offering patient copayment assistance for a variety of therapies. This team reaches out to a foundation while the patient is still on the phone to guide the patient through the funding registration process, thereby ensuring the patient receives the help they need. By the end of 2021, we had secured $1.7 billion in copayment assistance, making Accredo a market leader in providing such assistance to our patients.

## Extended Payment Program

Express Scripts® Pharmacy provides an Extended Payment Program that assists cost-conscious members to pay for their medications by allowing them to spread out their payments into three monthly installments payable by credit card, or Visa or MasterCard debit cards. ERS benefits from the lower plan costs associated with members filling prescriptions at Express Scripts® Pharmacy and from members who are able to remain more compliant with their medication regimen.

We work with our clients to determine an appropriate credit limit, which is typically $150. However, unless a member has exhibited poor payment practices, this limit is extended up to twice its original value. If members do not submit payment with a prescription order, or if they submit the wrong copayment amount and have not exhibited poor payment practices, Express Scripts® Pharmacy sends an invoice with the filled prescription order that states the amount due. This statement serves as their initial invoice. If payment is not remitted, the participant will receive subsequent statements in 25-day intervals, followed by a series of collection letters in 30-day increments beginning 60 days after the initial invoicing.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. The SaveOnSP program is not available for Medicare lives.

F.7. Discuss Respondent's process for handling recovery of overpayments/underpayments due to processing ineligible claims (for both Participant and pharmacy).

HealthSelect PDP: Our claims adjudication system verifies that the person is eligible for pharmacy benefit coverage so it is unlikely that there would be recovery associated with an ineligible claim. However, our process for handling recovery is outlined below.

At times, it may be necessary to make claim-level adjustments to change the dollar amount at which a claim was reimbursed. Adjustments may occur for a variety of reasons, such as when a claim was adjudicated incorrectly and a financial component such as deductible, copayment, brand-generic difference, penalty, or pricing processed incorrectly, resulting in an underpayment or overpayment.

Additionally, adjustments may occur when claims do not apply correctly to accumulators such as out-of-pocket costs, health reimbursement arrangement (HRA), true out-of-pocket (TrOOP), or drug spend.

We understand the importance of accurate accounting for our clients. As such, Express Scripts attempts to process requests and post non-regulated market adjustments to a client's account within 30 business days after the issue is corrected, a full impact analysis to determine the corrections needed is completed, and the client and Express Scripts have agreed to the adjustment amount. Based on complexity, this can occasionally take up to 90 business days.

## Adjustment Process

Express Scripts' adjustment process outlined below ensures timely and accurate financial adjustments to clients, members, and pharmacies.

1. Discovery — The need for claims adjustment is discovered.
2. Request — The account team requests a financial adjustment for claims impacted by the issue. The account team also confirms the issue is retroactively corrected to mitigate reoccurrence of the issue in the future and will determine root cause and preventive measure as part of the formal service reliability process.
3. Impact report creation — We create an impact report detailing the original impacted claims and provide impact details for each claim.
4. Claims adjustment — We adjust the claims as outlined in the agreed upon impact report.
    - After an issue is identified and the system retroactively fixed, Express Scripts maintains an adjustment system to extract impacted claims and reprocess to determine impact. Adjustments are generally processed to reimburse members within a 30 business day period after the system is retroactively fixed, impact assessed and both parties approve the impact report.

    - To ensure transparency, adjusted claims records are detailed in ERS's claims detail file that is provided with the invoice. Adjustments appear as individual transactions with their own unique IDs, in pairs with a credit record to reverse the original claim, and a debit record to provide adjusted financial information. Adjustments tie to their original claims through a transaction ID cross-reference field that provides the transaction ID from the original claim.
    - Adjustments are maintained in history files in the same manner in which claims history is stored.

5. Adjustment closed — After closing an adjustment request, we work with appropriate areas of the company to ensure similar issues are prevented from occurring in the future.

    - HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

At times, it may be necessary to make claim-level adjustments to change the dollar amount at which a claim was reimbursed. Adjustments may occur for a variety of reasons, such as when a claim was adjudicated incorrectly and a financial component such as deductible, copayment, brand-generic difference, penalty, or pricing processed incorrectly, resulting in an underpayment or overpayment. Additionally, adjustments may occur when claims do not apply correctly to accumulators such as out-of-pocket costs, health reimbursement arrangement (HRA), true out-of-pocket (TrOOP), or drug spend. Per Centers for Medicare & Medicaid Services (CMS) requirements, plan sponsors must maintain accurate TrOOP and drug spend accumulators for members participating in a Medicare Part D plan.

We understand the importance of accurate accounting for our clients. As such, Express Scripts attempts to process requests and post non-regulated market adjustments to a client's account within 30 business days after the issue is corrected, a full impact analysis to determine the corrections needed is completed, and the client and Express Scripts have agreed to the adjustment amount. Based on complexity, this can occasionally take up to 90 business days. For regulated market adjustments, every attempt is made to turn around the adjustment within 45 days, per CMS guidelines.

## Adjustment Process

Express Scripts' adjustment process outlined below ensures timely and accurate financial adjustments to clients, members, and pharmacies.
1. Discovery — The need for claims adjustment is discovered.
2. Request — The account team requests a financial adjustment for claims impacted by the issue. The account team also confirms the issue is retroactively corrected to mitigate reoccurrence of the issue in the future and will determine root cause and preventive measure as part of the formal service reliability process.
3. Impact report creation — We create an impact report detailing the original impacted claims and provide impact details for each claim.
4. Claims adjustment — We adjust the claims as outlined in the agreed upon impact report.

- For regulated market adjustments, we extract all member claims and reprice each to identify how the adjustment affected the adjudication of subsequent claims. This reverse/reprocess method ensures proper accrual of important accumulators such as drug spend, and accurate prescription drug event (PDE) records.
- To ensure transparency, adjusted claims records are detailed in ERS's claims detail file that is provided with the invoice. Adjustments appear as individual transactions with their own unique IDs, in pairs with a credit record to reverse the original claim, and a debit record to provide adjusted financial information. Adjustments tie to their original claims through a transaction ID cross-reference field that provides the transaction ID from the original claim.
- Adjustments are maintained in history files in the same manner in which claims history is stored.

5. Adjustment closed — After closing an adjustment request, we work with appropriate areas of the company to ensure similar issues are prevented from occurring in the future.

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F.8. Describe Participant's ability to view claims history online including the ability to save history by date range in order to submit for flexible spending account or health savings account reimbursement.

*Through the member website, participants are able to review claims, balances, and annual prescription expenses.* The claims and balances area allows members to track their out-of-pocket prescription expenses by month or by year for a 24-month period, as well as obtain detailed account information, such as their current balance and invoice details. This information helps members in compiling prescription costs at tax time, as well as for submission to flexible spending account administrators. Records are maintained for retail and home delivery prescriptions for the member and all eligible dependents. Prescription details, including when the medication was last filled, number of refills remaining, and associated medication information, are easily accessible. Members can download their claims into Excel for more flexibility in the use of this valuable information.

F.9. What is Respondent's average system down time for its online mail order and specialty pharmacy system?

- HealthSelect PDP: Due to our redundant systems, our dispensing system has not experienced unplanned downtime that resulted in our inability to dispense over the past 12 months. During this same period, the scheduled downtime for regular system maintenance was approximately one hour daily.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. No difference.

F.10. Describe Respondent's standard COB process to identify other primary coverage for participants including, but not limited to: whether Respondent receives enrollment data from other systems (such as CMS for Medicare eligibility or other payers), whether Respondent queries participants for other insurance information on a periodic basis, and any other methods of collecting, storing, and processing claims based on COB information. Provide details regarding how this is standardly managed and the participant impact.

HealthSelect PDP: Express Scripts supports both online and manual coordination of benefits (COB). To apply Primary Claim Avoidance (the foundation of COB) to your pharmacy benefit, ERS provides COB information for your members on the eligibility file. The COB indicator specifies if the member has primary or secondary insurance coverage under ERS's benefit. Marking the COB indicator as primary indicates the member does not have other insurance coverage and ERS is the primary insurer. COB can be provided without the eligibility indicator and without Primary Claim Avoidance with COB rules being applied to all beneficiaries.

## Electronic COB at Retail

Electronic coordination of benefits (eCOB) allows pharmacies to submit COB claims at the point of service. This saves your members from having to pay at the point of service, submit paper claims, and await reimbursement. When an eCOB claim is submitted, the payment to the pharmacy is determined using a secondary claim reimbursement formula chosen by ERS. Essentially, you can choose a secondary claim reimbursement formula that will never pay more for a COB claim than ERS would have paid as a primary payer. In most instances, you and your members save money — all in a real-time environment.

If COB members are flagged in the ERS eligibility file, Express Scripts can reject primary claims (Primary Claim Avoidance) submitted to members that only have secondary benefits under ERS. If you cannot provide COB information in the eligibility file, you may still implement eCOB. Even without coverage information, the pharmacy can submit secondary claims to Express Scripts electronically.

Our flexible adjudication system supports COB at a client, group, or benefit level. ERS must actively choose to implement eCOB and decide which secondary reimbursement formula should be utilized in order to coordinate benefits.
When ERS provides member COB information on the eligibility file, the COB indicator will show if the member has primary or secondary insurance coverage under ERS's benefit. Express Scripts can reject primary claims (i.e., primary claim avoidance) submitted to members that only have secondary benefits under ERS. The member can then purchase the drug using the primary pharmacy benefit. Marking the COB indicator as primary indicates the member does not have other insurance coverage and ERS is the primary insurer.
If ERS cannot provide COB information in the eligibility file, ERS may still implement eCOB. Even without coverage information, the pharmacy can submit secondary claims to Express Scripts electronically.

COB is administered as follows (Primary Claim Avoidance):

- If the COB indicator in the eligibility information for the member is marked as primary, the primary claim can be processed as a payable claim through our claims processing system under the ERS benefit.
- The claims processing system rejects primary claims for a member if the COB indicator is marked as secondary and the COB product, including eCOB, manual COB, or both if turned on. The member can purchase the drug using the primary pharmacy benefit.

## Manual COB at Retail

The member can submit a manual COB claim if they still need to pay a portion of the claim after the primary payer has processed the claim at point of sale. The member is responsible for submitting a COB

paper claim to Express Scripts for reimbursement. Express Scripts reimburses the member according to the secondary reimbursement formula chosen by ERS (for example, we might pay the remaining balance less applicable copayments).

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HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting “no difference” if applicable.

We understand the importance of proper coordination of benefits (COB) for any member with other primary insurance, which is why we can support either electronic or online COB (eCOB) and manual COB.

## Primary Payer Identification

The most important step in the COB process is first identifying the member as having other primary insurance. In most situations, ERS would identify members with other primary insurance and pass a specific value in the COB indicator field on the eligibility file to Express Scripts indicating member has other health insurance (OHI) and that ERS would be providing secondary coverage. The COB indicator allows Express Scripts to reject primary claims using National Council for Prescription Drug Programs (NCPDP) reject 41 and return point-of-sale messaging that indicates the member has another primary payer.

There may be situations in which the pharmacy, but not ERS, is aware that a member has other primary insurance — this usually occurs with Medicaid, Children's Health Insurance Program (CHIP), or Commercial members. As part of your COB setup, you can elect to allow secondary claims at the point of sale, even when you do not have the member flagged in the eligibility file as having other insurance. With this setting, we will adjudicate the claim as secondary according to the information provided by the pharmacy. Although the information on the primary payer is not stored long-term in the eligibility file, we can help ERS identify these claims through enhanced reporting so they can flag the members as having other insurance in the eligibility file and coordinate benefits for future claims to maximize COB savings.

## COB Processing at the Point of Sale

Pharmacies can submit COB claims electronically at the point of sale, which saves ERS’s members from having to pay at the point of service, submit paper claims, and await reimbursement.

- At the point of sale (POS), the pharmacy will first submit the claim to the primary payer for reimbursement. If there is any remaining member balance, the pharmacy will submit the claim to Express Scripts with another Other Coverage Code (OCC) that indicates details of the primary payer’s payment to be considered for payment under ERS’s plan. We then process the clam according to ERS’s benefit design and elected COB rules.
- If the pharmacy incorrectly submits a primary claim to Express Scripts for a member flagged as having other primary insurance, we will read the other insurance indicator on the member’s eligibility record and reject the claim with NCPDP reject 41. If we have information about the primary payer from an OCD file, we will return details about the primary payer to the pharmacy in a secondary message, to help them coordinate the claim with the appropriate primary payer.

Most COB adjudication occurs when you flag your members as having other primary insurance in the eligibility file. If you do not want to provide COB information in your eligibility file or you are not aware that a member has other primary insurance, you can still benefit from COB. Even without identification of a primary payer, you have the option to allow pharmacies to submit secondary claims for your members with you accepting the COB information they provide at point of sale. Although this COB is limited to the individual claim for which the pharmacy coordinated benefits, we have enhanced reporting available that can help you identify these members to flag them in the eligibility file going forward.

Express Scripts helps pharmacies submit COB claims electronically by passing clear reject messaging to pharmacies concerning secondary coverage and we outline procedures for COB and applicable claims submission in our network provider communications and provider agreements.

## Manual COB Processing

Although uncommon, if a member needs to submit a secondary claim on paper, Express Scripts has processes in place to accept and process those COB claims. Reimbursement will be made to the member using ERS's COB formulas after the member submits the claim and an explanation of benefits (EOB) from the primary payer.

## Medicare Part D COB at Retail

For Medicare Part D plans, Express Scripts can adjudicate COB claims electronically or on paper for retail and home delivery claims, both in network and out of network. A participant enrolled in a Medicare Part D plan will have two identification cards: one for the primary coverage (the prescription drug plan in which they are enrolled), and one for the secondary benefit. The participant will have to present their two cards at the point of sale, which notifies the pharmacist or provider when a claim should be paid by both a primary and a secondary payer.

After processing the Part D claim for COB or receiving notice of a non-Medicaid secondary payment (if ERS Medicare is the primary payer), Express Scripts will appropriately update the member's true out-of-pocket (TrOOP) accumulators.

## Medicare Part D COB at Home Delivery

When a Medicare Part D member fills a prescription through Express Scripts home delivery and Express Scripts administers a member's Medicare Part D primary and commercial/Medicaid secondary coverage, our home delivery pharmacy performs electronic COB (eCOB) similar to the process a member experiences in a retail setting. When Express Scripts returns the primary payment record from the primary Medicare Part D plan to the home delivery pharmacy, we include supplemental OHI records.

When the OHI identifies that Express Scripts administers the secondary payer, the home delivery pharmacy electronically transmits an eCOB claim to the member's secondary benefit plan. After the secondary claim adjudicates, a secondary payment response is returned to the home delivery pharmacy. This results in the member having a final copayment responsibility and eliminates the need for the member to submit a paper COB claim. All secondary claims data routes through the Centers for Medicare & Medicaid Services (CMS) TrOOP facilitator so that the member's TrOOP balance can be updated accordingly.

If the secondary payer is outside of Express Scripts, the Medicare Part D beneficiary must pay for prescriptions themselves and submit the COB claim to the secondary payer for reimbursement.

## Enhanced Medicare Part D Coverage

If ERS's members have a plan based on the Medicare Standard Defined benefit — for example, an employer group waiver program (EGWP) offering or a dual plan — Express Scripts adjudicates the claim based on client intent for coverage in a single claims transaction, with a single claim ID and without the need for COB. With some PBMs, the Part D coverage adjudicates as two claims — once through the standard benefit and once through the enhanced coverage, as a COB claim. This is often referred to as a Single Transaction COB (STCOB) claim subject to an administrative fee. Express Scripts does not adjudicate enhanced coverage as a second, or COB, claim. We look at the entirety of the benefit before adjudicating the claim, adjudicating it only once, with the appropriate enhanced coverage. Consequently, we do not charge a separate administrative fee for these claims.

## Coordinating Secondary Claim Payments with Medicare

Express Scripts applies secondary reimbursement rules in compliance with CMS requirements. Express Scripts applies secondary reimbursement rules as defined by ERS and reimburses the pharmacy according to these rules. The necessary TrOOP update from the secondary claim will be transmitted to the TrOOP facilitator and the member pays the pharmacy the unpaid balance.

Prescription Drug Plan ( PDP), Medicare Advantage Prescription Drug ( MAPD), Enhanced PDP, and Employer PDP plans are required to include secondary benefits and payments in a member's TrOOP balance. The TrOOP balance must be reduced by secondary benefit payments, since they reduce the member's TrOOP expense.

## Medicare Part B COB

Express Scripts offers ERS the capability for electronic coordination of benefits (eCOB) for your Part B claims, as well as manual COB via member-submitted paper claims. In the manual COB claim scenario, the member would pay out of pocket at the point of service for any copayment or coinsurance under their primary Medicare Part B benefit. The member would then submit a paper COB claim to Express Scripts to process the secondary benefit claims under the plan's COB rules.

## Dual Eligible COB Processing

For dual eligible members, Express Scripts will work with you to ensure you pay for the member's medications under the appropriate benefit and/or per your specifications such as:

- Covering Part B or Part D drugs up to a specific secondary payment limit
- Rejecting all Part D drugs under the Medicaid benefit and only covering them under the Part D benefit
- Adjudicating Part B drugs through the primary Medicare benefit and then routing them for COB under the enhanced Medicare benefit
- Rejecting non-covered Part D drugs, like over-the-counter (OTC) drugs, under the Medicare coverage and evaluating them for payment under the wraparound Medicaid benefit

## Reporting

Express Scripts offers different levels of coordination of benefits (COB) reporting through your Account Team, depending on ERS's needs, including but not limited to:

- *Ad hoc COB reporting* — Available if ERS implements COB in the plan design and provides COB information in the eligibility file. Your account team will work with you to determine what information you require on the report and then creates the appropriate report template.
- *Reporting on COB savings* — Reports the amount Express Scripts would have paid if ERS had paid the claim as the primary payer. We store this data element in our data warehouse for ad hoc reporting. To determine savings, the amount actually paid on the secondary claim is subtracted from what we would have paid if the claim were submitted as primary.
- *Enhanced reporting on secondary claims paid based on POS information* — Identifies members for whom secondary claims were reimbursed but the member is not identified as having OHI. This allows ERS to flag those members as having OHI to maximize COB savings.

F.10.a. Describe Respondent's COB process for coordinating appropriate coverage of Medicare Part B drugs. Respondent's description should include COB processes for retail, EDS, mail order, and specialty pharmacies.

- HealthSelect PDP: COB for Medicare Part B drugs is not applicable for your commercial lives.

HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable. Express Scripts offers ERS the capability for electronic coordination of benefits (eCOB) for your Part B claims, as well as manual COB via member-submitted paper claims. In the manual COB claim scenario, the member would pay out of pocket at the point of service for any copayment or coinsurance under their primary Medicare Part B benefit. The member would then submit a paper COB claim to Express Scripts to process the secondary benefit claims under the plan's COB rules.

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- Adjudicating Part B drugs through the primary Medicare benefit and then routing them for COB under the enhanced Medicare benefit
- Rejecting non-covered Part D drugs, like over-the-counter (OTC) drugs, under the Medicare coverage and evaluating them for payment under the wraparound Medicaid benefit

## Primary Payer Identification

The most important step in the COB process is first identifying the member as having other primary insurance. In most situations, ERS would identify members with other primary insurance and pass a specific value in the COB indicator field on the eligibility file to Express Scripts indicating member has other health insurance (OHI) and that ERS would be providing secondary coverage. The COB indicator allows Express Scripts to reject primary claims using National Council for Prescription Drug Programs (NCPDP) reject 41 and return point-of-sale messaging that indicates the member has another primary payer.

There may be situations in which the pharmacy, but not ERS, is aware that a member has other primary insurance — this usually occurs with Medicaid, Children's Health Insurance Program (CHIP), or Commercial members. As part of your COB setup, you can elect to allow secondary claims at the point of sale, even when you do not have the member flagged in the eligibility file as having other insurance. With this setting, we will adjudicate the claim as secondary according to the information provided by the pharmacy. Although the information on the primary payer is not stored long-term in the eligibility file, we can help ERS identify these claims through enhanced reporting so they can flag the members as having other insurance in the eligibility file and coordinate benefits for future claims to maximize COB savings.

## COB Processing at the Point of Sale

Pharmacies can submit COB claims electronically at the point of sale, which saves ERS's members from having to pay at the point of service, submit paper claims, and await reimbursement.

- At the point of sale (POS), the pharmacy will first submit the claim to the primary payer for reimbursement. If there is any remaining member balance, the pharmacy will submit the claim to Express Scripts with another Other Coverage Code (OCC) that indicates details of the primary payer's payment to be considered for payment under ERS's plan. We then process the clam according to ERS's benefit design and elected COB rules.
- If the pharmacy incorrectly submits a primary claim to Express Scripts for a member flagged as having other primary insurance, we will read the other insurance indicator on the member's eligibility record and reject the claim with NCPDP reject 41. If we have information about the primary payer from an OCD file, we will return details about the primary payer to the pharmacy in a secondary message, to help them coordinate the claim with the appropriate primary payer.

Most COB adjudication occurs when you flag your members as having other primary insurance in the eligibility file. If you do not want to provide COB information in your eligibility file or you are not aware that a member has other primary insurance, you can still benefit from COB. Even without identification of a primary payer, you have the option to allow pharmacies to submit secondary claims for your members with you accepting the COB information they provide at point of sale. Although this COB is limited to the individual claim for which the pharmacy coordinated benefits, we have enhanced reporting available that can help you identify these members to flag them in the eligibility file going forward.

Express Scripts helps pharmacies submit COB claims electronically by passing clear reject messaging to pharmacies concerning secondary coverage and we outline procedures for COB and applicable claims submission in our network provider communications and provider agreements.

## Manual COB Processing

Although uncommon, if a member needs to submit a secondary claim on paper, Express Scripts has processes in place to accept and process those COB claims. Reimbursement will be made to the member using ERS's COB formulas after the member submits the claim and an explanation of benefits (EOB) from the primary payer.

## Medicare Part D COB at Retail

For Medicare Part D plans, Express Scripts can adjudicate COB claims electronically or on paper for retail and home delivery claims, both in network and out of network. A participant enrolled in a Medicare Part D plan will have two identification cards: one for the primary coverage (the prescription drug plan in which they are enrolled), and one for the secondary benefit. The participant will have to present their two cards at the point of sale, which notifies the pharmacist or provider when a claim should be paid by both a primary and a secondary payer.

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When the OHI identifies that Express Scripts administers the secondary payer, the home delivery pharmacy electronically transmits an eCOB claim to the member's secondary benefit plan. After the secondary claim adjudicates, a secondary payment response is returned to the home delivery pharmacy. This results in the member having a final copayment responsibility and eliminates the need for the member to submit a paper COB claim. All secondary claims data routes through the Centers for Medicare & Medicaid Services (CMS) TrOOP facilitator so that the member's TrOOP balance can be updated accordingly.

If the secondary payer is outside of Express Scripts, the Medicare Part D beneficiary must pay for prescriptions themselves and submit the COB claim to the secondary payer for reimbursement.

## Coordinating Secondary Claim Payments with Medicare

Express Scripts applies secondary reimbursement rules in compliance with CMS requirements. Express Scripts applies secondary reimbursement rules as defined by ERS and reimburses the pharmacy according to these rules. The necessary TrOOP update from the secondary claim will be transmitted to the TrOOP facilitator and the member pays the pharmacy the unpaid balance.

Prescription Drug Plan (PDP), Medicare Advantage Prescription Drug ( MAPD), Enhanced PDP, and Employer PDP plans are required to include secondary benefits and payments in a member's TrOOP balance. The TrOOP balance must be reduced by secondary benefit payments, since they reduce the member's TrOOP expense.

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# G. Interrogatories – Program Reporting Requirements

G.1. **Reporting Requirements.** A list of Respondent's current client reports shall be included in Respondent's Proposal. In addition to providing Respondent's current client reports list, Respondent should describe the methods used to access reports electronically.

G.1.a. **HealthSelect PDP:**

| Title of Report | Detailed Description of the | Frequency | Method of Access | How It Is Used to Identify Problems and |
|---|---|---|---|---|

| | Information Provided in the Report | | | Monitor Performance |
|---|---|---|---|---|
| | | | | |
| | | | | |

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Please refer to Appendix O, Section G.1.a.

G.1.b. **HealthSelect Medicare Rx PDP:**

| Title of Report | Detailed Description of the Information Provided in the Report | Frequency | Method of Access | How it is Used to Identify Problems and Monitor Performance |
|---|---|---|---|---|
| | | | | |
| | | | | |

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Please refer to Appendix O, Section G.1.b.

G.2. Provide samples of Respondent's standard client reporting package(s) for commercial PDPs and Medicare Part D/ EGWP + Wrap PDPs, to include at a minimum the following:

- Performance Guarantees;
- Claims experience reports;
- Utilization and Experience History;
- Statistical Information (e.g., Lag report);
- Fraud, Waste and Abuse and overpayments;
- Utilization management program data and savings;
- Rebate and discount guarantees;
- Generic dispensing rates;
- Network activity and adequacy;
- Direct Subsidy reporting (Medicare Rx);
- Low Income Premium Subsidy reporting (Medicare Rx);
- Low Income Cost Share reporting (Medicare Rx);
- Catastrophic Discount Program reporting (Medicare Rx); and
- Coverage Gap Discount Program reporting (Medicare Rx).

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

G.3. Respondent shall fully describe the online reporting capabilities (on demand) that would be available to ERS' authorized representatives, as well as provide examples of online reports available to monitor Program-level activity. If Respondents' samples of online reports are the same as any of the standard reports submitted as part of Respondent's response to G.1 and G.2 above, Respondent shall specify which of those reports submitted can be accessed on demand.

HealthSelect PDP: Express Scripts offers efficient, on-demand reporting solutions through our client website to empower ERS with the information you need to more effectively manage your pharmacy benefit.

## Trend Central®

The Trend Central portal is the pathway to a wide variety of client reporting capabilities. With our flexible, web-based features, the portal gives users access to a suite of capabilities that can be used to review and

evaluate plan performance data and opportunities. Based on feedback from our users, we created an online client reporting experience that is innovative and intuitive.
Express Scripts' team of analytical experts spends a great deal of time assessing market trends, and collecting feedback and/or suggestions from our existing user community to provide the most useful and user-friendly application.
The Trend Central interface provides our users with self-service access to a set of tools and functionality designed to address the needs of a wide variety of knowledge worker requirements. The application contains both standard and custom reporting capabilities, in addition to a variety of supplementary analytical tools to help ERS analyze their historical pharmacy benefit, identify potential opportunities, and thereby guide decision-making for plan design.

## Standard Report Features

Trend Central provides an intuitive self-service method of accessing prescription claims and clinical programs performance reporting. Our years of research have helped us to create a stable of standard report templates, each designed with care to help in analyzing specific plan features. Our web-based, interactive data analysis solution enables ERS to manage performance and promptly identify emerging issues and trends.
Using Trend Central, users gain self-service access to:

- Generate reports that contain a subset of the client population, schedule recurring automated report generation, save reports as PDF or Excel files with the formatting preserved, and send reports to other Express Scripts Trend Central users
- Modify member populations or groups, timeframes, and other optional claim attributes to customize the report content

We realize there is often need for specialization. Advanced features within the tool provide a "deeper dive" and allow our support staff to specialize templates:

- Manipulate the content and format of any report template for special reporting needs through an intuitive edit function
- Depending on the report, drill into specific populations, create new variables or calculations, modify date ranges, apply dynamic online filtering and rankings, and conduct other variations of data editing through drag-drop functionality
- Save, share, and reuse favorite reports, and schedule reports for recurring automated generation

## Custom Report Features

Express Scripts understands the need to customize information extraction to suit specific needs. As such, Trend Central also includes an ad hoc reporting tool. Through this tool, users have the ability to create custom, tailored reports with ease. With a few simple clicks, you can quickly and easily create a report based on your specified criteria. The custom reporting tool:

- Allows users to readily choose from more than 300 prescription-drug claim data elements to learn more about costs and utilization specific to a given plan, drug, patient, prescriber, or pharmacy
- Supports the use of pre-built populations to allow users to easily construct reports that match the way ERS needs to see their data
- Quickly produces reports on demand or scheduled to run at a frequency you define

The evolution of the custom reporting feature was created with you in mind. Your time is important, as is your need for information that is relevant, timely, and easy-to-access. We have designed a tool that will appeal to experienced and new users alike.
Express Scripts' scalable, intuitive reporting tools give users the ability to easily locate the information that matters most. With simple-to-use navigation, data field descriptions, and direct access to key

metrics, while we do offer various training options, the need for it is virtually eliminated. No additional installation or set-up is required.

### Dashboard and Additional Features

Trend Central also includes a variety of added features. Users are given access to a tool that allows them to create and store population filters that can then be applied on demand within the standard and custom reporting tools.

The application dashboard gives direct access to hundreds of plan performance metrics and benchmarks at a glance. Users may keep apprised of developing plan trends and proactively suggest opportunities for improving overall performance and cost. All dashboard metrics are automatically updated as soon as data is available.

Through the dashboard user interface, users can:

- Gain on-demand decision support via this interactive management tool that transforms data into meaningful, actionable steps
- Quickly and easily view key metrics for a specific prescription plan and compare the data to industry benchmarks
- Explore our clinical program products and other savings opportunities
- Proactively identify trend drivers and receive guidance on the programs that best suit clients' pharmacy benefit goals and member needs
- Adjust parameters to drill into specific market segments and time frames

- 
- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.
- No difference

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

G.4. Does Respondent offer clients the capability to conduct online queries and interface with Respondent's database in order to generate ad hoc reports and extract specific information?

| | |
|---|---|
| Commercial PDPs: | ☒ Yes ☐ No |
| Medicare Part D/EGWP+ Wrap PDPs: | ☒ Yes ☐ No |

If so, describe the capabilities that exist for ad hoc reporting.

- HealthSelect PDP:

Express Scripts understands the need to customize information extraction to suit specific needs. As such, Trend Central also includes an ad hoc reporting tool. Through this tool, users have the ability to create custom, tailored reports with ease. With a few simple clicks, you can quickly and easily create a report based on your specified criteria. The custom reporting tool:

- Allows users to readily choose from more than 300 prescription-drug claim data elements to learn more about costs and utilization specific to a given plan, drug, patient, prescriber, or pharmacy
- Supports the use of pre-built populations to allow users to easily construct reports that match the way ERS needs to see their data

- Quickly produces reports on demand or scheduled to run at a frequency you define

The evolution of the custom reporting feature was created with you in mind. Your time is important, as is your need for information that is relevant, timely, and easy-to-access. We have designed a tool that will appeal to experienced and new users alike.
Express Scripts' scalable, intuitive reporting tools give users the ability to easily locate the information that matters most. With simple-to-use navigation, data field descriptions, and direct access to key metrics, while we do offer various training options, the need for it is virtually eliminated. No additional installation or set-up is required.

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- Quickly and easily view key metrics for a specific prescription plan and compare the data to industry benchmarks
- Explore our clinical program products and other savings opportunities
- Proactively identify trend drivers and receive guidance on the programs that best suit clients' pharmacy benefit goals and member needs
- Adjust parameters to drill into specific market segments and time frames

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference.

G.5. Describe reports that are typically requested by Respondent's clients. Indicate the frequency of these reports.
Express Scripts considers this response to be proprietary and confidential.

G.6. Describe any unique reporting capabilities that differentiate Respondent from its competitors. Indicate the source(s) of data and reports that Respondent can provide to assist ERS in benchmarking the Programs.

- HealthSelect PDP:

Express Scripts believes Big Data plays a powerful role in helping the U.S. achieve significant improvements in the quality and cost of healthcare. We also recognize that this requires more than just a vast quantity of data — it requires the knowledge to turn that data into actionable insights that drive smart and timely decision-making.

With this in mind, we offer ERS the unique MediCUBE ® platform, which delivers direct web-based access to more than 15 billion prescription claims and 5 billion medical claim records for nearly 200 million patients, all linked to the most comprehensive master provider database in U.S. healthcare, with more than 5 million unique provider records.

Beyond integrating and managing an impressive amount of data, MediCUBE's real value comes from its sophisticated analytic capabilities to connect the dots, uncover correlations, and present actionable insights in a few simple clicks.

MediCUBE allows ERS to:

- Reduce high-cost prescribing
- Identify and close gaps in care
- Detect fraud, waste, and abuse
- Improve HEDIS and STAR Ratings performance
- Proactively manage your provider network

### Reduce High-Cost Prescribing

Using MediCUBE, ERS can quickly and easily find medications with lower-cost equivalents. For example, a client's data showed that Tizanidine capsules cost $159 per claim, but Tizanidine **tablets** cost only **$10 per claim** . MediCUBE can also help ERS take on specific high-cost drugs by educating physicians on lower-cost alternatives. Fluocinonide 0.1% cream costs $1,058 per claim, but Clobetasol 0.05% cream costs much less at $142 per claim. Armed with this information, ERS's academic detailing team can work directly with prescribers to provide transparency to drug pricing and ways to reduce plan and patient costs. Additionally, you can leverage this information to better manage your formulary.

### Identify and Close Gaps in Care

Because MediCUBE can integrate medical and pharmacy data, ERS can use it to address both population-level and individual health risks. Our targeted outreach helped one client zero in on statin omissions in diabetics, resulting in a 32% increase in statin therapy prescribing.

### Detect Fraud, Waste, and Abuse

MediCUBE also helps our clients find outliers and address them in seconds. For example, for one health plan client, 1,065 members received opioid prescriptions from three or more prescribers; 41 members received opioid prescriptions from six or more prescribers. By quickly identifying these patients, care and case managers were able to work directly with those patients to ensure they received appropriate pain management therapy. ERS's academic detailing team can work with these providers to promote safe opioid prescribing.

### Proactively Manage Your Provider Network

This tool enables ERS to benchmark providers — both pharmacies and physicians — against peers in the same specialty, geographical region, or network using our book of business data, which covers 83 million Americans. MediCUBE can isolate pharmacies with pricing anomalies or physicians with high-cost prescribing in a certain class. ERS can use this information to drive costs down and build excellence in clinical care.

## HealthPredict

Express Scripts has developed HealthPredict, a tool comprising advanced analytic risk-score models that use data at an individual patient level and enable ERS to understand, predict, and manage population health. By combining healthcare data with personal, environmental, and socio-economic data, we are able to predict individuals' health risks, as well as the drivers and gaps that create those risks. These risk scores are available to our clients and have applications in care management, underwriting, and large

group sales strategy. HealthPredict provides an accurate tool to help ERS make clinical and business decisions with greater return on time and assets.

While some total population health management solutions offer predictive models and reporting functions, HealthPredict provides a full suite of rigorous, complementary analytic tools that provide top-to-bottom coverage of current and future analytic needs. Key advantages include:

- Breadth of data– Because HealthPredict includes data from Express Scripts' 85 million active members and more than 200 million historical patient records, we can build models that are more representative, more robust, and better able to predict outcomes.
- Speed – Express Scripts gets pharmacy data real-time — with no time lost in batching or transfers; most competitors are reliant on obtaining data from other sources and therefore lag in their reporting by up to 30 days. Population-level insights are directly linked to underlying member-level risk scores and clinical profiles. This gives customers get a true and timely decision loop. Instead of an analytics patchwork, HealthPredict bridges the financial and clinical gaps inherent to traditional reporting.
- Accuracy – Our risk scores are 4x more accurate than standard scores[1] powered by a clean and enriched data set that is ready for use and that includes pharmacy data, one of the greatest indicators of health. Additionally, we enable ERS to stratify risk across a broad range of predictive clinical models that can increase clinical outreach targeting effectiveness by more than 200 percent over base rates.
- Ease of integration – Easy integration into ERS's systems for immediate insight delivery and seamless workflows (including white labeling and single sign on).
- More than risk – HealthPredict goes beyond identifying the riskiest patients. We interrogate the data to find the highest closable gaps and individuals most likely to act to focus on interventions that matter – interventions that can actually drive health outcomes and financial savings.

[1] Study performed by Consulting Actuaries & Healthcare Specialists

## Benchmarking

Understanding how ERS's member utilization and plan specifics compare to those of similar clients can help you more effectively manage your pharmacy benefit. As such, we maintain a reporting resource that easily generates book-of-business data reports, which your account management team and Express Scripts' financial, benefit, and clinical analysts use to benchmark your members' utilization and plan design.

Each claim adjudicated through Express Scripts' claim payment system provides a wealth of information, such as brand drug versus generic drug and retail pharmacy versus Express Scripts PharmacySM. Our analysts collect and categorize this data, providing you with plan performance benchmarks grouped by various criteria to gauge your plan performance.

Leveraging benchmarking data helps Express Scripts work with you to develop lowest-cost plan management strategies. Our experience is based on years of guiding clients through similar benefit analysis. ERS and your members will directly benefit from our analysts' abilities to develop innovative plan options based on your data.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

Express Scripts recognizes the importance of transparency for plan sponsor oversight and has developed a suite of reports for Medicare clients to provide plans with the ability to monitor various Express Scripts processes. These reports are posted to the client website in varying frequencies ranging from daily,

weekly, bi-weekly, and quarterly. Our reporting capabilities have been assessed and validated by proactively engaging an external auditor who reviewed the accuracy and timeliness of our client reports. Auditor feedback confirmed our reporting is best in class in the industry, and that the comprehensiveness of the information we provide with each CMS report includes all information necessary to support the client, for both their submission to CMS and also for data validation audits. The auditor also recognized our standard client reporting deliverables, quality testing of reports, and reporting content as best practices in the industry.

We continue to enhance, or develop new oversight reports to meet the demands of the changing marketplace. We also provide on-demand access to policy documents, our Client Handbook, which provides an overview of how we support each delegated process, and detailed Business Use Cases for key processes that provide a comprehensive explanation. These tools will give you an in-depth understanding about internal Express Scripts processes. Finally, Express Scripts regularly monitors reporting-related guidance and directives issued by the Centers for Medicare and Medicaid Services (CMS). Our team of Medicare experts will review, interpret, and implement all new and revised guidance that is disseminated by the CMS via the Health Plan Management System (HPMS) and other communication vehicles.

To assist clients with their review of CMS Required Reports, Express Scripts has created associated detail reports as way for clients to perform additional independent oversight of the reporting data prior to CMS submission. The associated detail reports are not a CMS-required report and are not submitted to CMS. Both the CMS-required and associated detail reports will be provided to clients at a minimum of 14 days prior to the CMS submission deadline.

G.7. Does Respondent perform an internal analysis of client-specific data to develop recommendations for Program improvement? ☒ Yes ☐ No

G.7.a. If the answer to the preceding question is "yes," provide details including the background, training, and expertise of the personnel involved in the data analysis and formulation of program improvements.

- HealthSelect PDP:

Your clinical account executive is your account team's primary contact and consultant for clinical issues and initiatives during the plan performance review. ERS's clinical account executive participates in ERS's meetings to discuss clinical program and service offerings that would best augment your long-term goals and aspirations. The topics and discussion points for these meetings typically include:

- Formulary management
- Financial, formulary, and clinical modeling
- Trend evaluation
- ERS-specific business plan development
- Clinical program results evaluation
- Drug utilization evaluation to develop recommendations for appropriate clinical programs

Your analyst is also available for more complex clinical analysis.

- HealthSelect Medicare Rx PDP: Describe any differences specific to the HealthSelect Medicare Rx PDP, noting "no difference" if applicable.

No difference

G.8. Provide a listing of all claims experience reports currently available, a description of their purpose, and the frequency Respondent can provide these reports.

| Program | Name of Report | Description/Purpose | Frequency Available |
|---|---|---|---|
| HealthSelect PDP: | 1. Claims Detail File<br><br>2. Standard Reports available via Trend Central Self Service:<br><br>• Benchmark reports<br>• Billed date reports<br>• Drug reports<br>• Key performance metrics<br>• Patient analysis<br>• Pharmacy reports<br>• Prescriber reports<br>• Prescription detail<br>• Products and services reports<br>• Ranking and trend reports<br>• Specialty drug reports<br>• Utilization summary reports | 1. The detail file includes member, client and group, plan, drug, pharmacy, and pricing information accumulated during the billing cycle period.<br><br>2. Reports to ensure you have the clinical, financial, and trend information necessary to demonstrate value through actionable metrics and make informed decisions about your plan. | 1. Claims Detail Files are available on a billing cycle frequency.<br><br>2. The majority of utilization and performance reports are available 10 days after the end of each month. Additional reports, such as member profile reports, are available two to five days after a claim adjudicates. The self-serve Trend Central suite grants users access to a Custom Report Builder tool to create real time reports ad hoc at your convenience.<br><br>Our analytics team can provide more timely operational data and reports as needed and mutually |

| | | | |
|---|---|---|---|
| | | | agreed upon with ERS. |
| HealthSelect Medicare Rx PDP: | No difference | | |

G.9. Provide sample financial reporting for Medicare Rx PDP spending and, if applicable, CMS funding, including monthly payment, pharmacy discounts and reinsurance. Include rebate pass-through to HealthSelect Medicare Rx PDP reporting.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

G.10. In addition to providing custom claims detail files to ERS, Respondent shall provide these custom claims detail files to a third-party, such as ERS' consulting actuary. Respondent shall describe its experience and ability providing claims detail files to a designated third party.

Files can be provided to third party vendors in standard layouts free of charge, so long as the appropriate third-party confidentiality agreements are in place. It can take approximately 30 days to prepare and deliver a claims detail file to a third party where a data connection has already been established. It can take approximately 40 days to prepare and deliver a claims detail file to a third party where a data connection has not yet been established.

G.11. If Respondent cannot meet all file requirements as described in RFP Section VIII.E.9.a., provide examples of Respondent's recommended file layout, including data field descriptions.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

## H. Interrogatories – SOC-1 Requirements

H.1. Provide a full, un-redacted copy of Respondent's most recent SOC-1 report that was conducted in accordance with standards established by the American Institute of Certified Public Accounts on the effectiveness of internal controls related to operations and related general computer controls that are relevant to user entities' internal control over financial reporting. If there is not a SOC engagement performed, then any other report performed by an external entity assessing how the operational control activities meet the services to be performed under the RFP will be accepted. A SOC-2 report is not an acceptable report for purposes of this request. ERS reserves the right to perform an on-site inspection.

- HealthSelect PDP:

  ☐ Provided

  ☒ If unable to provide or if this is not applicable, check here and explain.

  Per responses to bidders questions on 6/15, Express Scripts will work with ERS to establish a process to review our SOC-1 report.

- HealthSelect Medicare Rx PDP:

☒ Confirm same response as provided above for the HealthSelect PDP.

☐ Unable to confirm; Respondent shall provide the relevant SOC-1 Report for the Part D/EGWP + Wrap PDPs.

H.1.a. If applicable, provide a copy of Respondent's sponsoring or parent company's most recent SOC-1 report that was conducted in accordance with standards established by the American Institute of Certified Public Accounts on the effectiveness of internal controls related to operations and related general computer controls that are relevant to user entities' internal control over financial reporting. If there is not a SOC engagement performed, then any other report performed by an external entity assessing how the operational control activities meet the

services to be performed under the RFP will be accepted. A SOC-2 report is not an acceptable report for purposes of this request. ERS reserves the right to perform an on-site inspection.

- HealthSelect PDP:

  ☐ Provided

  ☒ If unable to provide or if this is not applicable, check here and explain.
  Per responses to bidders questions on 6/15, Express Scripts will work with ERS to establish a process to review our SOC-1 report.

- HealthSelect Medicare Rx PDP:

  ☒ Confirm same response as provided above for the HealthSelect PDP.

  ☐ Unable to confirm; Respondent shall provide the relevant SOC-1 Report for their sponsoring or parent company over its Medicare Part D/EGWP + Wrap PDPs.

Per responses to bidders questions on 6/15, Express Scripts will work with ERS to establish a process to review our SOC-1 report.

H.1.b. If any data centers, development, or data services are outsourced or subcontracted, Respondent shall provide copies of Respondent's outsourcers' or subcontractors' most recent SOC-1 report that was conducted in accordance with standards established by the American Institute of Certified Public Accounts on the effectiveness of internal controls related to operations and related general computer controls that are relevant to user entities' internal control over financial reporting. If there is not a SOC engagement performed, then any other report performed by an external entity assessing how the operational control activities meet the services to be performed under the RFP will be accepted. A SOC-2 report is not an acceptable report for purposes of this request. ERS reserves the right to perform an on-site inspection.

- HealthSelect PDP:

  ☐ Provided

  ☒ If unable to provide or if this is not applicable, check here and explain.
  Per responses to bidders questions on 6/15, Express Scripts will work with ERS to establish a process to review our SOC-1 report.

- HealthSelect Medicare Rx PDP:

  ☒ Confirm same response as provided above for the HealthSelect PDP.

  ☐ Unable to confirm; Respondent shall provide the relevant SOC-1 Report for its relevant outsourced or subcontracted data centers.

## I. Interrogatories – HealthSelect Medicare Rx PDP

I.1. Describe any enrollment and discrepancy reporting available. Include how frequent the reports are provided, if these reports are automated, and any actions required by ERS.

**Express Scripts will provide a pre-edit report back to ERS that will show any front-line rejections related to the overall file submission. ERS or your elected enrollment vendor should review the report and resubmit any rejected transactions once corrected. If ERS utilizes passive enrollment, upon receipt of the enrollment record, Express Scripts will send the CMS-required pre-notification mailing to the member to inform them of their 21-day opt-out period. Once the 21-day period lapses, the member will be submitted to CMS for enrollment. Should a member be submitted for enrollment less than 21 days prior to the effective date, the member's enrollment will be processed to ensure access; however, in**

accordance with CMS guidelines, the member is still required to be allotted the 21-day opt-out period without recourse. This process should be used on an as-needed basis, as CMS guidance requires the 21-day opt-out period and recommends proactive transactions. If the member opts out during the opt-out period, Express Scripts, once notified, will not submit the member to CMS for enrollment.

Express Scripts will provide ERS with a weekly PDP Enrollment Report that shows all members and their status with CMS, as well as the associated rationale for 120 days of terminations and rejections. The weekly PDP Report is a snapshot of ERS's population and its status with CMS. This report shows Transaction Reply Report (TRR) history, enrollment status, low income status, late enrollment penalty status, and other pertinent member details. It also shows 120 days of rejects and terminations, as well as their associated reason codes — loss of eligibility, disenrollment due to death, and other termination and reject reasons. This report is provided to ERS weekly, and can be posted to the client website or transmitted via file transfer protocol (FTP), based on ERS's intent.

I.2. Describe the assistance, if any, Respondent can provide in connection with the Part D Income Related Monthly Adjustment Amount applicable to High Income HealthSelect Medicare Rx PDP Participants.

Since the Income Related Monthly Adjustment Amount (IRMAA) is handled directly between the member and the Social Security Administration (SSA), formal intervention cannot be provided by Express Scripts. However, Express Scripts is happy to share best practices that our other clients have utilized to address the member noise that Part D IRMAA can cause. For example, ERS may elect to reimburse members who disclose that they have been assessed Part D IRMAA, so long as the reimbursement is handled consistently across the population.

Express Scripts can also provide knowledge and additional insight into the IRMAA process. For example, retirement is a life-changing event; therefore, if a member is assessed IRMAA at the time of retirement based on their prior income levels, the member may appeal the IRMAA decision with SSA on the basis of a life-changing event.

Should the Centers for Medicare & Medicaid Services (CMS) disenroll a member due to Part D IRMAA, Express Scripts will mail the member the CMS-required exhibit letter, explaining the occurrence to them. Additionally, this information will be passed back to ERS on the Weekly Prescription Drug Plan (PDP) Enrollment Report, which contains a specific reason code associated to disenrollment for failure to pay Part D IRMAA.

I.3. Describe the business, financial and/or administrative processes that would be used to collect funding from the following sources for the HealthSelect Medicare Rx PDP, including the timing and frequency with which such funds would be submitted to ERS:

- Direct Subsidy:
  Direct Subsidy is managed by Express Scripts based on information from CMS. It is paid to self-insured EGWP clients by the 15th of the month as passed by CMS. Subsidy statements and details are posted to the client website for review, and will remain on the client website for 60 days from posting. The statements and details are not needed to receive the payments, but are available to ERS.

- Coverage Gap Discount Program:

  Coverage Gap Discount Program payments are managed by Express Scripts as payments are made by Pharma. These payments are paid to self-insured EGWP clients on a quarterly basis, on roughly a six-month lag, as they are received. Member level detail and statement information is provided to ERS with each payment.

- Catastrophic Reinsurance:

Year End Reconciliation, commonly referred to as Catastrophic Reinsurance, includes reinsurance dollars, low-income cost-sharing subsidy (LICS), and other items that are reconciled by plans and CMS annually, such as plan-to-plan transfers. Historically, this payment was made to self-insured EGWPs roughly one year after the end of the plan year. As of 1/1/17, CMS pays reinsurance dollars as a prospective per member per month (PMPM) payment based on baseline data for the EGWP market. Express Scripts will pay self-funded EGWP clients prospective reinsurance based on their expected member utilization. The payment will be combined with the monthly Direct Subsidy payment; details are available on the client website. The prospective reinsurance payments will be reconciled to actual member utilization for the plan year during the annual reconciliation process. Any additional dollars owed for reinsurance and the other components of the year-end reconciliation will be passed to clients in the January timeframe, following the CMS annual reconciliation. Should the prospective amount have overstated reinsurance owed, Express Scripts will recoup the funds from ERS, as outlined by CMS.

- Low Income Cost Sharing Subsidies:

  Express Scripts meets all CMS requirements for subsidy pass back to our clients.
  - Direct Subsidy and low income premium subsidy are typically received the 1st of the month from CMS and are passed month of within 15 days.
  - Reconciled reinsurance includes low income cost sharing (LICS) subsidy and is passed no later than January 31st after the close of CMS reconciliation.

  For additional information about the Low Income Subsidy and associated reporting:
  - Low Income Premium Subsidy — Advance monthly payments for premium subsidies on behalf of qualified low income subsidy (LIS) members. Around the 15th of the month, LIS is passed to our clients or their membership based on the client's election with associated reporting at the member level. Should the client receive the payment directly, LIS must be passed back to members within 30 days of receipt.
  - Low Income Cost Sharing Subsidy (LICS) — Annual payment for cost-sharing subsidies on behalf of qualified LIS members. LICS are passed to clients following the annual CMS reconciliation process in the January timeframe following CMS Reconciliation, with associated reporting

- Low Income Premium Subsidies:

  Low-income subsidy is paid to self-insured EGWP clients by the 15th of the month as passed by CMS. Subsidy statements and details are posted to the client website for review, and will remain on the client website for 60 days from posting. The statements and details are not needed to receive the payments, but are available to ERS. LIPS can be handled based upon your intent. These dollars can be passed to applicable beneficiaries directly by Express Scripts, or can be passed to you to pass to the member either directly or via premium reduction. Client set-up will be discussed further during the implementation process. If you pay 100% of the member premium, you may retain applicable LIPS dollars.

- Manufacturer Rebates:

  Express Scripts' process consists of four phases and ensures timely, accurate rebate payment:

  - Claims System Phase — The prescription moves through a three-step process that includes standard point-of-service edits, benefit determination, and formulary status.
  - Rebate Adjudication Phase — The prescription moves through a three-step process that includes drug exclusions, manufacturer contract assignments, and rebate application.
  - Invoice Phase — Typically, during the first week following the end of each period, the system generates an electronic summary of rebate-eligible claims by manufacturer by

filled/processed period within contract terms. Express Scripts' proprietary online tool, Invoice Direct, is available to manufacturers, and the invoicing phase is complete.

- Payment Application and Allocation Phase — We receive manufacturer payments, complete reconciliations, and apply the payments to open invoices. When the receipt and reconciliation processes are complete, the paid amounts are available for ERS allocation. Express Scripts will pay out rebates received for ERS eligible utilization within approximately 30 days following the end of the quarter.

I.4. Provide any CMS rule or regulation changes that Respondent has implemented, or plans to implement, for Medicare Part D plans in 2023 or later.

CMS finalized a proposal to modify the definition of "negotiated price" in Part D to fully reflect, or "pass through," all pharmacy price concessions at the point-of-sale. The proposal originally called for implementation in 2023, however, CMS finalized the rule with a 1 year delay requiring the new policy to be in place for 2024. CMS also finalized the policy to apply in all phases of the Part D benefit, including the Coverage Gap, reversing an earlier proposal to allow flexibility in the Coverage Gap. Our networks has been aggressively working on the DIR solution for 2024 including working with additional time for any recontracting necessary for 2024 including any detail on how this will work with Coverage Gap.

I.5. Respondent shall describe any anticipated or upcoming CMS changes to Medicare Part D/EGWP coverage requirements or benefits, including but not limited to the Out-of-Pocket and True Out-of-Pocket expenses, formulary drug coverage requirements, etc.

CMS recently finalized a rule that would require pharmacy price concessions, a form of direct and indirect remuneration (DIR) in Medicare Part D, to be fully incorporated into the definition of a drug's negotiated price and reflected at the point of sale. This policy will be effective beginning January 1, 2024. While this policy does not directly change program rules governing coverage requirements or benefits in Part D, it is expected to impact the pace at which a beneficiary accumulates true out-of-pocket (TrOOP) spending and moves through the phases of the Part D benefit.

Beginning January 1, 2026, CMS will implement a rule that will require manufacturer rebates, another form of DIR in Medicare Part D, to be fully passed through to the beneficiary at the point-of-sale. While CMS originally finalized this rule in 2021, the U.S. Congress passed legislation that delayed the implementation date to 2026. While it is possible future legislative action could shift the 2026 implementation even further, that is not certain and current law stipulates the policy will implement in 2026.

While we closely monitor the Part D and EGWP policy environment on a consistent basis, we prioritize active engagement with policymakers at the Federal level to influence potential changes to the Medicare program. The annual issuance of rules and guidance follows our robust process of review, analysis, and project planning. Express Scripts actively engages with industry partners, including the Pharmaceutical Care Management Association and America's Health Insurance Plans, to share expert opinions, establish advocacy priorities, and influence CMS's final decisions on payment and policy for the coming years. Through our Government Affairs team, we also provide comments to and advocate with CMS on proposed, future policy changes. Throughout this process, your account team and Medicare Strategist provide ongoing updates and work to address your needs.

We work closely with our clients to provide updates, discuss your upcoming plan year needs, and share details for Express Scripts' support for new requirements stemming from new policies. We also provide updates throughout the second half of the year on all Express

Scripts systems development efforts and procedural changes implemented to support new requirements.

I.6. How does Respondent keep its Medicare Rx PDP clients updated with CMS activities and actions impacting their group?

Express Scripts maintains a robust guidance intake and distribution process to ensure that both we, as the PBM, and our clients are informed of all aspects of ongoing Centers for Medicare & Medicaid Services (CMS) guidance. CMS releases new guidance memos and chapter revisions (Directives) on a daily basis via the Health Plan Management System (HPMS) website, which Express Scripts monitors. Our Government Programs team, which includes our Medicare Compliance group, tracks all CMS Directives, entering them into a common database. From there, Medicare workflows route the guidance to the appropriate subject matter experts to analyze, assess, and determine any impacts to Express Scripts and our clients. We also track regulatory sites such as the Paperwork Reduction Act and Federal Register websites, as well as other sources for pertinent releases.

We hold cross-functional guidance reviews multiple times a week to rapidly and comprehensively review all guidance changes and ensure all teams are aware of any new impacts. Following these meetings, identified Express Scripts action items, plan sponsor action items, and any needed system enhancements are communicated to clients through bi-weekly client forum calls and email business alerts. This process was recognized by CMS as a best practice during our PDP audit and was also reiterated at a CMS Oversight and Enforcement conference.

For large-scale guidance releases, such as the Annual Call Letter, we review it in full as an organization and provide our clients with an outline of all pertinent changes, their impact, and insight in to our comments back to CMS so that they may also inform any comments you want to make as a plan. These comments are provided in advance of the comment due date to ensure ample time to review and provide us with feedback as well.
We also host biweekly forums via a web teleconference call. We present on Medicare Part D topics and CMS Directives, as well as strategic updates around Star Ratings and market updates, all designed to keep our health plan clients abreast of the latest CMS and industry information. Every year, Express Scripts posts a calendar of events and client forum dates and sends invitations to our clients to hold the dates for these forums. Prior to each forum event, Express Scripts emails the forum agenda and presentation materials to ERS. Each teleconference includes a formal presentation followed by a question-and-answer session.

In addition to the above, your designated Medicare Strategist is responsible for reviewing CMS guidance and market changes with you to help you understand the potential impact to the market, you as the plan, and your membership. Your strategist will review the guidance with a lens specific to your needs and your goals, to ensure that messaging and information is tailored to your business.

I.7. Provide a detailed description, and/or workflow, of eligibility coordination with CMS.

Centers for Medicare & Medicaid Services (CMS) guidance outlines that enrollment requests should be effective on the first day of the month and disenrollment requests should be effective on the last day of the month.

When a member is Medicare eligible, ERS may submit the member for enrollment into the Employer Group Waiver Plan (EGWP). CMS permits group enrollment so that ERS may submit enrollment on behalf of your retirees. ERS should supply all data elements required to

process an enrollment request including the Medicare Beneficiary Identifier (MBI), demographic data, address, group ID, and appropriate prospective effective date. In accordance with CMS requirements, Express Scripts provides the member with the required communication and allows the member the opportunity to opt out of the plan in advance of enrollment submission to CMS. ERS should transmit the enrollment request at least 25 days in advance of the retiree's effective date of enrollment, whenever possible, to allow mailing of the enrollment pre-notification notice 21 days prior to enrollment effective date in accordance with CMS timeframes. If ERS utilizes active enrollment, the member will be submitted to CMS for enrollment immediately upon receipt of the enrollment record.

Express Scripts will provide a pre-edit report back to ERS that will show any front-line rejections related to the overall file submission. ERS or your elected enrollment vendor should review the report and resubmit any rejected transactions once corrected. If a member passes the pre-edit stage, they are sent to CMS for approval. CMS typically provides a response within 24 to 72 hours. If ERS utilizes passive enrollment, upon receipt of the enrollment record, Express Scripts will send the CMS-required pre-notification mailing to the member to inform them of their 21-day opt-out period. Once the 21-day period lapses, the member will be submitted to CMS for enrollment. Should a member be submitted for enrollment less than 21 days prior to the effective date, the member's enrollment will be processed to ensure access; however, in accordance with CMS guidelines, the member is still required to be allotted the 21-day opt-out period without recourse. This process should be used on an as-needed basis, as CMS guidance requires the 21-day opt-out period and recommends proactive transactions. If the member opts out during the opt-out period, Express Scripts, once notified, will not submit the member to CMS for enrollment.

Upon receipt of CMS acceptance, Express Scripts will begin the process to generate the member's ID card, which will be sent to the member within 10 days in accordance with CMS requirements. If CMS does not immediately accept the enrollment transaction and requires additional demographic information be verified, Express Scripts will contact the member via letter and phone call to attempt to obtain the required information. If obtained, Express Scripts will submit the updated information to CMS directly to complete the enrollment transaction. If the information is not obtained, CMS will reject the enrollment record. Express Scripts will provide ERS with a weekly PDP Enrollment Report that shows all members and their status with CMS, as well as the associated rationale for 120 days of terminations and rejections.

Disenrollment requests are transmitted upon receipt of the request from ERS. CMS responds to Express Scripts with the acceptance or rejection of a disenrollment request. In accordance with CMS requirements, Express Scripts provides the appropriate notification to the member, confirming disenrollment or notifying the member about the disenrollment rejection. Express Scripts reconciles all data and, as applicable, attempts to obtain additional information to make corrections and re-submit the request for processing.

ERS can submit enrollment and disenrollment requests via electronic file or through our online system, eSD enroll. For one-off requests, ERS can also make ad-hoc enrollment requests through your designated Medicare Service Center Agent (MSCA) team.

We will work closely with ERS to introduce pertinent CMS procedures and to ensure that applicable CMS guidelines are met. We have developed client materials that outline CMS instructions and processes to comply with mandates, such as CMS guidelines monitoring, enrollment processes oversight, and performance metrics. The weekly PDP Report is a snapshot of ERS's population and its status with CMS. This report shows Transaction Reply Report (TRR) history, enrollment status, low income status, late enrollment penalty status, and other pertinent member details. It also shows 120 days of rejects and terminations, as well as their associated reason codes — loss of eligibility, disenrollment due to death, and other termination and reject reasons. This report is provided to ERS weekly, and can be

posted to the client website or transmitted via file transfer protocol (FTP), based on ERS's intent.

Express Scripts also has the capability to provide additional support for managing CMS eligibility responses. We work directly with CMS, your retirees, or both to resolve issues without the involvement of ERS or your eligibility vendor. This reduces work on behalf of ERS and allows all the benefits of the EGWP, with significantly less administrative involvement and a better member experience.

I.8. Describe in detail how Respondent processes data files, the type(s) of files that Respondent requires from ERS, and any special nuisances and handling of the data that Respondent uses (or that Respondent requires of its clients) in order to successfully exchange and process eligibility information to/from its clients and CMS.

When a member is Medicare eligible, ERS may submit the member for enrollment into the Employer Group Waiver Plan (EGWP). CMS permits group enrollment so that ERS may submit enrollment on behalf of your retirees. ERS should supply all data elements required to process an enrollment request including the Medicare Beneficiary Identifier (MBI), demographic data, address, group ID, and appropriate prospective effective date. In accordance with CMS requirements, Express Scripts provides the member with the required communication and allows the member the opportunity to opt out of the plan in advance of enrollment submission to CMS. ERS should transmit the enrollment request at least 25 days in advance of the retiree's effective date of enrollment, whenever possible, to allow mailing of the enrollment pre-notification notice 21 days prior to enrollment effective date in accordance with CMS timeframes. If ERS utilizes active enrollment, the member will be submitted to CMS for enrollment immediately upon receipt of the enrollment record.

Express Scripts will provide a pre-edit report back to ERS that will show any front-line rejections related to the overall file submission. ERS or your elected enrollment vendor should review the report and resubmit any rejected transactions once corrected. If a member passes the pre-edit stage, they are sent to CMS for approval. CMS typically provides a response within 24 to 72 hours. If ERS utilizes passive enrollment, upon receipt of the enrollment record, Express Scripts will send the CMS-required pre-notification mailing to the member to inform them of their 21-day opt-out period. Once the 21-day period lapses, the member will be submitted to CMS for enrollment. Should a member be submitted for enrollment less than 21 days prior to the effective date, the member's enrollment will be processed to ensure access; however, in accordance with CMS guidelines, the member is still required to be allotted the 21-day opt-out period without recourse. This process should be used on an as-needed basis, as CMS guidance requires the 21-day opt-out period and recommends proactive transactions. If the member opts out during the opt-out period, Express Scripts, once notified, will not submit the member to CMS for enrollment.

Upon receipt of CMS acceptance, Express Scripts will begin the process to generate the member's ID card, which will be sent to the member within 10 days in accordance with CMS requirements. If CMS does not immediately accept the enrollment transaction and requires additional demographic information be verified, Express Scripts will contact the member via letter and phone call to attempt to obtain the required information. If obtained, Express Scripts will submit the updated information to CMS directly to complete the enrollment transaction. If the information is not obtained, CMS will reject the enrollment record. Express Scripts will provide ERS with a weekly PDP Enrollment Report that shows all members and their status with CMS, as well as the associated rationale for 120 days of terminations and rejections.

I.9. ERS follows all CMS requirements for determining enrollment and disenrollment eligibility and effective dates. ERS is responsible for managing enrollment, coverage declinations, and coverage cancellations for nonpayment of ERS-required premiums. PBM shall confirm it will direct participant to ERS in these scenarios.

☒ Confirm ☐ Cannot confirm (requires explanation)

I.10. Describe the enrollment/disenrollment process and include detail regarding the timing of when enrollment/disenrollment changes go into effect/are reported back to ERS.

Centers for Medicare & Medicaid Services (CMS) guidance outlines that enrollment requests should be effective on the first day of the month and disenrollment requests should be effective on the last day of the month.

When a member is Medicare eligible , ERS may submit the member for enrollment into the Employer Group Waiver Plan (EGWP). CMS permits group enrollment so that ERS may submit enrollment on behalf of your retirees. ERS should supply all data elements required to process an enrollment request including the Medicare Beneficiary Identifier (MBI), demographic data, address, group ID, and appropriate prospective effective date. In accordance with CMS requirements, Express Scripts provides the member with the required communication and allows the member the opportunity to opt out of the plan in advance of enrollment submission to CMS. ERS should transmit the enrollment request at least 25 days in advance of the retiree's effective date of enrollment, whenever possible, to allow mailing of the enrollment pre-notification notice 21 days prior to enrollment effective date in accordance with CMS timeframes. If ERS utilizes active enrollment, the member will be submitted to CMS for enrollment immediately upon receipt of the enrollment record.

Express Scripts will provide a pre-edit report back to ERS that will show any front-line rejections related to the overall file submission. ERS or your elected enrollment vendor should review the report and resubmit any rejected transactions once corrected. If a member passes the pre-edit stage, they are sent to CMS for approval. CMS typically provides a response within 24 to 72 hours. If ERS utilizes passive enrollment, upon receipt of the enrollment record, Express Scripts will send the CMS-required pre-notification mailing to the member to inform them of their 21-day opt-out period. Once the 21-day period lapses, the member will be submitted to CMS for enrollment. Should a member be submitted for enrollment less than 21 days prior to the effective date, the member's enrollment will be processed to ensure access; however, in accordance with CMS guidelines, the member is still required to be allotted the 21-day opt-out period without recourse. This process should be used on an as-needed basis, as CMS guidance requires the 21-day opt-out period and recommends proactive transactions. If the member opts out during the opt-out period, Express Scripts, once notified, will not submit the member to CMS for enrollment.

Upon receipt of CMS acceptance, Express Scripts will begin the process to generate the member's ID card, which will be sent to the member within 10 days in accordance with CMS requirements. If CMS does not immediately accept the enrollment transaction and requires additional demographic information be verified, Express Scripts will contact the member via letter and phone call to attempt to obtain the required information. If obtained, Express Scripts will submit the updated information to CMS directly to complete the enrollment transaction. If the information is not obtained, CMS will reject the enrollment record. Express Scripts will provide ERS with a weekly PDP Enrollment Report that shows all members and their status with CMS, as well as the associated rationale for 120 days of terminations and rejections.

Disenrollment requests are transmitted upon receipt of the request from ERS. CMS responds to Express Scripts with the acceptance or rejection of a disenrollment request. In accordance with CMS requirements, Express Scripts provides the appropriate notification to the member,

confirming disenrollment or notifying the member about the disenrollment rejection. Express Scripts reconciles all data and, as applicable, attempts to obtain additional information to make corrections and re-submit the request for processing.

ERS can submit enrollment and disenrollment requests via electronic file or through our online system, eSD enroll. For one-off requests, ERS can also make ad-hoc enrollment requests through your designated Medicare Service Center Agent (MSCA) team.

We will work closely with ERS to introduce pertinent CMS procedures and to ensure that applicable CMS guidelines are met. We have developed client materials that outline CMS instructions and processes to comply with mandates, such as CMS guidelines monitoring, enrollment processes oversight, and performance metrics. The weekly PDP Report is a snapshot of ERS's population and its status with CMS. This report shows Transaction Reply Report (TRR) history, enrollment status, low income status, late enrollment penalty status, and other pertinent member details. It also shows 120 days of rejects and terminations, as well as their associated reason codes — loss of eligibility, disenrollment due to death, and other termination and reject reasons. This report is provided to ERS weekly, and can be posted to the client website or transmitted via file transfer protocol (FTP), based on ERS's intent.

Express Scripts also has the capability to provide additional support for managing CMS eligibility responses. We work directly with CMS, your retirees, or both to resolve issues without the involvement of ERS or your eligibility vendor. This reduces work on behalf of ERS and allows all the benefits of the EGWP, with significantly less administrative involvement and a better member experience.

I.11. What CMS eligibility verification method is the most prevalent method used by Respondent for Medicare Part D/EGWP plans?

Enrollment requests are validated through the Enrollment Processing System and through the CMS Beneficiary Eligibility Query (BEQ) to determine if the Medicare beneficiary is eligible for enrollment into an EGWP Plan or if the request is complete. Express Scripts adheres to the following guidelines when the enrollment request is deemed to be incomplete:

1. Verifies completeness of an enrollment request and Medicare eligibility.
2. Mails appropriate RFI Exhibit Letter within 10 calendar days from enrollment request receipt.
3. Conducts telephonic outreach to obtain information required to complete the enrollment request if beneficiary's phone number on file

When the requested information is received via a written correspondence or telephonically, within seven calendar days of receipt of the requested information Vendor shall submit the enrollment to the Centers for Medicare and Medicaid Services (CMS) for the effective date as determined by the election period being used.

If missing information is not provided within the CMS timeframes, the enrollment request is denied within 10 calendar days from the missing information due date

I.12. Describe annual changes that Respondent expects, if any, to the HealthSelect Medicare Rx Direct Subsidy, which is based on the national average individual market PDP competitive bids for the year; adjusted for area and risk-profile of employer's population.
Express Scripts considers this response to be proprietary and confidential.

I.13. Describe any changes to the HealthSelect Medicare Rx PDP plan design described herein, if applicable, that Respondent recommends ERS consider to maximize collection of all available subsidies, reinsurance, discounts or rebates.

There are multiple considerations ERS can evaluate in order to maximize the collection of all available subsidies, reinsurance, discounts, or rebates. However, many of them require a plan design change that would impact members. On an annual basis, Express Scripts works with our clients to determine their goals and objectives for plan design for the following year's benefit. Your account team and EGWP Strategist will partner together with you to ensure that we bring suggestions and solutions forward that align with your goals. Based on trends and utilization, we may offer recommendations for plan design changes to meet your goals. These changes can include, but are not limited to, revisiting ERS's current copay set up, formulary election, or enrollment in clinical programs and utilization management. For suggestions that are of interest to you, we will provide a full financial analysis as well as a report that denotes any potential disruption across your population.

We are also cognizant of opportunities that are ultimately a benefit to the member and the plan. For example, we worked with a client who had a member out-of-pocket maximum that was limiting coverage gap payments and catastrophic reinsurance, and found the right balance of a coinsurance with a maximum that slowed member movement to the MOOP but was positive to the member on a net/net basis. Further, we recommend ERS utilize a performance-based network. Performance networks use proven strategies to create competition among pharmacies. By incentivizing pharmacies through quality measurement, Express Scripts can help ERS unlock untapped value in your network strategy while also helping to improve your members' health outcomes. Our National Performance Medicare Network (NPN) is a CMS-compliant solution focusing on CMS Star metrics to improve quality ratings and member outcomes. NPN offers competitive rates and a broad setup that doesn't require plan design changes (unless used as a wrap network), while members receive improved care.

I.14. ERS does not cover high income and late enrollment penalties. Describe how Respondent standardly handles high income and late enrollment penalties.

Express Scripts supports ERS' stance to not cover high income and late enrollment penalties as a plan decision. We have experience with both plans who cover and those who do not. LEP information is passed by CMS, thus we have insight in to that member level information and pass it to ERS in order to collect appropriately. Since Part D IRMAA is billed directly by SSA to the member, ERS does not have to be directly involved in that process.

## LEP

We offer multiple enhanced options to the standard Late Enrollment Penalty (LEP) process that can assist you with creditable coverage attestations, yielding an improved result for your plan and members. A brief explanation of each of these options is provided below:

- *Global attestation* — ERS can sign a global LEP attestation, meaning that ERS attests that all members enrolled in the ERS EGWP plan came from creditable coverage. Through this method, no uncovered months will be submitted to the Centers for Medicare & Medicaid Services (CMS) for the time period immediately preceding a member's enrollment in the ERS EGWP. In addition, the member will not need to attest, as ERS has elected a blanket attestation for all members.
- *Monthly attestation* — Via our monthly attestation process, Express Scripts generates a monthly report for ERS that includes all members identified as having a potential gap in creditable coverage by CMS within the past month. This file posts to the client website

on the first of the month and is due back by the 15th of the month to ensure timely submission of uncovered month validation to CMS. Through this process, ERS will be able review each member and attest or not attest on a member-level basis. Additionally, both the member and the client have the opportunity to attest, and the favorable attestation will prevail.

- *Creditable coverage indicator* — ERS can also attest on a member-level basis by using the creditable coverage indicator feature on the enrollment file. Through this method, ERS can proactively attest that a member came from creditable coverage when the member is submitted for initial enrollment in the EGWP. If ERS attests to the member's creditable coverage on the initial submission, the member will not need to be given the opportunity to attest. If ERS does not attest and the member is identified as having a potential gap in creditable coverage, the individual attestation process will ensue, as outlined by CMS.
- *Initial file attestation* — ERS can attest that all members sent on the initial enrollment file came from creditable coverage. With this method, the members on the initial file will not need to attest, as ERS has elected a blanket initial attestation. For all subsequent files with new enrollees and age-in members, ERS would need to elect one of the other options listed above if you desire an ongoing enhanced attestation process.

Please note that the attestation processes outlined above require documentation for audit purposes. Additionally, these processes apply to gaps in coverage immediately preceding the member's enrollment in ERS's EGWP. Express Scripts cannot allow ERS to attest for LEPs assessed by a prior plan. If no enhanced LEP attestation process is elected, Express Scripts will require the member to attest on their own behalf, as outlined in CMS guidance. If the member does not attest within the required timeframe, they will be assessed a LEP by CMS. Express Scripts will pass the LEP assessment to ERS on a monthly basis. ERS can make an election to cover LEP assessments on behalf of its membership or pass the amounts to the applicable members so long as the decision is applied uniformly across the population. Express Scripts will provide ERS with member-level detail on any LEP assessment within the monthly financial reporting package that is posted to client website.

## IRMAA

Since the Income Related Monthly Adjustment Amount (IRMAA) is handled directly between the member and the Social Security Administration (SSA), formal intervention cannot be provided by Express Scripts. However, Express Scripts is happy to share best practices that our other clients have utilized to address the member noise that Part D IRMAA can cause. For example, ERS may elect to reimburse members who disclose that they have been assessed Part D IRMAA, so long as the reimbursement is handled consistently across the population.

Express Scripts can also provide knowledge and additional insight into the IRMAA process. For example, retirement is a life-changing event; therefore, if a member is assessed IRMAA at the time of retirement based on their prior income levels, the member may appeal the IRMAA decision with SSA on the basis of a life-changing event.

Should the Centers for Medicare & Medicaid Services (CMS) disenroll a member due to Part D IRMAA, Express Scripts will mail the member the CMS-required exhibit letter, explaining the occurrence to them. Additionally, this information will be passed back to ERS on the Weekly Prescription Drug Plan (PDP) Enrollment Report, which contains a specific reason code associated to disenrollment for failure to pay Part D IRMAA.

I.14.a. Describe Respondent's processes to obtain the necessary information from the participant if ERS does not have the complete information for CMS program eligibility (e.g., incorrect or missing Medicare Beneficiary Number).

If ERS does not have a particular MBI on file or if the SSN is provided in the SSN field and the MBI field is blank, the member record will fall to "Request for Information" or RFI, whereby Express Scripts reach out to the member in an attempt to obtain the missing MBI. If identified, it will be used to submit the member for enrollment and passed to ERS on the Weekly PDP Report.

I.14.b. Would Respondent be willing to do an outreach directly to Participants to obtain the Medicare Beneficiary Numbers? ☒ Yes ☐ No

I.15. Describe the processes Respondent standardly uses for coordinating benefits between the Medicare Part D EGWP plans and a Wrap, including any inconvenience or delay that may be experienced by the Participant, if applicable.

With the Express Scripts EGWP *Plus* option, ERS can maximize your savings, while continuing to offer an enhanced plan to your membership, by offering the CMS-defined standard plan as primary and wrapping all stages with a secondary plan. This allows ERS to take advantage of the maximum amount of manufacturer reimbursement dollars, thus increasing savings. This option can be applied with either a self-insured or fully insured EGWP.

Express Scripts provides ERS enhanced coverage alongside the Medicare standard defined benefit in single benefit build and with support of a single formulary, without the need for a coordination of benefits (COB) claim. Our processing allows ERS's benefit to be supported as a single plan offering rather than supporting the benefit in two pieces (a base Medicare plan and a secondary "wrap" plan). This best-in-class process allows the plan design to meet ERS's intent and supports a streamlined member experience, driving efficiencies with member communications and other functions of the plan. Supporting a true single claim transaction in a single claim ID provides members with a consistent, clear experience with their benefit. Eliminating the need for a COB claim provides synergies for the member that can be seen in their explanation of benefits (EOB), as well as throughout the appeals and direct claims processes.

CMS guidance considers any coverage above and beyond the standard defined benefit to be enhanced coverage or Other Health Insurance (OHI). Express Scripts supports this enhanced coverage to meet ERS's intent. All of Express Scripts' EGWP plans offer some level of enhanced coverage, meaning that Express Scripts successfully supports this type of "wrap" coverage for 1.6 million retirees.

I.16. Describe how Respondent proposes to handle "D" drugs that are typically provided under the medical benefit based on their route of administration, such as IV injectable.

Our experience in working with diverse clients means we have implemented and supported a wide array of plan designs and models. During implementation, we will work with ERS to gain an understanding of your coverage rules, including for specialty products like IV injectables. Our specialty pharmacy, Accredo® is enrolled as a Part B supplier. For Medicare Part B medications and supplies, Express Scripts also works with licensed Part B home delivery vendor pharmacies. These providers fulfill Part B medications and Medicare billing for those clients who choose to provide this coverage through their Express Scripts prescription drug benefit.

## Part D versus Part B Drugs

All prescription drugs approved by the Food and Drug Administration (FDA) are considered potential Medicare Part D drugs. We receive frequent updates of new drugs, dosage forms, and manufacturers along with other relevant information, including which drugs are eligible

for Medicare Part B. Some Part B drugs may be covered under Medicare Part B or Medicare Part D depending on use. For those drugs, Express Scripts supports a prior authorization process in accordance with Centers for Medicare & Medicaid Services (CMS) requirements to determine how the claim should process. We have developed special prior authorization criteria to determine whether certain drugs should be paid under Medicare Part B or Part D. For each drug, as appropriate, our prior authorization process determines the patient's diagnosis, setting, location, previous history, and other factors as needed to make the correct Medicare Part B/D determination. Drugs targeted for a B/D determination are submitted and approved by CMS through the formulary submission process.

The Express Scripts Medicare Part B versus D list is based on interpretation of CMS regulations and guidance and is subject to change. This list identifies drugs that may require a determination of Medicare Part B eligibility to further ensure Part D eligibility (that is, if a drug is Medicare Part B eligible, it is not Medicare Part D eligible). The criteria for inclusion of a drug on the Medicare B versus D list are based on review of the Medicare Prescription Drug Benefit Manual, Chapter 6, and the Medicare Benefit Policy Manual, Chapter 15.

Express Scripts also employs automation logic for Part B versus Part D determinations in a number of ways. These tools serve to minimize member and pharmacy disruption while ensuring plans remain adherent to CMS guidance. For example:

- For antiemetics, authorization to Medicare Part D occurs when an antiemetic medication is prescribed and the days' supply is greater than two days.
- For nebulized drugs, authorization to Medicare Part D occurs for those members with patient residence codes that indicate the member is in a long-term care facility, skilled nursing facility, or nursing home.

Additionally, Express Scripts continually looks for opportunities to minimize disruption through enhancements to our automated review processes. We now utilize diagnosis codes submitted via pharmacy claims to automate the Part D eligibility determination for some claims. The diagnosis code is systematically reviewed to identify whether the claim would be Part B or Part D eligible based upon CMS guidance.

In addition to Part D versus Part B determinations, if the prescription and member are determined to be eligible for Part B, Express Scripts has the capability to include these drugs alongside the Part D benefit, where delegated by the plan. Part B claims maximum out-of-pocket (MOOP) reporting and ad-hoc reporting can be made available for plan oversight. We can also provide whether the claim was paid as Part B or Part D on your paid claims files.

### Drug-Specific Coverage

For clients who provide coverage under the medical benefit or pharmacy benefit based on the drug, Express Scripts works with each client to understand and document the client’s criteria. In many instances, the site of service determines the avenue of coverage. For example, products that can be self-injected might be covered under the pharmacy benefit, while products that require administration in a physician’s office would be covered under the medical benefit.

### Recommended Approach

Express Scripts’ recommended approach is to analyze your medical and pharmacy specialty data to determine which benefit solutions would best meet your specialty management needs. This analysis will determine if your spend could be managed more effectively through our suite of specialty management programs. For some clients, it may be a better to exclude coverage in the medical benefit with our Medical Channel Management (MCM) program.

I.17. Provide a description of Respondent's medication therapy management program(s), including the processes for enrollment, targeting, intervention, and outcomes reporting, including a participant opt-out process for medication therapy management, if applicable.
Express Scripts considers this response to be proprietary and confidential.

I.18. Describe how Respondent would administer CMS Part D Transitional Fills, including the notification process to Participants, in connection with the HealthSelect Medicare Rx PDP.

Express Scripts meets all Centers for Medicare & Medicaid Services (CMS) timeframes and requirements for providing a one-month transition fill for transition-eligible prescriptions within the first 90 days of the member's CMS effective date, as well as the first 90 days of the plan year following as applicable for existing utilizers.

> After review of Express Scripts' Transition Fill program, it is evident that the investment that Express Scripts has made in dedicated staffing, Information Technology testing environments, and frequency of monitoring parameters has paid dividends as reported in their success in CMS Program Audits and Transition Monitoring Program Analysis audits.
>
> – *External Auditing Firm*

If a member is on a Medicare Part D medication that is not on Express Scripts' formulary, or has utilization management edits, we will provide a temporary transition supply. Please see the process flow and description below for additional details.

## Transition Supply Process

Our transition supply policy covers members for whom it cannot be ascertained if they are on established regimens with Part D drugs to ensure they have access to a temporary supply of drugs, as well as members with a prior history of the drug. A transition supply will be made available for the immediate needs of a member where the drug is nonformulary or has utilization management edits, such as prior authorization, step therapy, or quantity limits.

Transition supplies apply to:

- New enrollees into prescription drug plans at the beginning of a contract year
- The transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year
- The transition of individuals who switch from one plan to another after the beginning of a contract year
- Enrollees residing in long-term care (LTC) facilities
- In some cases, current enrollees affected by formulary changes from one contract year to the next

All CMS requirements are considered during the transition process to ensure the member receives the fill as required. If the prescription and member are eligible per CMS requirements, the member will be able to receive their prescription at point-of-sale, without interruption to their therapy.

Transition fills offer a one-month supply within the transition window, which is typically 90 days. Should the member fill less than a one-month supply, their next fill will adjudicate as written until their one-month allowance is exhausted.

Members in an LTC setting are also provided a one-month temporary supply. For LTC enrollees falling outside of the 90-day transition window, Express Scripts covers an emergency supply of one month, unless the prescription is written for less, during this exception process.

Both the member and the prescriber will be notified of the transition fill via letter. The letter will be triggered within 24 hours of the transition fill adjudication and will notify the member and prescriber what needs to occur prior to the member's next fill in order to ensure continuation of therapy.

ERS will have the ability to enter exceptions at any time of year, including December, to avoid transition fills as appropriate.

## EGWP Transition of Care

On an annual basis for existing enrollees, as well as upon enrollment in the plan for new enrollees, members are eligible for a transition supply so long as the fill in question meets all necessary transition requirements set forth by CMS. Should a member fill a transition-eligible claim within the first 90 days of their enrollment in the Express Scripts EGWP — or the first 90 days of the plan year — the member receives a transition fill to ensure continuation of therapy. When a transition fill is adjudicated, both the member and the prescribing physician receive a letter from Express Scripts outlining next steps that should be taken prior to the member's next fill. As an enhancement to the CMS-required process, Express Scripts has logic in place to ensure that the beneficiary receives their transition allowance in full. Through this "auto-effectuate" logic, if the beneficiary does not receive a full transition allowance on the first fill, refills will be permitted until the transition day supply is exhausted. This is to ensure the member receives the full benefit of the transition window and remains adherent.

I.19. Describe the documents that are required to be filed initially and on an ongoing basis with CMS for the HealthSelect Medicare Rx PDP, including the timing of submitting required CMS documents to ERS and CMS for review.

In addition to regular meetings with your Account Team and Regulated Markets Strategist, Express Scripts also hosts regular client forums to review pertinent information, as well as publishes an annual Client Handbook that can be referenced for these types of topics as well. ERS can utilize one or all of these methods, and your support time will align with your intent.

That being said, the Readiness Checklist summarizes key operational requirements as established in statutes, regulations, manual chapters, Health Plan Management System (HPMS) memos, applications, and other advisory materials. In partnership, we review the checklist carefully and take the necessary measures to fulfill these key requirements for the upcoming contract year. To further support your organization in this effort Express Scripts will provide you with a description of how the Express Scripts systems are set up to address the CMS requirements for the functions that you delegate to us or are a shared responsibility.

Express Scripts provides you with a list of checklist items identified as one of three categories:
1. Plan-Owned - These items do not include any responsibility delegated to Express Scripts
2. Shared Ownership - These items include portions that are delegated to Express Scripts but that also require plan action

3. Express Scripts-Delegated - These items are wholly delegated to Express Scripts. However, plans are required to attest to these items in HPMS

For categories two and three, Express Scripts' subject matter experts review items related to the functions that you have delegated to us and describe how the Express Scripts' systems meet the CMS requirement. We then provide our clients with a description of how the Express Scripts' systems are set up to address the CMS requirements for the functions we support. To support ERS in your readiness assessment, Express Scripts will:

- Review the CMS Readiness Checklist and provide feedback on tasks, changes, requirements, etc.
- Identify and communicate responsibilities for checklist items, as described above
- Provide a descriptive attestation of how we are set up to address the CMS requirements in the Readiness Checklist
- Provide additional assistance as needed

From a timing perspective, the CMS Readiness Checklist is typically communicated to plans through HPMS in early October. Express Scripts will provide clients with a responsibility matrix shortly after release of the guidance, as explained above. By mid-November, or earlier as needed, Express Scripts will provide our clients with a descriptive attestation of how we address the CMS requirements for the functions that are delegated to us or that are shared; as well as any additional, required information.

## J. Interrogatories – Optional Services (Informational Only)

J.1. Describe in detail, any products, services, ideas, or facilities which may enhance the Programs' services, but are not essential in providing the required Services. Respondent shall provide an accurate and detailed description of any additional enhancements to services offered by Respondent, including the implementation history for each service. As part of the Price Proposal in **Appendix Q**, Respondent will be asked to provide pricing on a per Subscriber basis for HealthSelect PDP and per Participant basis for the HealthSelect Medicare Rx PDP. ERS will not be obligated to select any of the options provided. If any option is selected by ERS, it will be specifically stated in writing which option(s) are selected.
Express Scripts considers this response to be proprietary and confidential.

# Employees Retirement System of Texas (ERS) Request for Proposal

## For Pharmacy Benefit Management Services 06.23.2022

Express Scripts appreciates the opportunity to present ERS with this proposal for PBM services. We look forward to building on our past relationship and developing a strong partnership to help solve your toughest challenges in the pharmacy benefit today and in the future.

### A Challenging Landscape

The current healthcare landscape presents many challenges as you work to manage costs, while ensuring your members and their families receive first-in-class care. But even in the face of challenge, it also presents great opportunity. ERS has the unique opportunity to embrace the uncertainty in today's healthcare and simplify the experience for your organization and members — while not sacrificing benefits of the latest innovations. Let us help you take the complexities out of healthcare as we take on the toughest challenges, expose opportunities to reduce costs, and help prepare for what's next.

Based on the requirements you have presented in your RFP, we believe our focus on the unique partnership with our clients, our EGWP experience, our track record of successful implementations, our proposed account team structure, and commitment to innovation offer significant value to ERS and make us your ideal pharmacy partner.

### Our Promise

We believe everyone deserves access to the medication they need at a price that's affordable. That's why the needs of ERS and your members are at the forefront of everything we do. By choosing Express Scripts to help manage your prescription drug benefit, you will be partnering with a healthcare opportunity company that believes healthcare can do more.

### Economic Impact

As healthcare becomes more complex, new drug therapies become more expensive, and budgets become more constrained, plans like ERS are faced with a challenge. How do you continue to offer high-value benefits while also managing to increasing budget constraints? In our proposal to ERS, we demonstrate how we will partner with you to deliver on our commitments to support the requirements of your RFP with a high-quality, affordable pharmacy benefit that effectively controls plan costs.

While most PBMs provide efficient administration and execute on your initiatives to help you control costs, only Express Scripts is able to do all these things while bringing you first-to-market solutions that are customized to your member population, saving you money on both the prescription and medical plan, and making your members healthier and more adherent.

Now, more than ever, ERS must identify every significant opportunity to effectively contain its budget while safeguarding the health of plan participants. As your PBM partner, we will help you look beyond the current state of the world and help you anticipate long-term budget needs. From managing the supply chain, to mitigating stockpiling and hoarding of prescriptions, to waiving out-of-pocket costs for COVID-19 treatment, to maximizing the receipt of Pharma dollars for the most expensive specialty medications, we are committed to helping ERS meet their fiscal responsibilities while providing plan participants with the care they expect and deserve.

## Public Sector Experience

As an Express Scripts client, you will partner with an experienced public sector client service team built to serve ERS' needs. Through one consistent team with clearly defined roles and points of contact, we deliver greater accountability while ensuring we have a deep understanding of your plan. This helps your account team serve as your trusted partner, anticipating your needs and providing the right recommendations for you and your members. ERS' account team will drive appropriate collaboration with Express Scripts' extended service teams, which include experts in operational areas such as plan design, eligibility, and billing, as well as Medicare support. You also have access to the President of Express Scripts, Amy Bricker. She will be serving as your Executive Sponsor. She will be your advocate within Express Scripts, demonstrating a commitment to ERS by providing strategic insight and corporate vision.

Our public sector team has extensive experience serving clients similar to ERS, including those with public oversight requirements. Our book of business includes 15 public sector agencies located in Texas, serving nearly 500,000 lives. ERS will value our significant experience helping public sector clients manage costs and improve health outcomes, with customized approaches based on your current metrics, member population, risk tolerance, and specific goals for your pharmacy plan.

Our service for ERS also reflects what we know matters to you: local presence. Express Scripts has been part of Texas for more than 30 years. Recently, we demonstrated our commitment to the Texas community through our Walk in Wellness Clinic Tour, which provided free biometric screenings, flu shots, and health coaching services to Texans as the latest demonstration of our mission to elevate health for all. This is one part of our broader effort to bring industry leading health and wellness programs to underserved communities throughout the country and to the people who need it most.

In closing, we look forward to renewing our partnership that helps you continue to appropriately manage costs while improving the health of your members and their families. We know that the decision to move to a new healthcare partner is not one to take lightly. We truly believe that working collectively as a team early on will allow us to be innovative and forward thinking, whether ERS want to be aggressive with innovation or would like to ease into new solutions. Our goal is to be more transparent and better align with your needs and deliver real accountability for plan performance. You have high expectations for your pharmacy benefit manager, and we're confident that Express Scripts will deliver the highest quality care and most cost-effective benefit for you.

As you review our enclosed proposal, please don't hesitate to contact Roger Holland, Vice President of Sales, with any questions. He will be your principal proposal contact during this process. His contact information is below:

Roger Holland

Vice President of Sales — Public Sector

One Express Way

St. Louis, MO 63121

Tel: 949.499.2042 / 949.412.1440

roger_holland@express-scripts.com

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# Prescription Drug Plan Description

Administered by Express Scripts, Inc

## INTRODUCTION

The coverage described in this booklet is for the CLIENT Prescription Drug Program administered by Express Scripts. The program information applies to Enrollees in the CLIENT-sponsored health care plans administered by HEALTH PLAN. Prescription drug coverage is offered under the CLIENT Health Care Program. Furthermore, coverage under the program may be modified or eliminated at any time by the CLIENT. Prescription drug coverage, like all other coverage under the CLIENT Health Care Program, is not guaranteed. CLIENT hopes to continue the program indefinitely, but reserves the right to change or discontinue all or part of the program for all or a class of eligible benefit recipients and covered dependents at any time. Premiums, copayments, deductibles and all other charges or fees paid by an Enrollee may change from year to year.

This booklet states the terms and conditions under which prescription drug coverage is available through the HEALTH PLAN. The terms and conditions stated in this booklet shall control in the case of any question or dispute concerning such coverage.

The benefits provided by the program are not insured with Express Scripts; they are paid from CLIENT funds. Express Scripts provides certain administrative services under the program. The program is not an ERISA-covered plan.

This program is separate and distinct from any other health care plan available while the Enrollees in this program were actively employed by any public employer. This program does not constitute a continuation of any health plan through active employment.

Proceeds received by CLIENT as a result of any contract for prescription drugs are used to offset the cost of prescription drug claims and the administration of the program to the benefit of all Enrollees.

**Notice:** If you or your Eligible Dependents are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section in this document, and compare them with the rules of any other plan that covers you or your family.

## AUTHORIZATION TO RELEASE INFORMATION

By accepting coverage under an CLIENT-sponsored health care plan, all Enrollees, including any enrolled dependents, shall: (1) furnish CLIENT or its designees any and all information and proof CLIENT may reasonably require pertaining to health care coverage and the operations of its health care plan; and (2) authorize and direct any person or organization that has provided services to the Enrollee to furnish CLIENT or its designees any and all information and records (or copies of records) relating to care or services provided directly to the Enrollee or services provided indirectly to the Enrollee related to the administration of the health care program. Such information and records may be requested by CLIENT or its designees at or within any reasonable time.

CLIENT will protect, use and disclose information pertaining to your protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to the extent that HIPAA applies to the program. The program is permitted to use and disclose your protected health information (1) in connection with medical treatment you receive; (2) for payment purposes, which include uses and/or disclosures related to payment for services you receive, payments of premiums to the program, determining eligibility for benefits, claims management and/or utilization review; and (3) to

conduct health care operations. The program may also disclose protected health information for other purposes, which are more fully described in the document, *CLIENT Notice of Privacy Practices*, which may be obtained by calling the CLIENT Member Services Center toll-free at 1-888-227-7877 or by visiting the CLIENT Web site at WEBSITE.COM. Your rights regarding your protected health information are also addressed in the *CLIENT Notice of Privacy Practices*.

Any and all records pertaining to health care services that CLIENT in its sole discretion determines: (1) are necessary to implement and administer the terms of health care and prescription drug coverage; and/or (2) are for the appropriate review and management of its health care plans and prescription drug program may be used by and released to CLIENT and its designees or used and released among CLIENT designees.

All information and records pertaining to health care and prescription drug coverage and services are considered by CLIENT to be confidential and will not be given, sold or transferred to any person or organization not designated by CLIENT. Enrollees may obtain a copy of the complete *CLIENT Notice of Privacy Practices* by contacting the CLIENT Member Services Center toll-free at 1-888-888.8888.

## FRAUD

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against the provider of benefits, submits an application or files a claim containing a false or deceptive statement, is guilty of a crime or fraud against the legal entity providing benefits under this program and such conduct may result in the termination of any or all coverage under this program. Any person who commits fraud will be responsible for any of the costs of benefits paid.

## RECOVERY OF COSTS

CLIENTshall be entitled to recover the costs of any claims paid on behalf of an Enrollee if it is determined that the individual was not eligible for coverage at the time the claims were incurred, regardless of the amount of time that has passed.

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Effective Date: 1/1/2008, unless otherwise specified

Issue Date:

# CLIENTPRESCRIPTION DRUG PROGRAM

As an enrollee in a HEALTH PLAN, you are entitled to the prescription drug coverage described on the following pages. This coverage is provided by CLIENT and administered by Express Scripts. With your prescription drug coverage, you may purchase Prescription Drugs through retail pharmacies and the Express Scripts Home Delivery Pharmacy.

The program is offered to Eligible Beneficiaries and Eligible Dependents enrolled in the health maintenance organizations (HMOs) offered by CLIENT.

The program provides protection for out-of-pocket prescription drug expenses. Once an enrollee has paid a total of $2,000 out of pocket in retail and Home Delivery Copayments for drugs that were dispensed in a calendar year, that enrollee will pay nothing for covered drugs dispensed during the remainder of the calendar year. *?MOP and PSL for Plus and Basic should be described here?*

As an enrollee in an CLIENT-sponsored health care plan, you do not need to enroll in Medicare Part D. CLIENT has determined that the prescription drug coverage included in your HEALTH PLAN is as good as or better than the standard Medicare Part D prescription drug coverage (see Notice of Creditable Coverage). **Note: If you are enrolled in XXXXX, your current hospital/medical benefits will be terminated by Medicare if you also enroll in a Medicare Part D prescription drug plan.**

## DEFINITIONS AS USED IN THIS PROVISION

**Brand-Name Drug:** A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

**Copayment:** The specified charge that you are required to pay for a prescription drug product.

**Eligible Beneficiary:** An individual who is receiving, or is eligible to receive, a monthly pension benefit payment from CLIENT and is properly enrolled in the Plan as determined by CLIENT. The term "you" or "your" means an Eligible Beneficiary.

**Eligible Dependent:** The Eligible Beneficiary's spouse, unmarried child(ren) or sponsored dependent(s), as described in the CLIENT Health Care Program eligibility guidelines, who is properly enrolled in the Plan as determined by CLIENT.

**Enrollee:** An Eligible Beneficiary or Eligible Dependent, as determined by CLIENT, who has met all conditions of eligibility and has successfully enrolled under this program.

**Generic Drug:** Typically, this means a drug that contains the same active ingredient as the brand-name product. For purposes of pricing, drug classification (e.g., brand vs. generic) will be established by a nationally recognized drug pricing and classification source.

**Legend Drug:** A drug that federal or state law prohibits dispensing without a prescription.

**Home Delivery Drug:** Medications (generally Maintenance Drugs) ordered via the mail from the Express Scripts Home Delivery Pharmacy.

**Home Delivery Pharmacy:** A pharmacy that is under contract with CLIENT to fill prescriptions by mail for covered persons under this plan.

**Maintenance Drug:** A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., anti-hypertensive medication taken daily to control high blood pressure).

**Nonparticipating Retail Pharmacy:** A retail pharmacy that is not under contract with Express Scripts.

**Over-the-Counter Drug:** Any medical substance that can be purchased without a prescription.

**Participating Retail Pharmacy:** A retail pharmacy that is under contract with Express Scripts.

**Prescription Drug:** Any medication, which by federal or state law, may not be dispensed without a prescription.

**Specialty Pharamcy Services:** A pharmacy that dispenses specialty medications (injectables, supplies, etc) as well as, care management services designed to provide therapy assistance.

**Tier 1 (generic):** Prescription medications typically associated with the lowest Copayment. Note: The Express Scripts Home Delivery Pharmacy only dispenses A-rated generics, which are generics that have the same active ingredients and clinical results as their brand-name counterparts. You will not receive the generic form of your medication through the Home Delivery Pharmacy if it is not an A-rated generic.

**Tier 2 (select brand-name):** Prescription medications associated with a lower Copayment when compared to Tier 3 (other brand-name) drugs.

**Tier 3 (other brand-name):** Prescription medications typically associated with the highest Copayment.

## COVERED MEDICATIONS

The following items and Prescription Drugs are eligible for coverage under both the retail and Home Delivery Pharmacy programs:

- _Pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist.
- _Compounded preparations (e.g., ointments and lotions) prepared by a licensed pharmacist according to the written prescription of a physician.
- Insulin and diabetic supplies including:
  – Insulin
  – Test strips
  – Alcohol prep pads
  – Lancets
  – Dextrose chew tabs
  – Insulin needles and syringes
  – Insulin injectors
  – Glucagon emergency kits
  – Blood glucose meter testing solutions

  _To obtain coverage for these items, a written prescription from your doctor indicating that the medication or supply item is prescribed in the diagnosis or treatment of your diabetes is required.
- _Injectable drugs when self-administered. These include:
  – Acthar HP¨
  – Anzemet¨ — subject to quantity limits
  – Apokyn¨ (apomorphine hydrochloride)
  – Arixtra¨ — requires prior authorization
  – Benadryl¨ (diphenhydramine HCL)
  – Buprenex¨ — requires prior authorization
  – Calcimar¨ (calcitonin)
  – Caverject¨ (alprostadil) — subject to quantity limits
  – Coly-Mycin M¨ parenteral

– Copaxone¨ — requires prior authorization
– Darbepoeitin¨
– Delatestryl¨ — requires prior authorization
– Demerol¨ — requires prior authorization
– Depo-Testosterone¨ — requires prior authorization
– Desmopressin
– D.H.E.-45¨
– Edex¨ (alprostadil) — subject to quantity limits
– Emergency allergic reaction kits/insect sting kits (e.g., Ana-kit¨)
– Enbrel¨ (eternacept) — requires prior authorization
– Erythropoetin¨
– Fertility agents when not used for in vitro fertilization, artificial insemination and/or embryo transfer procedures — requires prior authorization
– Fuzeon¨
– Glucagon
– Growth hormones — requires prior authorization
– Heparin and low molecular weight heparins (e.g., Lovenox¨, Fragmin¨, Innohep¨) — subject to quantity limits
– Humira¨ (adalimumab) — requires prior authorization
– Imitrex¨ injection (sumatriptan) — subject to quantity limits
– InFed¨ — requires prior authorization
– Injectable B-1 (e.g., thiamine) — requires prior authorization
– Injectable B-6 (e.g., pyridoxine)
– Injectable B-12 (e.g., cyanocobalamin)
– Injectable vitamin K (e.g., Aquamephyton¨)
– Insulin, lispro, glargine, aspart, Byetta¨, Symlin¨, Levemir¨
– Interferons (e.g., Avonex¨, Betaseron¨, Rebif¨) — requires prior authorization
– Kineret¨ (anakinra) — requires prior authorization
– Kytril¨ — subject to quantity limits
– Legend antibiotics — requires prior authorization
– Legend benzodiazepines — requires prior authorization
– Lutrepulse¨ (gonadorelin)
– Methotrexate — requires prior authorization
– Miacalcin¨ (calcitonin)
– Myeloid stimulants (e.g., Leukine¨, Neulasta¨, Neupogen¨)
– Neumega¨ (oprelvekin)
– Numorphan¨ — requires prior authorization
– Phenergan¨ (promethazine) — requires prior authorization
– Proleukin¨
– Raptiva¨ (efalizumab) — requires prior authorization
– Sandostatin LAR¨ (octreotide), Sandostatin SC¨ (octreotide) — requires prior authorization
– Sodium Chloride injection
– Stadol¨ injection (butorphanol tartrate) — requires prior authorization
– Sterile water
– Supprelin SC¨
– Toradol¨ — subject to quantity limits
– Zofran¨ — subject to quantity limits

- _Although not self-injectable, the following injectable medications are also covered:

  - – Botox¨ (botulinum toxin type A) — requires prior authorization
  - – Ceredase¨ (alglucerase) — requires prior authorization
  - – Cerezyme¨ (imiglucerase) — requires prior authorization
  - – Factor VIII
  - – Gamma globulins
  - – Legend injectable steroids
  - – Legend glucagon products
  - – Myobloc¨ (botulinum toxin type A) – requires prior authorization
  - – Remicade¨ (infliximab) — requires prior authorization
  - – Xolair¨ (omalizumab) — requires prior authorization
- _Legend oral contraceptives, excluding contraceptive devices, appliances, implants and injectables
- Legend smoking deterrents — requires prior authorization

COPAYMENTS

Copayments must be paid at the time the prescription order is submitted. **Note:** Copayments are based on the tier status of your medication. Medication generic and brand tier status is established by a nationally recognized drug pricing and classification source.

**Retail Pharmacy Program**
You can obtain up to a maximum 30-day supply of medication, as prescribed by your doctor, through a retail pharmacy.

**Participating Retail Pharmacies —** When you have your prescriptions filled at a Participating Retail Pharmacy between
Jan. 1, 2008, and Dec. 31, 2008, your Copayment amounts are as follows:

- – Tier 1 (generic) $10
- – Tier 2 (select brand-name) $30
- – Tier 3 (other brand-name) $50

If the cost of the drug is less than the Copayment, you will be charged the lower amount. For a list of Participating Retail Pharmacies, contact Express Scripts Customer Care toll-free at 1-866-685-2792.

**Nonparticipating U.S. Retail Pharmacies —** If you obtain your prescriptions from a Nonparticipating Retail Pharmacy, you will pay the full price of the medication at the time of purchase. After completing and submitting a claim form to Express Scripts, along with the prescription receipts, you will be reimbursed the lowest amount CLIENT would have been charged had you used a Participating Retail Pharmacy, less the applicable Copayment. Nonparticipating Retail Pharmacies have not agreed to discounted pricing, so your costs will usually be higher. You must submit claims to Express Scripts for prescriptions obtained from Nonparticipating Retail Pharmacies within 24 months of the dispensing date to be eligible for reimbursement.

**Foreign Pharmacies —** If you obtain your prescriptions from a pharmacy outside of the United States or Puerto Rico, you will pay the full price of the medication at the time of purchase. After completing and submitting a foreign claim form to Express Scripts within 24 months, along with the prescription receipts, you will be reimbursed the amount CLIENT would have been charged had you used a Participating Retail Pharmacy, less the applicable Copayment.

**Nursing Home Residents —** When you have your prescriptions filled at a participating nursing home pharmacy between
Jan. 1, 2008, and Dec. 31, 2008, your Copayment amounts are as follows:

- – Tier 1 (generic) $10
- – Tier 2 (select brand-name) $30
- – Tier 3 (other brand-name) $50

If the cost of the drug is less than the Copayment, you will be charged the lower amount. If you obtain your prescriptions at a nonparticipating nursing home pharmacy, you will pay the full price of the medication at the time of purchase. After completing and submitting a claim form to Express Scripts, along with the prescription receipts within 24 months, you will be reimbursed 80% of the amount charged for the prescription.

**Home Delivery Pharmacy Program**
Up to a maximum 90-day supply may be obtained through the Express Scripts Home Delivery Pharmacy. Copayments must be paid at the time the Home Delivery order is submitted. Medications will generally be delivered to your home within two weeks from the date Express Scripts receives your prescription order.

When you have your prescriptions filled through the Home Delivery Pharmacy between Jan. 1, 2008, and Dec. 31, 2008, your Copayment amounts are as follows:

– Tier 1 (generic) $25
– Tier 2 (select brand-name) $75
– Tier 3 (other brand-name) $125

If the cost of the drug is less than the Copayment, you will be charged the lower amount.

**Curascript Specialty Pharmacy Services, An Express Scripts Company**
Certain injectable and specialty medications may be dispensed by Express Scripts's specialty pharmacy provider: Curascript, Inc. This service offers medications and supplies for chronic conditions. Examples of medication classes filled at the specialty pharmacy include blood modifiers, growth hormones and immunoglobulins, as well as medications to treat cancer, deep vein thrombosis, Gaucher's disease, hemophilia, Hepatitis C, infertility, multiple sclerosis, psoriasis, pulmonary disease and rheumatoid arthritis. Curascript also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Curascript specialty pharmacy services may help save you time and money on injectable and specialty medications. In some cases, up to a maximum 90-day supply may be obtained; however, most specialty medications will be dispensed in 30-day increments. When your medication is dispensed in 30-day increments, you will pay one-third of the total 90-day Copayment each month.

Medications will be shipped to your home within 24–72 hours of receiving your order. Prescriptions filled through Express Scripts Specialty Pharmacy Services between Jan. 1, 2008, and Dec. 31, 2008, are subject to the following 90-day Copayments:

– Tier 1 (generic) $25
– Tier 2 (select brand-name) $75
– Tier 3 (other brand-name) $125

*Note: 30-day specialty medication copayments are one-third of the 90-day copayments

If the cost of the drug is less than the Copayment, you will be charged the lower amount.

**Enrollee's Maximum Annual Benefit**
There is no maximum annual benefit for covered drugs under the HEALTH PLAN. CLIENT will pay an unlimited amount for covered retail and Home Delivery prescriptions for each enrollee per calendar year.

**Enrollee's Maximum Prescription Drug Expense**
Once an enrollee has paid a total of $2,000 out of pocket in retail and Home Delivery Copayments for drugs that were dispensed in a calendar year, that enrollee will pay nothing for covered drugs dispensed during the remainder of the calendar year.

LIMITATIONS

- Up to a maximum 30-day supply of medication per original prescription or refill, as prescribed by your doctor, may be obtained at one time from a retail pharmacy.
- Up to a maximum 90-day supply of medication per original prescription or refill, as prescribed by your doctor, may be obtained through the Express Scripts Home Delivery Pharmacy Program.

- Prescribed medications, especially certain controlled substances, may be subject by law to dispensing limitations and to the professional judgment of the retail or Home Delivery pharmacist.
- Under the Express Scripts Home Delivery Pharmacy Program, if your doctor prescribes a drug that is available as both a Generic Drug and a Brand-Name Drug, the Generic Drug will be dispensed if allowed by state law unless you or your doctor specifically indicate otherwise.

## EXCLUSIONS

No benefits will be paid for:

- Non-Legend Drugs except those listed as covered herein;
- Charges you are not required to pay or charges made only because health care benefits exist (subject to the right, if any, of the U.S. government to recover reasonable and customary charges for care provided in a military or veterans' hospital);
- Medication for which benefits are payable under workers' compensation or any occupational disease or similar law, whether such benefits are insured or self-insured;
- Impotency products for covered persons under the age of 18;
- Drugs or supplies that are covered under the medical portion of your health care benefits;
- Contraceptive devices, appliances, implants or injectables;
- Blood glucose monitoring equipment (e.g., meters) and other therapeutic devices or appliances;
- Drugs whose FDA-approved indication is to promote or stimulate hair growth regardless of the prescriber's
  intended use;
- Drugs whose FDA-approved indication is for cosmetic purposes regardless of the prescriber's intended use;
- Drugs or medicines lawfully obtainable without a prescription order of a licensed authorized prescriber, except insulin;
- Immunization agents, biological sera, blood or blood plasma, allergy serum and vaccines (including the giving of these items);
- Drugs labeled: "Caution — limited by federal law to investigational use," or experimental drugs, even though a charge is made to the covered person;
- Any charge for the administration or injection of any drug;
- Any medication that is consumed or administered at the place where it is dispensed;
- Any amount of medicine that is more than a 30-day supply filled at the retail pharmacy or more than a 90-day supply filled through the Home Delivery Pharmacy Program;
- Drugs that may be received by an Eligible Beneficiary or an Eligible Dependent at no charge under local, state or federal programs;
- Drugs to be taken by or given to by an Eligible Beneficiary or an Eligible Dependent while he or she is confined in a hospital;
- Any prescription or refill in excess of the number specified by the licensed professional or applicable law or any refill dispensed after one year from the licensed professional's original order;
- Drugs prescribed for sickness or injury resulting from war or acts of war;
- Fertility agents when used in conjunction with in vitro fertilization, artificial insemination or embryo transfer procedures; and
- Injectable medications that are not self-administered, unless listed as covered (see Covered Medications).

## Prior Authorization

Certain drugs need to be preapproved by Express Scripts before they will be covered under the CLIENT Prescription Drug Program (see Drugs Requiring Prior Authorization). Drugs subject to prior authorization may cause potentially serious side effects and/or have a high potential for inappropriate use.

Your doctor may initiate the prior authorization process by calling Express Scripts toll-free at xxx-xxx-xxxx. If you plan to have your prescription for a prior authorization drug filled at a Participating Retail Pharmacy, consider completing the prior authorization process before you go to the retail pharmacy.

If approved, your prescription will be filled within any stated plan limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug. However, rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section on Page 12.

Drugs Requiring Prior Authorization
(This list is subject to change at any time without notice.)

| Drug Category | Drug Name (generic name) |
|---|---|
| **ADHD/Narcolepsy** | Adderall¨ (amphetamine) |
| | Adderall XR¨ (amphetamine) |
| | Concerta¨ (methylphenidate) |
| | Cylert¨ (pemoline) |
| | Desoxyn¨ (methamphetamine) |
| | Dexedrine¨ (dextroamphetamine) |
| | Dextrostat¨ (dextroamphetamine) |
| | Focalin¨ (dexmethylphenidate) |
| | Focalin XR¨ (dextroamphetamine) |
| | Metadate¨ CD (methylphenidate) |
| | Metadate¨ ER (methylphenidate) |
| | Provigil¨ (modafinil) |
| | Ritalin¨ (methylphenidate) |
| | Ritalin-SR¨ (methylphenidate) |
| | Ritalin LA¨ (methylphenidate) |
| | Strattera¨ (atomoxetine) |
| **Drug Category** | **Drug Name (generic name)** |
| **Alzheimer's therapy** | Aricept¨ (donepezil) |
| | Cognex¨ (tacrine) |
| | Exelon¨ (rivastigmine) |
| | Namenda¨ (memantine) |
| | Razadyne¨ (galantamine HBr) |
| | Razadyne¨ ER (galantamine HBr) |
| **Antifungals** | Diflucan¨ — 50 mg., 100 mg., 200 mg. |
| | Lamisil¨ (terbinafine) |
| | Sporanox¨ (itraconazole) |
| **Antiobesity drugs** | Didrex¨ (benzphetamine) |
| | Ionamin¨ (phentermine) |
| | Meridia¨ (sibutamine) |
| | Phendimetrazine |
| | Tepanil¨, Tenuate¨ (diethylpropion) |
| | Xenical¨ (orstat) |
| **Arthritis therapy** | Arava¨ (leflunomide) |
| | Enbrel¨ (etanercept) |
| | Humira¨ (adalimumab) |
| | Kineret¨ (anakinra) |
| | Remicade¨ (infliximab) |
| **Asthma therapy** | Xolair¨ (omalizumab) |

| | |
|---|---|
| **Cancer therapy** | Gleevec¨ (imatinib) |
| | Iressa¨ (gefitinib) |
| | Tarceva¨ (erlotinib) |
| **Drugs for dermatological use** | Accutane¨ (isotretinoin) |
| | Panretin¨ (alitretinoin) |
| | Regranex¨ gel (becaplermin) |
| **Fertility drugs*** | Bravelle¨ (urofollitropin) |
| | Cetrotide¨ (cetrorelix) |
| | Chorex-10¨ (HCG) |
| | Clomid¨ (clomiphene) |
| | Crinone¨/Prochieve¨ (progesterone gel) |
| | Fertinex¨ (urofollitropin) |
| | Follistim¨ (follitropin beta) |
| | Ganirelix Acetate Injection (ganirelix acetate) |
| | Gonal-F¨ (follitropin alpha) |
| | Humegon¨ (menotropins) |
| | Menopur¨ (menotropins) |
| | Milophene¨ (clomiphene) |
| | Novarel¨ (HCG) |
| | Ovidrel¨ (choriogonadotropin alpha) |
| | Perganol¨ (menotropins) |

| **Drug Category** | **Drug Name (generic name)** |
|---|---|
| **Fertility drugs* (continued)** | Pregnyl¨ (HCG) |
| | Profasi¨ (HCG) |
| | Repronex¨ (HCG) |
| | Serophene¨ (clomiphene) |
| **Gaucher's disease** | Ceredase¨ (alglucerase) |
| | Cerezyme¨ (imiglucerase) |
| | Zavesca¨ (miglustat) |
| **Growth hormones** | Genotropin¨ (somatropin) |
| | Geref¨ (sermorelin) |
| | Humatrope¨ (somatropin) |
| | Increlex¨ (mecasermin) |
| | Iplex¨ (mecasermin rinfabate) |
| | Norditropin¨ (somatropin) |
| | Nutropin¨ (somatropin) |
| | Nutropin AQ¨ (somatropin) |
| | Protropin-AQ¨ (somatrem) |
| | Saizen¨ (somatropin) |
| | Zorbtive¨ (somatropin) |
| **HIV therapy** | Fuzeon¨ (enfuvirtide) |
| | Serostim¨ (somatropin) |
| **Interferons** | Copegus¨ (ribavirin) |
| | Infergen¨ (interferon alfacon-1) |
| | Intron A¨ (interferon alfa-2b) |
| | Pegasys¨ (peginterferon alfa-2a) |
| | PEG-Intron¨ (peginterferon alfa-2b) |
| | Rebetol¨ (ribavirin) |

| | |
|---|---|
| | Rebetron¨ (ribavirin, interferon alfa-2b) |
| | Ribasphere¨ (ribavirin) |
| | Roferon-A¨ (interferon alfa-2a) |
| **Gastrointestinal therapy** | Amitiza¨ (lubiprostone) |
| | Lotronex¨ (alosetron) |
| | Zelnorm¨ (tegaserod maleate) |
| **Miscellaneous injectables** | Botox¨ (botulinum toxin type A) |
| | Buprenex¨ (buprenorphine) |
| | Delatestryl¨ (testosterone enanthate) |
| | Demerol¨ (meperidine) |
| | Depo Testosterone¨ |
| | InFed¨ (iron dextran) |
| | Methotrexate |
| | Myobloc¨ (botulinum toxin type A) |
| | Numorphan¨ (oxymorphone) |
| | Phenergan¨ (promethazine) |
| | Sandostatin SC¨ (octreotide) |
| | Thiamine¨ (vitamin B1) |
| | Toradol¨ (ketorolac tromethamine) |
| **Multiple sclerosis therapy** | Avonex¨ (interferon beta-1a) |
| | Betaseron¨ (interferon beta-1b) |
| | Copaxone¨ (glatiramer acetate) |
| | Rebif¨ (interferon beta-1a) |
| **Osteoporosis therapy** | Forteo¨ (teriparatide) |
| **Pain therapy** | Stadol¨ injection (butorphanol tartrate) |
| **Psoriasis** | Raptiva¨ (efalizumab) |
| | Soriatane¨ (acitretin) |
| **Pulmonary hypertension** | Revatio¨ (sildenafil) |
| | Tracleer¨ (bosentan) |
| | Ventavis¨ (iloprost) |
| **Smoking cessation** | Various products |

## Drug Limitations

Select medications are covered up to preset limits to promote safety and reduce costs associated with inappropriate use. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, prior authorization is required. In such cases your doctor should initiate prior authorization by calling Express Scripts's Prior Authorization Department toll-free at xxx-xxx-xxxx.

### Drugs Subject to Limitations
(This list is subject to change at any time without notice.)

| **Drug Category** | **Drug Name (generic name)** |
|---|---|
| **Antiemetics** | Anzemet¨ (dolasetron) |
| | Cesamet¨ (nabilone) |
| | Emend¨ (aprepitant) |
| | Kytril¨ (granisetron) |
| | Marinol¨ (dronabinol) |
| | Zofran¨ (ondansetron) |

**Antifungals** Diflucan¨ — 150 mg. (fluconazole)

**Low molecular weight heparins** Arixtra¨ (fondaparinux)
Fragmin¨ (dalteparin)
Innohep¨ (tinzaparin)
Lovenox¨ (enoxaparin)

**Migraine therapy** Amerge¨ (naratriptan)
Axert¨ (almotriptan)
Frova¨ (frovatriptan)
Imitrex¨ (sumatriptan)
Maxalt¨, Maxalt MLT¨ (rizatriptan)
Migranal NS¨ (dihydroergotamine)
Relpax¨ (eletriptan)
Zomig¨, ZomigNS¨, Zomig ZMT¨ (zolmitriptan)

**Pain therapy** Stadol NS¨ (butorphanol)
Toradol¨ (ketorolac tromethamine)

**Proton Pump Inhibitors** Aciphex¨ (rabeprazole)
Nexium¨ (esomeprazole)
Omeprazole
Prevacid¨ (lansoprazole)
Prilosec¨ (omeprazole)
Protonix¨ (pantoprazole)

Other select medications are covered up to preset limits to promote safety and reduce costs associated with inappropriate use. If you request that a prescription be filled for a drug listed below that is subject to quantity limitations, the prescription will be filled up to the preset limits. If additional quantities are needed, you will be responsible for the entire cost associated with the medication. Appeals for coverage of additional quantities will not be considered for the following medications:

**Male erectile dysfunction therapy** Caverject¨ (alprostadil)
Cialis¨ (tadalafil)
Edex¨ (alprostadil)
Levitra¨ (vardenafil)
MUSE¨ (alprostadil)
Viagra¨ (sildenafil)

## Step Therapy

Certain Prescription Drugs are subject to step therapy review. Step therapy entails trying one or more first-line medications that are less costly but may be as clinically effective, before a second more costly medication will be covered. This practice encourages appropriate sequencing of drug therapy while conserving costs.

If step therapy criteria is not met, prior authorization will be required. Your doctor can initiate the prior authorization process by calling Express Scripts's Prior Authorization Department toll-free at xxx-xxx-xxxx.

### Drugs Subject to Step Therapy
(This list is subject to change at any time without notice.)

**Drug Category** **Drug Name (generic name)**

**Drugs for dermatological use** Avita¨ (tretinoin)
Differin¨ (adapalene)
Retin-A¨ (tretinoin)
Retin-A Micro¨ (tretinoin gel, microsphere)

Tazorac¨ (tazarotene)

**NSAIDs therapy** Celebrex¨ (celecoxib)

## Coordination of Benefits

There is no coordination of benefits (COB) between a HEALTH PLAN and the CLIENT Prescription Drug Program administered by Express Scripts. However, there may be COB between the CLIENT Prescription Drug Program and any other prescription drug coverage you may have. To be eligible for COB, you must follow Express Scripts's plan requirements including, but not limited to, those relating to prior authorization.

Under COB, you will be reimbursed the lesser of the amount CLIENT would have paid as primary payer or submitted charges, less the applicable Copayment. Submitted charges are defined as the remainder not paid by the primary payer on the prescription. For more information about COB under this program, call Express Scripts Customer Care toll-free at 1-866-685-2792.

## Appeals

### Internal Review

When a claim for a Prescription Drug that is covered under the CLIENT Prescription Drug Program is rejected, you may request that Express Scripts reconsider the rejection by requesting an appeal. Appeals for coverage of drugs that are not covered under the program will not be considered (see Exclusions). In addition, certain drugs that are subject to quantity limitations cannot be appealed (see Drug Limitations).

To request an appeal, call Express Scripts Customer Care toll-free at 1-866-685-2792. Upon receipt of your request for appeal, Express Scripts will send you a Prescription Claim Appeals Form. You and/or your physician should complete the form and mail or fax it to Express Scripts. Express Scripts's mailing address and fax number are noted below.

XXXXX
Express Scripts, Inc
P.O. Box XXXX
XXXXXXXXX
Fax: 1-xxx-xxx-xxxx

Upon receipt of your completed Prescription Claim Appeals Form, Express Scripts will conduct an internal review of your appeal request. You will receive written notification of the outcome of Express Scripts's internal review within 30 days of the date Express Scripts received your completed Prescription Claim Appeals Form. If the original rejection is overturned on appeal and coverage is granted, benefits will be authorized by Express Scripts. If the appeal is rejected for coverage, benefits will not be provided under the CLIENT Prescription Drug Program; however, you may obtain the drug on your own at your own expense. A second request for internal review will be honored only if your condition changes and you supply new clinical information that was not available at the time of the original request.

### External Review

If your appeal under the internal review process is rejected for coverage based on medical necessity grounds and you do not agree with that decision, you or your doctor (on your behalf) may submit a second request for medical necessity review. Medical necessity reviews are conducted by an external review organization not affiliated with Express Scripts. All available clinical information must be submitted when a request for an external review for medical necessity is made.

You should receive written notification of the outcome of the external review within 30 days of the date Express Scripts receives your request for medical necessity review.

If the external review organization overturns the original rejection and coverage is granted, benefits will be authorized by Express Scripts. If the appeal is rejected for coverage, benefits will not be provided under the CLIENT Prescription Drug Program; however, you may obtain the drug on your own at your own expense. A second request for external review will be honored only if your condition changes and

you supply new clinical information that was not available to your doctor at the time of the original request.

**Urgent Appeal Requests**
If you or your doctor believe an appeal request is urgent, write "urgent" on the written appeal request. Urgent appeals will be reviewed and a determination should be made within 72 hours of Express Scripts's receipt of the appeal request.

## NOTICE OF CREDITABLE COVERAGE

The following notice provides important information about your current prescription drug coverage through an CLIENT-sponsored health care plan and Medicare Part D prescription drug coverage. If you or any of your dependents enrolled in the CLIENTHealth Care Program are Medicare-eligible or will become eligible for Medicare within the next 12 months, please read this information carefully.

As an enrollee in an CLIENT-sponsored health care plan, you do not need to enroll in a Medicare Part D prescription drug plan. CLIENT has determined that the 2008 prescription drug coverage included in the CLIENT-sponsored health care plans is creditable, meaning it is as good as or better than the standard Medicare Part D prescription drug coverage.

If you are eligible for Medicare Part A and/or Part B, you will have an opportunity to enroll in Medicare Part D each year from Nov. 15 through Dec. 31. If you are not currently eligible for Medicare, you can enroll in Medicare Part D when you turn age 65. Keep in mind, however, that creditable prescription drug coverage is included in your CLIENT health care plan. This means you do not need to enroll in Medicare Part D.

If you are not currently enrolled in Medicare Part A and/or Part B, the initial enrollment period is the seven-month period that begins three months before you first meet Medicare eligibility requirements and ends three months after the month of first eligibility. You may pay a higher Medicare Part D premium if you go without creditable prescription drug coverage for 63 consecutive days or longer after your initial enrollment period ends.

**(Medicare HMO) enrollees only.** If you enroll in Medicare Part D, your hospital/medical coverage under HMO will be terminated by Medicare. Call HMO toll-free at X.XXX.XXX.XXX for more information.

Please note that if you terminate health care coverage under CLIENT, you will lose hospital/medical coverage and prescription drug coverage provided by CLIENT. In addition, you will only have the coverage you qualify for under Medicare Part A and/or Part B unless you purchase a separate supplemental plan. Keep in mind that Medicare Parts A & B do not cover most Prescription Drugs.

**Keep this notice for your records.** If you decide to enroll in Medicare Part D in the future, you may need to present a copy of this notice to avoid paying a higher monthly premium amount under Medicare. You may request a copy of this document from CLIENT at any time.

**For more information:**

1. Call CLIENT's Member Services Center toll-free at X.XXX.XXX.XXX for information about this notice or to request additional copies.
2. Call Express Scripts Customer Care toll-free at X.XXX.XXX.XXX for information about your current prescription drug plan coverage.
3. Call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov for information about your options under Medicare Part D.
4. Call the Social Security Administration toll-free at 1-800-772-1213 or visit www.ssa.gov to find out if you may qualify for extra assistance to help pay for Medicare prescription drug plan costs.

*_Fertility drugs prescribed in conjunction with artificial insemination, in vitro fertilization or similar procedures are excluded from coverage.
*_Fertility drugs prescribed in conjunction with artificial insemination, in vitro fertilization or similar procedures are excluded from coverage.

**For information about your prescription drug program,**
**call Express Scripts Customer Care toll-free at** X.XXX.XXX.XXX
**or log on to www.Express-Scripts.com.**

12-930C, 12/06/1.5M

<CLIENT OR TPA>>
<ATTN: NAME OR DEPT.>
<ADDRESS>
<CITY, AA 12345>
<SMPL INT_CARDS_>

EXPRESS SCRIPTS®

CHAMPIONS FOR BETTER℠

EXPRESS SCRIPTS®

**Prescription ID Card**

ERS Employees Retirement System of Texas

| | | | |
|---|---|---|---|
| RxBIN | <123456> | Issued | <XX/XX/XXXX> |
| RxPCN | <A4> | | |
| RxGrp | <Default> | | |
| Issuer (12345) | <1234567890> | | |
| ID | <00000000000> | | |
| Name | <JOHN Q SAMPLE> | | |

<JOHN Q SAMPLE> <JOHN Q SAMPLE> <JOHN Q SAMPLE>
<JOHN Q SAMPLE> <JOHN Q SAMPLE> <JOHN Q SAMPLE>

EXPRESS SCRIPTS®

**Prescription ID Card**

ERS Employees Retirement System of Texas

| | | | |
|---|---|---|---|
| RxBIN | <123456> | Issued | <XX/XX/XXXX> |
| RxPCN | <A4> | | |
| RxGrp | <Default> | | |
| Issuer (12345) | <1234567890> | | |
| ID | <00000000000> | | |
| Name | <JOHN Q SAMPLE> | | |

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2017999999 - 000000001 CID PMM-CWK
<JOHN Q SAMPLE>
<123 ANYSTREET>
<APT. 456>
<SOMETOWN, US 99999-9999>

# WELCOME TO EXPRESS SCRIPTS!

As your Champions for Better℠, we're here to give you better, simpler ways to manage your prescriptions and your health. Here are a few highlights you can expect:

## Easy
Register online or download the Express Scripts® mobile app and have your info with you at all times.

## Accessible
Connect with pharmacists in the app, or online and by phone 24/7.

## Personalized
Communication options so you can control how you hear from us.

## Convenient
Order refills, track shipments, compare prices and access your plan info – all online.[1]

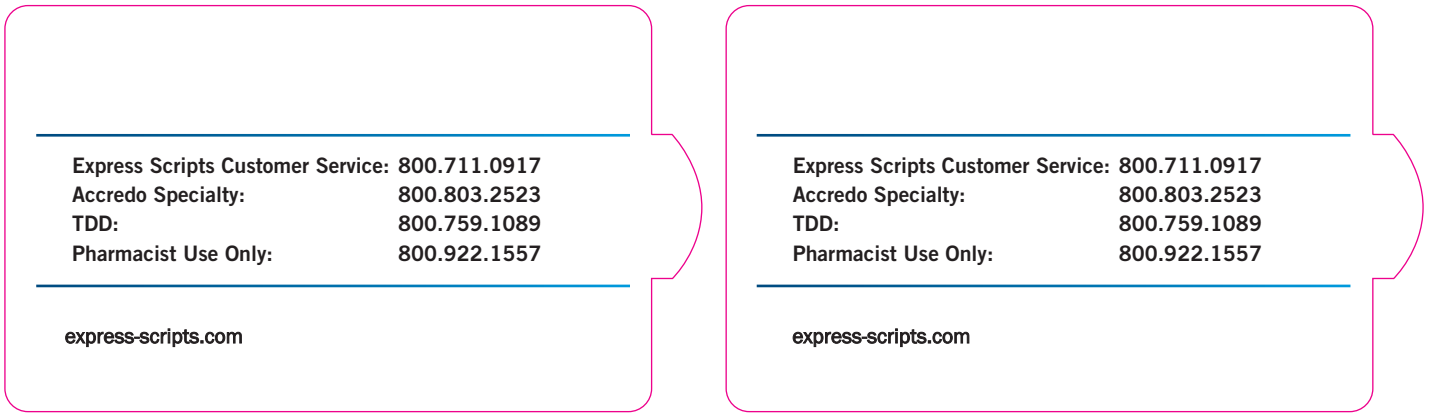
1. First-time visitors must register using their member ID number or Social Security Number. You can manage your medicine online when your coverage takes effect. Before then, you can set up your online account, including your preferred shipping address, preferences, and payment method(s) for home delivery orders.
2. Automated text message will be sent to you. Message and data rates apply. Not a condition of purchase.

## 3 easy ways to set up your account and get started:

Visit express-scripts.com

Visit your favorite app store to download the Express Scripts® mobile app

Text JOIN to 69717 for a link to our registration page[2]




Use your new member ID card at participating retail pharmacies near you.

**<Pharmacy Name>**
**<Address 1>**
**<Address 2>**
**<City, State, Zip>**

**<Pharmacy Name>**
**<Address 1>**
**<Address 2>**
**<City, State, Zip>**

**<Pharmacy Name>**
**<Address 1>**
**<Address 2>**
**<City, State, Zip>**

# WE'RE YOUR CHAMPIONS FOR BETTER℠

## Skip the trip with home delivery.

Get long-term medication (and savings) delivered right to your door from Express Scripts.

## Pay less, relax more.

- Up to a <90>-day supply for just one copay
- Free standard shipping[1]
- Refill online, by phone and with our app
- Sign up for automatic refills and we'll send your medication to you when it's time to refill

## Get personalized care from our specialty pharmacy.

You'll use Accredo to fill specialty medications that treat complex conditions like multiple sclerosis, hepatitis C and cancer. Through Accredo, you'll have 24/7 access to specialty-trained pharmacists and nurses who understand your condition. Call us at <XXX.XXX.XXXX> to get started.

## Choose from a variety of retail pharmacies.

- Place orders in person, at the pharmacy or over the phone
- Pick up your prescription at a participating network retail pharmacy
- You may need to fill long-term medications with home delivery, but you can always fill your acute prescriptions at retail

## <Before your next retail fill, please take action to avoid paying full cost for your medication. We can help.>

<Convenient home delivery from Express Scripts Pharmacy℠ is required by your plan. You can continue going to a retail pharmacy every month, but you'll pay full cost for your long-term medication.>

[1] Standard shipping costs are included as part of your prescription plan benefit.

## Sample Survey — Home Delivery

We have provided a sample telephone script below.

| Question | Response Options |
|---|---|
| Have you filled a prescription using Home Delivery in the last 30 or more days? ** | Yes/No |
| How would you rate your overall experience with Express Scripts? ** | 1/2/3/4/5 |
| How would you rate your overall experience with Express Scripts Home Delivery Service? ** | 1/2/3/4/5 |
| Please tell me yes or no, did you order your most recent prescription yourself? | Yes/No |
| How did you order your prescription? ** | Phone/Web/Email |
| How easy was it to use our automated voice system? | 1/2/3/4/5 |
| How difficult or easy was it for you to order your prescription online? | 1/2/3/4/5 |
| Did you receive your prescription order when you needed it? ** | Yes/No |
| How acceptable was the amount of time you spent waiting to receive your prescription order in the mail? ** | 1/2/3/4/5 |
| In your own words, we'd love to know what is the single most important thing Express Scripts can do to improve the Home Delivery Service? ** | Transcribed Response |
| How likely is it that you'd recommend Express Scripts to a friend or family member? ** | 0/1/2/3/4/5/6/7/8/9/10 |

**Denotes questions asked in every survey. The others are only asked if they apply.

## Sample Survey — Retail

We have provided a sample telephone script below.

| Question | Response Options |
|---|---|
| Have you filled a prescription at a retail pharmacy in the last 30 or more days? ** | Yes/No |
| Please tell me yes or no are you aware that Express Scripts is the company that provides your pharmacy benefits? ** | Yes/No |

| Question | Response Options |
|---|---|
| How would you rate your overall experience with Express Scripts? ** | 1/2/3/4/5 |
| In your own words, we'd love to know what, if anything, would make filling your prescriptions a better experience for you. ** | Transcribed response |
| How likely is it that you'd recommend Express Scripts to a friend or family member? ** | 0/1/2/3/4/5/6/7/8/9/10 |

**Denotes questions asked in every survey. The others are only asked if they apply.

## Sample Survey — Contact Center

We have provided a sample telephone script below.

| Question | Response Options |
|---|---|
| Have you called Express Scripts Member Services in the last 30 or more days? ** | Yes/No |
| And when you called, did you speak with a live representative? ** | Yes/No |
| How would you rate your overall experience with Express Scripts? ** | 1/2/3/4/5 |
| Was your issue resolved? | Yes/No |
| What is your overall satisfaction with the person who handled your most recent call? | 1/2/3/4/5 |
| In your own words, we'd love to know what is the single most important thing Express Scripts can do to improve our Member Services Line? ** | Transcribed response |
| How likely is it that you'd recommend Express Scripts to a friend or family member? ** | 0/1/2/3/4/5/6/7/8/9/10 |

**Denotes questions asked in every survey. The others are only asked if they apply.

# Sample Reporting Portfolio

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

CARRIER NUMBER: 0000 .. EXPRESS SCRIPTS,INC. 123519 PAGE 1
PERIOD COVERED: XX/XX/XX THRU XX/XX/XX BILLING DETAIL INVOICE DATE: XX/XX/XX
CONTRACT: 00001234 GROUP: GR07 LOCATOR:
.

| MEMBER ID | MEMBER NAME | PATIENT R NO | NAME | NDC | DRUG NAME | DATE FILLED | RX NUMBER | QTY | INGR COST | PRO FEE | SALES TAX | PATIENT AMOUNT | NET RX COST | C T | BATCH |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 166253266 | SMITH, JANE E | 2 01 | TERRY | 00052026106 | | 012103 | 0816496 | 28 | 17.59 | 2.00 | 0.00 | 3.92 | 15.67 | RP | 703824158808 |
| 166253266 | SMITH, JANE E | 2 01 | TERRY | 00182103001 | | 010703 | 0816403 | 30 | 16.18 | 2.50 | 0.00 | 3.74 | 14.94 | RP | 703824158355 |
| 166253266 | SMITH, JANE E | 2 01 | TERRY | 00173046002 | | 010703 | 0825459 | 9 | 89.14 | 2.00 | 0.00 | 58.23 | 32.91 | RP | 703824157375 |
| 166253266 | SMITH, JANE E | 2 01 | TERRY | 00173046002 | | 012303 | 0825459 | 9 | 92.30 | 2.00 | 0.00 | 18.86 | 75.44 | RP | 703824360220 |
| 315426941 | JOHNSON, MARY A | 1 01 | MARY | 00186109205 | | 012303 | 0887774 | 7 | 4.56 | 2.00 | 0.20 | 6.76 | 0.00 | RP | 703824404635 |
| 315426941 | JOHNSON, MARY A | 1 01 | MARY | 00186109205 | | 011403 | 4158220 | 90 | 53.75 | 0.03 | 0.54 | 16.00 | 38.32 | MS | 703814756185 |
| 428531029 | DAVIS, JOHN | 1 01 | JOHN | 00378110501 | | 011303 | 0209133 | 100 | 18.23 | 2.50 | 0.00 | 20.73 | 0.00 | RP | 703815443270 |
| 428531029 | DAVIS, JOHN | 1 01 | JOHN | 00603499821 | | 012103 | 0209271 | 20 | 2.69 | 2.50 | 0.00 | 5.19 | 0.00 | RP | 703816280292 |
| 428531029 | DAVIS, JOHN | 1 01 | JOHN | 00536253001 | | 012103 | 0209272 | 40 | 2.55 | 2.50 | 0.00 | 5.05 | 0.00 | RP | 703816280444 |
| 455031543 | BAKER, STEPHEN | 2 01 | SUSAN | 00173038742 | | 011903 | 0801550 | 28 | 81.13 | 2.00 | 1.17 | 16.86 | 67.44 | RP | 703815158332 |
| 455031543 | BAKER, STEPHEN | 2 01 | SUSAN | 00049491066 | | 011703 | 0808591 | 30 | 57.88 | 2.00 | 0.81 | 48.03 | 11.72 | RP | 703815048333 |
| 479050099 | DOYLE,BRAD E | 1 01 | BRAD | 00048107005 | | 011903 | 0351492 | 100 | 17.38 | 2.00 | 0.25 | 19.63 | 0.00 | RP | 703815167285 |
| 479050099 | DOYLE,BRAD E | 1 01 | BRAD | 00002314460 | | 012403 | 0388486 | 100 | 139.20 | 2.00 | 2.00 | 52.94 | 90.26 | RP | 703824580179 |
| 481380367 | WARNER,MICHAEL | 1 01 | MICHAE | 00069154066 | | 011803 | 6794999 | 30 | 56.75 | 2.00 | 0.00 | 51.75 | 7.00 | RP | 704804010252 |
| 481380367 | WARNER,MICHAEL | 3 01 | JULIE | 50111045603 | | 012203 | 0206512 | 60 | 8.17 | 2.50 | 0.00 | 10.67 | 0.00 | RP | 703824242804 |
| 481380367 | WARNER,MICHAEL | 3 01 | JULIE | 00074621413 | | 012103 | 0238726 | 60 | 33.48 | 2.00 | 0.00 | 35.48 | 0.00 | RP | 703824158899 |

REIMBURSED BY MEDCO

PHARMACY REIMBURSEMENTS:

| CLAIM TYPE | COUNT | INGR. COST | PROF FEE | SALES TAX | PATIENT AMT | TOTAL |
|---|---|---|---|---|---|---|
| MAIL- | | | | | | |
| CLAIMS | 1 | 53.75 | 0.03 | 0.54 | 16.00 | 38.32 |
| CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| RETAIL- | | | | | | |
| CLAIMS | 15 | 637.23 | 32.50 | 4.43 | 358.78 | 315.38 |
| CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| PHCY SUBTOTALS **** | 16 | 690.98 | 32.53 | 4.03 | 374.78 | 353.70 |
| MEDCO TOTALS ******* | 16 | 690.98 | 32.53 | 4.03 | 374.78 | 353.70 |
| <<< GRAND TOTALS >> | 16 | 690.98 | 32.53 | 4.03 | 374.78 | 353.70 |

BREAKDOWN BY RELATIONSHIP TO MEMBER

| CLAIM TYPE | MEMBER RX COUNT | MEMBER TOTAL | SPOUSE RX COUNT | SPOUSE TOTAL | DEP RX COUNT | DEP RX TOTAL | TOTAL RX | TOTAL |
|---|---|---|---|---|---|---|---|---|
| PHARMACY REIMBURSEMENTS: | | | | | | | | |
| MAIL- | | | | | | | | |
| CLAIMS | 1 | 38.32 | 0 | 0.00 | 0 | 0.00 | 1 | 38.32 |
| CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| RETAIL- | | | | | | | | |
| CLAIMS | 7 | 03.26 | 6 | 218.12 | 2 | 0.00 | 15 | 315.38 |
| CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| <<< GRAND TOTALS >> | 8 | 135.58 | 6 | 218.12 | 2 | 0.00 | 16 | 353.70 |

| CLAIM TYPE | COUNT | INGR. COST | PROF FEE | SALES TAX | PATIENT AMT | TOTAL |
|---|---|---|---|---|---|---|
| REIMBURSED | | | | | | |
| PHARMACY REIMBURSEMENTS: | | | | | | |
| MAIL- | | | | | | |
| CLAIMS | 8,557 | 824,461.05 | 256.71 | 2,099.59 | 104,479.31 | 722,338.04 |
| CREDITS | 4 | 247.54- | 0.12- | 0.00 | 52.00- | 195.66- |
| SUPPLEMENTS | 1 | 2,065.64 | 0.00 | 0.00 | 0.00 | 2,065.64 |
| AUDIT CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| RETAIL- | | | | | | |
| CLAIMS | 36,843 | 1,071,361.15 | 79,841.25 | 9,829.16 | 611,431.56 | 549,600.00 |
| CREDITS | 331 | 10,834.31- | 711.00- | 72.44- | 5,904.41- | 5,713.34- |
| SUPPLEMENTS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| PHCY SUBTOTALS **** | 45,736 | 1,886,805.99 | 79,386.84 | 11,856.31 | 709,954.46 | 1,268,094.68 |
| MEMBER REIMBURSEMENTS: | | | | | | |
| DIRECT REIMBURSEMENT | | | | | | |
| CLAIMS | 2,377 | 77,867.87 | 10,637.54 | 333.56 | 21,836.21 | 67,002.76 |
| CREDITS | 1 | 20.71- | 0.00 | 0.00 | 0.00 | 20.71- |
| SUPPLEMENTS | 6 | 94.32 | 0.00 | 0.00 | 0.00 | 94.32 |
| MEMB SUBTOTALS **** | 2,384 | 77,941.48 | 10,637.54 | 333.56 | 21,836.21 | 67,076.37 |
| MEDCO SUBTOTALS **** | 48,120 | 1,964,747.47 | 90,024.38 | 12,189.87 | 731,790.67 | 1,335,171.05 |
| COB REIMBURSEMENTS: | | | | | | |
| CLAIMS | 502 | 38,315.44 | 1,741.00 | 170.00 | 1,424.34 | 5,047.08 |
| CREDITS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| COB SUBTOTALS ***** | 502 | 38,315.44 | 1,741.00 | 170.00 | 1,424.34 | 5,047.08# |
| MEDCO TOTALS ******* | 48,622 | 2,003,062.91 | 91,765.38 | 12,359.87 | 733,215.01 | 1,340,218.13 |
| <<< GRAND TOTALS >> | 48,622 | 2,003,062.91 | 91,765.38 | 12,359.87 | 733,215.01 | 1,340,218.13 |

BREAKDOWN BY RELATIONSHIP TO MEMBER

| CLAIM TYPE | MEMBER RX COUNT | MEMBER TOTAL | SPOUSE RX COUNT | SPOUSE TOTAL | DEP RX COUNT | DEP RX TOTAL | TOTAL RX | TOTAL |
|---|---|---|---|---|---|---|---|---|
| PHARMACY REIMBURSEMENTS: | | | | | | | | |
| MAIL- | | | | | | | | |
| CLAIMS | 5,461 | 467,113.71 | 3,013 | 239,808.78 | 83 | 15,415.55 | 8,557 | 722,338.04 |
| CREDITS | 3 | 169.48- | 1 | 26.18- | 0 | 0.00 | 4 | 195.66- |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 1 | 2,065.64 | 1 | 2,065.64 |
| AUDIT CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| RETAIL- | | | | | | | | |
| CLAIMS | 20,839 | 326,432.29 | 12,438 | 191,913.88 | 3,566 | 31,253.83 | 36,843 | 549,600.00 |
| CREDITS | 184 | 3,659.33- | 99 | 1,617.98- | 48 | 436.03- | 331 | 5,713.34- |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| AUDIT CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| MEMBER REIMBURSEMENTS: | | | | | | | | |
| DIRECT REIMBURSEMENT | | | | | | | | |
| CLAIMS | 1,595 | 41,393.37 | 694 | 23,907.41 | 88 | 1,701.98 | 2,377 | 67,002.76 |
| CREDITS | 0 | 0.00 | 0 | 0.00 | 1 | 20.71- | 1 | 20.71- |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 6 | 94.32 | 6 | 94.32 |
| COB REIMBURSEMENTS: | | | | | | | | |
| CLAIMS | 109 | 1,161.46 | 378 | 3,720.39 | 15 | 165.23 | 502 | 5,047.08 |
| CREDITS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| SUPPLEMENTS | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| <<< GRAND TOTALS >> | 28,191 | 832,272.02 | 16,623 | 457,706.30 | 3,808 | 50,239.81 | 48,622 | 1,340,218.13 |

DJDE JDL=IBSLCP,JDE=IBSE02,END;

# ADMIN FEE INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417

EXPRESS SCRIPTS®

**Account Number:** XXYY-01009
**Account Name:** ABC CORPOR
**Account Address:**

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 08/31/XX - 09/29/XX

## SUMMARY OF CHARGES

| SERVICE CATEGORY | DESCRIPTION | QUANTITY | AMOUNT |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| | MAIL SERVICE CLAIMS | 14 | $0.00 |
| | RETAIL PHARMACY CLAIMS | 55 | $0.00 |
| | TOTAL CLAIMS: | 69 | $0.00 |
| | **TOTAL AMOUNT DUE:** | | **$0.00** |

# ADMIN FEE INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417

EXPRESS SCRIPTS®

**Account Number:** XXYY-01009
**Account Name:** ABC CORPOR CORP

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 08/31/XX - 09/29/XX

| DESCRIPTION | QTY | UNIT PRICE | AMOUNT | SUBTOTAL |
|---|---|---|---|---|
| GROUP : 01009 | | | | |
| CLAIMS PROCESSING | | | | |
| MAIL SERVICE CLAIMS | 14 | 0.000 | 0.00 | |
| RETAIL PHARMACY CLAIMS | 55 | 0.000 | 0.00 | |
| TOTAL | 69 | | $0.00 | |
| TOTAL FOR GROUP | | | | $0.00 |

# ADMINISTRATIVE FEE INVOICE

Remit To: Express Scripts, Inc.
21653 Network Place
Chicago, IL 60673-1216

EXPRESS SCRIPTS®

**Account Number:** XXYY-01009
**Account Name:** ABC CORPOR CORP

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 08/31/XX - 09/29/XX

## REMIT PAGE

| Account Number | Invoice Date | Invoice Number | Total Amount Due |
|---|---|---|---|
| XXYY-01009 | 09/30/XX | | 0.00 |

**Any unpaid balances may be subject to late payment fees.**

**If this invoice is a credit balance, please deduct the credit from your next invoice. If a deduction is not taken, a refund will be sent to you. If you have any questions, please contact your Account Management Team.**

**PLEASE REMIT PAYMENT**

**Remit Information**

**ACH Transfer - Electronic Payments**

**Fedwire Transfer - Electronic Payments**



**Return this page with your payment**

**Payment Questions:**

Please contact Accounts Receivable

**Change to your Billing Address:**

Please contact Billing Department
Billing Representative: Phone:
Email:

**All Other Questions:**

Please contact Account Management Representative:
Phone:
Email:

# CLAIMS INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417

EXPRESS SCRIPTS®

**Account Number:** 6698
**Account Name:** XYZA COMPANY
**Account Address:**

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 09/13/XX - 09/26/XX

## SUMMARY OF CHARGES

| SERVICE CATEGORY | DESCRIPTION | QUANTITY | AMOUNT |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| | RETAIL PHARMACY | 6,461 | $474,059.14 |
| | RETAIL PHARMACY ADJ. | 225 | $21,424.32 CR |
| | MAIL SERVICE | 8,412 | $1,193,704.68 |
| | MAIL SERVICE ADJ. | 10 | $1,109.05 CR |
| | RETAIL DIRECTS ADJ. | 662 | $4,176.30 |
| | SPECIALTY PHARMACY CLAIMS | 38 | $319,788.46 |
| | **TOTAL CLAIMS:** | **15,808** | **$1,969,195.21** |
| INVOICE ADJUSTMENTS | | | |
| | MEMBER BALANCE APPLIED AMOUNT | 34 | 961.77 CR |
| | MEMBER RECOVERY AMOUNT | 130 | 1,263.93 |
| | **TOTAL ADJUSTMENTS:** | | **$302.16** |
| ADMIN COUNT SUMMARY | | | |
| | TRANSACTIONS + | 15,110 | |
| | TRANSACTIONS - | 0 | |
| | TRANSACTIONS NO EFFECT | 698 | |
| | **TOTAL ADMIN. COUNT:** | **15,110** | |

| | |
|---|---|
| **TOTAL AMOUNT DUE:** | **$1,969,497.37** |

# CLAIMS INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417

EXPRESS SCRIPTS®

**Account Number:** 6698
**Account Name:** XYZA COMPANY

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 09/13/XX - 09/26/XX

| DESCRIPTION | QTY | AMOUNT | SUBTOTAL |
|---|---|---|---|
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGLIS1** | | | |
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 5 | 103.93 | |
| TOTAL | 5 | $103.93 | |
| **TOTAL FOR ELGBL/GRP** | | | $103.93 |
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGLIS2** | | | |
| CLAIMS PROCESSING | | | |
| MAIL SERVICE | 1 | 5.68 | |
| TOTAL | 1 | $5.68 | |
| **TOTAL FOR ELGBL/GRP** | | | $5.68 |
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGSTD** | | | |
| CLAIMS PROCESSING | | | |
| RETAIL DIRECTS ADJ. | 6 | 13.15 | |
| MAIL SERVICE | 145 | 23,992.82 | |
| RETAIL PHARMACY | 62 | 2,855.79 | |
| RETAIL PHARMACY ADJ. | 1 | 0.00 | |
| TOTAL | 214 | $26,861.76 | |
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGSTD** | | | |
| INVOICE ADJUSTMENT | | | |
| MEMBER BALANCE APPLIED AMOUNT | 1 | | 25.96 CR |
| MEMBER RECOVERY AMOUNT | 2 | | 25.17 |
| TOTAL | | $0.79 CR | |
| **TOTAL FOR ELGBL/GRP** | | | $26,860.97 |
| **TOTAL FOR CONTRACT** | | | $26,970.58 |
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGSTD** | | | |
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 17 | 595.19 | |
| RETAIL PHARMACY ADJ. | 1 | 6.00 CR | |
| TOTAL | 18 | $589.19 | |
| **TOTAL FOR ELGBL/GRP** | | | $589.19 |
| **CONTRACT : ABCDDRUG ELGBL/GRP : ABCDDRUGSTD** | | | |
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 11 | 409.38 | |

# CLAIMS INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive Franklin Lakes New Jersey 07417

EXPRESS SCRIPTS®

Account Number: 6698
Account Name: XYZA COMPANY

Invoice Number:
Invoice Date: 09/30/XX
Period Covered: 09/13/XX - 09/26/XX

| DESCRIPTION | QTY | AMOUNT | SUBTOTAL |
|---|---|---|---|
| CONTRACT : ABOBMSEL ELGBL/GRP: ABCDDRUGLISI3 | | | |
| TOTAL | 11 | $409.38 | |
| TOTAL FOR ELGBL/GRP | | | $409.38 |
| CONTRACT : ABCDDRUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| RETAIL DIRECTS ADJ. | 5 | 55.68 CR | |
| MAIL SERVICE | 206 | 21,279.97 | |
| MAIL SERVICE ADJ. | 2 | 456.55 CR | |
| RETAIL PHARMACY | 210 | 7,271.62 | |
| RETAIL PHARMACY ADJ. | 3 | 107.45 CR | |
| TOTAL | 426 | $27,931.91 | |
| CONTRACT : ABCOORUG ELGBL/GRP: ABCDDRUGLISI | | | |
| INVOICE ADJUSTMENT | | | |
| MEMBER RECOVERY AMOUNT | 6 | | 59.89 |
| TOTAL | | $59.89 | |
| TOTAL FOR ELGBL/GRP | | | $27,991.80 |
| TOTAL FOR CONTRACT | | | $28,990.37 |
| CONTRACT : ABCOORUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| MAIL SERVICE | 10 | 1,188.03 | |
| RETAIL PHARMACY | 150 | 9,043.60 | |
| RETAIL PHARMACY ADJ. | 14 | 59.21 CR | |
| TOTAL | 174 | $10,172.42 | |
| TOTAL FOR ELGBL/GRP | | | $10,172.42 |
| CONTRACT : ABCOORUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| RETAIL DIRECTS ADJ. | 2 | 1.20 | |
| MAIL SERVICE | 4 | 418.37 | |
| RETAIL PHARMACY | 26 | 1,423.27 | |
| RETAIL PHARMACY ADJ. | 1 | 3.73 CR | |
| TOTAL | 33 | $1,839.11 | |
| TOTAL FOR ELGBL/GRP | | | $1,839.11 |

# CLAIMS INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive Franklin Lakes New Jersey 07417

EXPRESS SCRIPTS®

Account Number: 6698
Account Name: XYZA COMPANY

Invoice Number:
Invoice Date: 09/30/XX
Period Covered: 09/13/XX - 09/26/XX

| DESCRIPTION | QTY | AMOUNT | SUBTOTAL |
|---|---|---|---|
| CONTRACT : ABCDDRUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| MAIL SERVICE | 8 | 806.01 | |
| RETAIL PHARMACY | 21 | 2,246.50 | |
| TOTAL | 29 | $3,052.51 | |
| TOTAL FOR ELGBL/GRP | | | $3,052.51 |
| CONTRACT : ABCDDRUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 5 | 167.10 | |
| TOTAL | 5 | $167.10 | |
| TOTAL FOR ELGBL/GRP | | | $167.10 |
| CONTRACT : WTSTSUP1 ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| RETAIL DIRECTS ADJ. | 459 | 2,072.67 | |
| MAIL SERVICE | 6,233 | 936,966.82 | |
| MAIL SERVICE ADJ. | 5 | 0.00 | |
| RETAIL PHARMACY | 4,203 | 313,069.67 | |
| RETAIL PHARMACY ADJ. | 151 | 18,479.20 CR | |
| SPECIALTY PHARMACY CLAIMS | 30 | 198,287.15 | |
| TOTAL | 11,081 | $1,431,917.11 | |
| CONTRACT : ABCDDRUG ELGBL/GRP: ABCDDRUGLISI | | | |
| INVOICE ADJUSTMENT | | | |
| MEMBER BALANCE APPLIED AMOUNT | 24 | | 547.19 CR |
| MEMBER RECOVERY AMOUNT | 94 | | 748.72 |
| TOTAL | | $201.53 | |
| TOTAL FOR ELGBL/GRP | | | $1,432,118.64 |
| TOTAL FOR CONTRACT | | | $1,447,349.78 |
| CONTRACT : ABCDDRUG ELGBL/GRP: ABCDDRUGLISI | | | |
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 117 | 7,002.32 | |
| TOTAL | 117 | $7,002.32 | |
| TOTAL FOR ELGBL/GRP | | | $7,002.32 |

# CLAIMS INVOICE

Express Scripts Holding Company
100 Parsons Pond Drive, Franklin Lakes, New Jersey 07417

EXPRESS SCRIPTS®

**Account Number:** 6698
**Account Name:** XYZA COMPANY

**Invoice Number:**
**Invoice Date:** 09/30/XX
**Period Covered:** 09/13/XX - 09/26/XX

C ELGBL/GRP :

| | | | |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 6 | 120.56 | |
| TOTAL | 6 | $120.56 | |
| TOTAL FOR ELGBL/GRP | | | $120.56 |

CONTRACT : ABCDDRUG ELGBL/GRP : XYZAMSUP2LIS3

| | | | |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| MAIL SERVICE | 3 | 109.02 | |
| RETAIL PHARMACY | 14 | 1,142.81 | |
| TOTAL | 17 | $1,251.83 | |
| TOTAL FOR ELGBL/GRP | | | $1,251.83 |

CONTRACT : ABCDDRUG ELGBL/GRP : XYZAMSUP2LIS5

| | | | |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| RETAIL PHARMACY | 1 | 35.10 | |
| TOTAL | 1 | $35.10 | |
| TOTAL FOR ELGBL/GRP | | | $35.10 |

CONTRACT : XYZASUP2 ELGBL/GRP : XYZAMSUP2STD

| | | | |
|---|---|---|---|
| CLAIMS PROCESSING | | | |
| RETAIL DIRECTS ADJ. | 190 | 2,144.96 | |
| MAIL SERVICE | 1,802 | 208,937.96 | |
| MAIL SERVICE ADJ. | 3 | 652.50 | CR |
| RETAIL PHARMACY | 1,613 | 128,572.30 | |
| RETAIL PHARMACY ADJ. | 54 | 2,768.73 | CR |
| SPECIALTY PHARMACY CLAIMS | 8 | 121,501.31 | |
| TOTAL | 3,670 | $457,735.30 | |

CONTRACT : XYZASUP2 ELGBL/GRP : XYZAMSUP2STD

| | | | |
|---|---|---|---|
| INVOICE ADJUSTMENT | | | |
| MEMBER BALANCE APPLIED AMOUNT | 9 | | 388.62 CR |
| MEMBER RECOVERY AMOUNT | 28 | | 430.15 |
| TOTAL | | $41.53 | |
| TOTAL FOR ELGBL/GRP | | | $457,776.83 |
| TOTAL FOR CONTRACT | | | $466,186.64 |

# CLAIMS INVOICE

Remit To:

EXPRESS SCRIPTS®

Account Number: 6698
Account Name: XYZA COMPANY

Invoice Number:
Invoice Date: 09/30/XX
Period Covered: 09/13/XX - 09/26/XX

## REMIT PAGE

| Account Number | Invoice Date | Invoice Number | Total Amount Due |
|---|---|---|---|
| 6698 | 09/30/XX | | $1,969,497.37 |

Any unpaid balances may be subject to late payment fees.

If this invoice is a credit balance, please deduct the credit from your next invoice. If a deduction is not taken, a refund will be sent to you. If you have any questions, please contact your Account Management Team.

PLEASE REMIT PAYMENT

**Remit Information**

**Please Wire Payment to:**



**Return this page with your payment**

**Payment Questions:**

Please contact Accounts Receivable Representative:
Phone:
Email:

**Change to your Billing Address:**

Please contact Billing Department
Billing Representative:
Phone:
Email:

**All Other Questions:**

Please contact Account Management Representative:
Phone:
Email:

EXPRESS SCRIPTS®

# Lag Triangle Report

Test Population

Channel: Mail and Retail

Claim Invoice Dates:MM/YY - MM/YY

**Bill Month**

| Fill Month | | MM YYYY | MM YYYY | MM YYYY | MM YYYY | MM YYYY | MM YYYY | MM YYYY | MM YYYY | MM YYYY | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MM | Invoice Cost | $0 | $0 | $0 | $0 | $38,544,523.90 | $11,444,348.26 | $160,837.69 | $62,135.04 | $34,142.43 | **$50,245,987.32** |
| YYYY | Claim Count | 0 | 0 | 0 | 0 | 584,587 | 147,321 | 1,738 | 728 | 358 | **734,732** |
| MM | Invoice Cost | $0 | $0 | $0 | $0 | $0 | $31,195,795.26 | $14,425,492.80 | $211,836.19 | $55,850.36 | **$45,888,974.61** |
| YYYY | Claim Count | 0 | 0 | 0 | 0 | 0 | 495,443 | 197,886 | 2,318 | 793 | **696,440** |
| MM | Invoice Cost | $0 | $0 | $0 | $0 | $0 | $0 | $27,573,841.75 | $19,077,130.04 | $298,447.86 | **$46,949,419.65** |
| YYYY | Claim Count | 0 | 0 | 0 | 0 | 0 | 0 | 441,716 | 264,317 | 2,486 | **708,519** |
| MM | Invoice Cost | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $24,047,726.58 | $24,011,553.57 | **$48,059,280.15** |
| YYYY | Claim Count | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 382,056 | 348,496 | **730,552** |
| MM | Invoice Cost | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $18,549,448.11 | **$18,549,448.11** |
| YYYY | Claim Count | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 300,888 | **300,888** |
| **Total** | **Invoice Cost** | **$41,398,762.35** | **$44,470,479.69** | **$44,846,183.13** | **$43,933,130.51** | **$67,983,128.96** | **$42,951,015.02** | **$42,296,156.92** | **$43,561,892.22** | **$43,092,173.43** | **$414,532,922.23** |
| **Total** | **Claim Count** | **641,973** | **672,799** | **671,843** | **664,962** | **1,003,605** | **646,540** | **643,387** | **650,943** | **654,343** | **6,250,395** |





BL020

EXPRESS SCRIPTS®

# Utilization Report - by Month

Test Population

Prescription Service Dates: MM/YYYY - MM/YYYY

## Plan Utilization

| Month | Avg Mbr Count | Rx Count | Ingredient Cost | Dispensing Fee | Sales Tax | Member Cost | Plan Cost | Member Cost/ Rx | Plan Cost/ Rx |
|---|---|---|---|---|---|---|---|---|---|
| MM YYYY | 617,282 | 712,239 | $65,695,675.04 | $591,596.25 | $44,142.78 | $16,074,964.04 | $50,256,450.03 | $22.57 | $70.56 |
| MM YYYY | 614,644 | 670,467 | $61,409,541.24 | $589,219.42 | $41,216.09 | $15,014,779.87 | $47,025,196.88 | $22.39 | $70.14 |
| MM YYYY | 615,325 | 703,248 | $64,117,303.73 | $616,277.53 | $42,010.73 | $15,743,781.70 | $49,031,810.29 | $22.39 | $69.72 |
| MM YYYY | 616,179 | 680,918 | $62,526,619.49 | $591,125.51 | $42,497.06 | $14,942,069.50 | $48,218,172.56 | $21.94 | $70.81 |
| MM YYYY | 617,150 | 705,194 | $65,533,161.38 | $610,110.60 | $43,271.01 | $15,309,999.92 | $50,876,543.07 | $21.71 | $72.15 |
| MM YYYY | 618,353 | 664,362 | $60,180,117.13 | $568,565.69 | $40,198.81 | $14,273,264.53 | $46,515,617.10 | $21.48 | $70.02 |
| **Grand Total** | **616,489** | **4,136,428** | **$379,462,418** | **$3,566,895** | **$253,336** | **$91,358,860** | **$291,923,790** | **$22.09** | **$70.57** |

## Performance

| Month | Retail Rx % | Mail Rx % | Mbr Sub Rx % | SSB Rx % | MSB Rx % | Generic Rx % | Preferred Drug Rx % | Generic Conv % |
|---|---|---|---|---|---|---|---|---|
| MM YYYY | 70.3 % | 28.9 % | 0.8 % | 20.2 % | 1.0 % | 78.7 % | 93.5 % | 98.7 % |
| MM YYYY | 71.7 % | 27.4 % | 0.8 % | 20.1 % | 1.0 % | 78.9 % | 93.5 % | 98.8 % |
| MM YYYY | 71.6 % | 27.6 % | 0.8 % | 19.9 % | 1.1 % | 79.0 % | 93.7 % | 98.6 % |
| MM YYYY | 70.8 % | 28.5 % | 0.7 % | 19.4 % | 1.1 % | 79.5 % | 94.0 % | 98.7 % |
| MM YYYY | 70.8 % | 28.5 % | 0.7 % | 18.9 % | 1.1 % | 80.0 % | 93.9 % | 98.7 % |
| MM YYYY | 70.4 % | 28.9 % | 0.6 % | 18.5 % | 1.0 % | 80.4 % | 94.0 % | 98.7 % |
| **Grand Total** | **70.9 %** | **28.3 %** | **0.7 %** | **19.5 %** | **1.1 %** | **79.4 %** | **93.8 %** | **98.7 %** |

## Member Demographics

| Month | Avg Mbr Count | Avg Util Mbr/ Mnth | Mbr Avg Age | 65+ % of Mbrs | Female % of Mbrs | Male % of Mbrs | PMPM Rx | PMPM Plan Cost |
|---|---|---|---|---|---|---|---|---|
| MM YYYY | 617,282 | 252,990.00 | 50.72 | 32.2 % | 50.7 % | 49.3 % | 1.15 | $81.42 |
| MM YYYY | 614,644 | 247,716.00 | 50.80 | 32.4 % | 50.7 % | 49.3 % | 1.09 | $76.51 |
| MM YYYY | 615,325 | 254,229.00 | 50.75 | 32.4 % | 50.7 % | 49.3 % | 1.14 | $79.68 |
| MM YYYY | 616,179 | 249,087.00 | 50.75 | 32.4 % | 50.7 % | 49.3 % | 1.11 | $78.25 |



MM/DD/YY



RC040

EXPRESS SCRIPTS®

# Indication Ranking - Top 25 by Ingredient Cost

Test Population

Prescription Service Dates: MM/YYYY- MM/YYYY

| Indication | Ing Cost Rank | Ingredient Cost | Rx Count Rank | Rx Count | Plan Cost Rank | Plan Cost | Ingredient Cost/Rx | Plan Cost/Rx | Mail Rx % | Non-Preferred Drug Rx% | Generic Rx % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HIGH BLOOD CHOLESTEROL | 1 | $15,210,484.89 | 2 | 170,080 | 1 | $11,377,247.38 | $89.43 | $66.89 | 49.2% | 1.7% | 79.1% |
| DIABETES | 2 | $14,640,054.73 | 5 | 102,361 | 3 | $10,667,650.95 | $143.02 | $104.22 | 37.0% | 8.0% | 53.2% |
| HIGH BLOOD PRESS/HEART DISEASE | 3 | $14,245,038.57 | 1 | 318,513 | 2 | $10,781,647.51 | $44.72 | $33.85 | 39.3% | 1.3% | 89.9% |
| ASTHMA | 4 | $8,349,782.61 | 9 | 56,855 | 6 | $6,217,098.64 | $146.86 | $109.35 | 23.7% | 12.3% | 35.3% |
| CANCER | 5 | $8,088,416.95 | 36 | 10,927 | 4 | $8,225,078.35 | $740.22 | $752.73 | 37.4% | 3.6% | 88.2% |
| ULCER DISEASE | 6 | $7,599,250.31 | 8 | 76,935 | 7 | $5,744,067.71 | $98.77 | $74.66 | 37.7% | 4.5% | 81.2% |
| INFLAMMATORY CONDITIONS | 7 | $7,023,512.31 | 50 | 4,754 | 5 | $6,773,344.03 | $1,477.39 | $1,424.77 | 55.8% | 10.1% | 30.8% |
| DEPRESSION | 8 | $6,315,295.77 | 6 | 96,164 | 8 | $4,679,736.59 | $65.67 | $48.66 | 25.1% | 1.4% | 90.0% |
| MENTAL/NEURO DISORDERS | 9 | $5,961,055.92 | 22 | 28,231 | 9 | $4,486,562.39 | $211.15 | $158.92 | 26.5% | 2.7% | 69.7% |
| URINARY DISORDERS | 10 | $4,743,142.20 | 12 | 50,203 | 12 | $3,612,013.71 | $94.48 | $71.95 | 40.4% | 7.9% | 78.2% |
| INFECTIONS | 11 | $4,646,938.92 | 3 | 164,658 | 11 | $3,752,457.72 | $28.22 | $22.79 | 1.4% | 1.1% | 98.3% |
| PAIN | 12 | $4,371,343.63 | 4 | 121,597 | 13 | $3,529,480.44 | $35.95 | $29.03 | 6.9% | 3.3% | 96.0% |
| MULTIPLE SCLEROSIS | 13 | $3,784,091.87 | 66 | 623 | 10 | $3,818,491.15 | $6,073.98 | $6,129.20 | 93.4% | 6.4% | 0.0% |
| ANTICOAGULANT | 14 | $3,597,185.55 | 21 | 28,734 | 14 | $2,919,041.37 | $125.19 | $101.59 | 28.7% | 3.7% | 82.5% |
| ATTENTION DISORDERS | 15 | $3,293,815.07 | 33 | 14,952 | 16 | $2,785,691.64 | $220.29 | $186.31 | 9.2% | 10.2% | 74.9% |
| VIRAL INFECTIONS | 16 | $3,273,999.87 | 30 | 17,119 | 15 | $2,809,202.49 | $191.25 | $164.10 | 9.5% | 0.6% | 59.7% |
| HORMONAL SUPPLEMENTATION | 17 | $3,210,503.74 | 26 | 23,621 | 20 | $2,228,740.83 | $135.92 | $94.35 | 32.2% | 9.3% | 47.3% |
| SKIN CONDITIONS | 18 | $3,108,090.00 | 20 | 29,204 | 18 | $2,557,237.80 | $106.43 | $87.56 | 9.0% | 4.3% | 86.6% |
| PAIN AND INFLAMMATION | 19 | $2,837,243.73 | 13 | 49,529 | 22 | $2,064,355.95 | $57.28 | $41.68 | 18.7% | 9.6% | 82.2% |
| ALLERGIES | 20 | $2,800,669.52 | 14 | 44,072 | 21 | $2,176,298.68 | $63.55 | $49.38 | 19.8% | 4.0% | 82.0% |
| SEIZURES | 21 | $2,763,502.47 | 11 | 50,685 | 23 | $1,947,490.40 | $54.52 | $38.42 | 23.2% | 2.9% | 90.5% |



MM/DD/YY



DG240

EXPRESS SCRIPTS®

# Specialty Utilization Summary

Test Population

Prescription Service Dates: MM/YY - MM/YY

| | Rx Count | Unique Patients | Ingredient Cost | Dispensing Fee | Sales Tax | Member Cost | Plan Cost |
|---|---|---|---|---|---|---|---|
| Total (All Drugs) | 8,278,554 | 471,783 | $750,404,581 | $7,169,492 | $502,156 | $177,350,301 | $580,725,928 |
| Total Specialty | 30,836 | 8,774 | $115,088,304 | $13,197 | $45,574 | $4,961,386 | $110,185,689 |
| Total Specialty filled at Accredo | 22,714 | 4,909 | $105,995,337 | $4,337 | $40,171 | $4,401,047 | $101,638,799 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Total Specialty as a % of All Drugs | 0.4 % | 1.9 % | 15.3 % | 0.2 % | 9.1 % | 2.8 % | 19.0 % |
| Accredo Fills as a % of Total Specialty | 73.7 % | 55.9 % | 92.1 % | 32.9 % | 88.1 % | 88.7 % | 92.2 % |

**Total Specialty Rxs as a % of All Drugs**


**Total Specialty Plan Cost as a % of All Drugs**


**Accredo Rxs as a % of Total Specialty**




ESI current all-inclusive specialty drug list was used to generate this report.

EXPRESS SCRIPTS®

# Channel and Specialty by Preferred Drug Status by Month

Demo Test Population

Prescription Service Dates: MM/YY - MM/YY

**MM YYYY**

| | | Rx Count | Ingredient Cost | Dispensing Fee | Sales Tax | Member Cost | Plan Cost | Member Cost/Rx | Plan Cost/Rx |
|---|---|---|---|---|---|---|---|---|---|
| Retail | Preferred Brand | 124117 | $34,008,975.99 | $146,304.87 | $1,333.42 | $4,386,842.64 | $29,769,771.64 | $35.34 | $239.85 |
| | Non-Preferred Brand | 17404 | $3,970,148.67 | $21,689.04 | $30.01 | $740,524.63 | $3,251,343.09 | $42.55 | $186.82 |
| | Generic | 519176 | $15,934,956.63 | $837,473.49 | $312.61 | $5,546,895.39 | $11,225,847.34 | $10.68 | $21.62 |
| **Retail** | **Subtotal** | **660697** | **$53,914,081** | **$1,005,467** | **$1,676** | **$10,674,263** | **$44,246,962** | **$16.16** | **$66.97** |
| Mail | Preferred Brand | 5644 | $5,712,430.42 | $831.40 | $24.48 | $418,006.18 | $5,295,280.12 | $74.06 | $938.21 |
| | Non-Preferred Brand | 512 | $471,107.67 | $74.46 | $0.05 | $43,403.79 | $427,778.39 | $84.77 | $835.50 |
| | Generic | 15255 | $1,223,592.43 | $2,174.61 | $21.48 | $274,016.04 | $951,772.48 | $17.96 | $62.39 |
| **Mail** | **Subtotal** | **21411** | **$7,407,131** | **$3,080** | **$46** | **$735,426** | **$6,674,831** | **$34.35** | **$311.75** |
| Mbr Sub | Preferred Brand | 122 | $27,117.36 | $150.58 | $1.28 | $2,975.26 | $24,293.96 | $24.39 | $199.13 |
| | Non-Preferred Brand | 119 | $61,610.56 | $174.50 | $0.00 | $4,492.03 | $57,293.03 | $37.75 | $481.45 |
| | Generic | 307 | $9,136.18 | $487.90 | $0.00 | $1,645.96 | $7,978.12 | $5.36 | $25.99 |
| **Mbr Sub** | **Subtotal** | **548** | **$97,864** | **$813** | **$1** | **$9,113** | **$89,565** | **$16.63** | **$163.44** |
| | **Month Total** | **682656** | **$61,419,076** | **$1,009,361** | **$1,723** | **$11,418,802** | **$51,011,358** | **$16.73** | **$74.72** |

| | | Rx Count | Ingredient Cost | Dispensing Fee | Sales Tax | Member Cost | Plan Cost | Member Cost/Rx | Plan Cost/Rx |
|---|---|---|---|---|---|---|---|---|---|
| Specialty | Preferred Brand | 2830 | $9,982,527.45 | $3,052.15 | $923.67 | $124,232.75 | $9,862,270.52 | $43.90 | $3,484.90 |
| | Non-Preferred Brand | 266 | $925,180.88 | $264.72 | $0.00 | $25,630.23 | $899,815.37 | $96.35 | $3,382.76 |
| | Generic | 2571 | $612,219.65 | $4,286.70 | $52.64 | $35,565.15 | $580,993.84 | $13.83 | $225.98 |
| **Specialty** | **Subtotal** | **5667** | **$11,519,928** | **$7,604** | **$976** | **$185,428** | **$11,343,080** | **$32.72** | **$2,001.60** |
| Non-Specialty | Preferred Brand | 127053 | $29,765,996.32 | $144,234.70 | $435.51 | $4,683,591.33 | $25,227,075.20 | $36.86 | $198.56 |
| | Non-Preferred Brand | 17769 | $3,577,686.02 | $21,673.28 | $30.06 | $762,790.22 | $2,836,599.14 | $42.93 | $159.64 |
| | Generic | 532167 | $16,555,465.59 | $835,849.30 | $281.45 | $5,786,992.24 | $11,604,604.10 | $10.87 | $21.81 |
| **Non-Specialty** | **Subtotal** | **676989** | **$49,899,148** | **$1,001,757** | **$747** | **$11,233,374** | **$39,668,278** | **$16.59** | **$58.60** |
| | **Month Total** | **682656** | **$61,419,076** | **$1,009,361** | **$1,723** | **$11,418,802** | **$51,011,358** | **$16.73** | **$74.72** |

EXPRESS SCRIPTS®

# Benchmark Key Performance Comparison

Benchmark Population: Commercial Division (CD)

Member Population: Demo Test Population

Prescription Service Dates: MM/YY - MM/YY

| | Benchmark | | | Member Population |
|---|---|---|---|---|
| **Overall Performance** | **LOW** | **MEDIUM** | **HIGH** | |
| **Plan Cost PSPM** | $69.49 | $113.03 | $168.59 | $138.44 |
| **Rx Measures** | | | | |
| **Rxs PSPM** | 0.86 | 1.28 | 1.79 | 1.63 |
| **Average Plan Cost/Rx** | $71.36 | $87.81 | $107.74 | $85.14 |
| **Average Mbr Cost/Rx** | $13.26 | $17.10 | $21.65 | $9.73 |
| **Average AWP/Rx** | $0.00 | $0.00 | $193.10 | $180.67 |
| **Average Days of Therapy/Rx** | 32.00 | 37.00 | 42.00 | 33.62 |
| **Average Plan Cost/Day** | $2.00 | $2.39 | $2.80 | $2.53 |
| **Avg Plan Cost/Day - Retail** | $1.91 | $2.40 | $2.94 | $2.19 |
| **Avg Plan Cost/Day - Mail** | $1.70 | $2.26 | $2.84 | $3.00 |
| **Member Cost %** | 12.1 % | 15.9 % | 20.9 % | 10.3 % |
| **Member Cost % - Retail** | 14.1 % | 19.3 % | 25.4 % | 11.7 % |
| **Member Cost % - Mail** | 8.1 % | 12.4 % | 17.4 % | 8.8 % |
| **Channel** | | | | |
| **Rx % - Mail** | 8.9 % | 16.7 % | 28.7 % | 16.7 % |
| **Rx % - Retail** | 71.2 % | 83.2 % | 91.0 % | 83.2 % |
| **Rx % - Member Submit** | 0.0 % | 0.0 % | 0.1 % | 0.1 % |
| **Rx Types** | | | | |
| **Rx % - SSB** | 18.3 % | 20.7 % | 23.2 % | 20.5 % |
| **Rx % - MSB** | 0.3 % | 0.8 % | 1.5 % | 1.8 % |
| **Rx % - Generic** | 75.5 % | 78.4 % | 81.0 % | 77.7 % |
| **SSB Rx % - Retail** | 16.5 % | 19.2 % | 22.0 % | 18.8 % |
| **MSB Rx % - Retail** | 0.3 % | 0.8 % | 1.4 % | 1.9 % |
| **Generic Rx % - Retail** | 76.8 % | 79.9 % | 82.8 % | 79.4 % |
| **SSB Rx % - Mail** | 22.1 % | 26.0 % | 29.8 % | 29.3 % |
| **MSB Rx % - Mail** | 0.1 % | 0.9 % | 1.8 % | 1.1 % |
| **Generic Rx % - Mail** | 68.4 % | 73.0 % | 76.8 % | 69.6 % |
| **Rx % - Preferred Drug** | 92.9 % | 94.3 % | 95.4 % | 92.3 % |
| **Preferred Drug Rx % - Retail** | 92.7 % | 94.2 % | 95.6 % | 91.8 % |
| **Preferred Drug Rx % - Mail** | 92.1 % | 94.3 % | 96.1 % | 94.9 % |
| **Rx % - DAW** | 1.1 % | 1.7 % | 2.6 % | 3.0 % |
| **DAW Rx % - Retail** | 0.8 % | 1.7 % | 2.7 % | 3.2 % |
| **DAW Rx % - Mail** | 1.0 % | 1.9 % | 3.2 % | 1.7 % |
| **Generic Conversion %** | 98.1 % | 99.0 % | 99.6 % | 97.8 % |
| **Generic Conversion % - Retail** | 98.3 % | 99.1 % | 99.7 % | 97.7 % |
| **Generic Conversion % - Mail** | 97.4 % | 98.7 % | 99.9 % | 98.4 % |
| **Demographics** | | | | |
| **Average Age** | 33.9 | 37.2 | 41.8 | 31.89 |
| **Male Members %** | 45.2 % | 49.6 % | 53.4 % | 55.1 % |
| **Female Members %** | 46.5 % | 50.4 % | 54.7 % | 44.9 % |

Your Path To Greater Care
and Zero Waste

# Operational Performance Report

EXPRESS SCRIPTS®

**DATE:**

**MM/YY - MM/YY**

**ABC Company, Inc.**

The Express Scripts Pharmacy delivers better health and value to you and your members.

The Express Scripts Pharmacy is the means for providing everything you're looking for in your pharmacy benefit.

- The lowest cost channel and drug mix
- Optimal health and safety outcomes
- Member engagement and satisfaction
- Ease of use

More than just a means for realizing unit cost savings, the Express Scripts Pharmacy enables you and your members to realize the full value of the pharmacy benefit - with measurable results.

Express Scripts' commitment to our customers has been noticed. The JD Power and Associates 2013 U.S. Pharmacy Study(sm) ranked overall satisfaction of home delivery from the Express Scripts Pharmacy above the industry average for online registration, prescription tracking and use of automatic refills. The report also cites Express Scripts satisfaction improvements with prescription ordering and delivery experiences.

Source: J.D. Power and Associates 2013 National Pharmacy Study; Express Scripts Patient Satisfaction Survey Results, Operations Reporting and Analysis, 2013.

**Home Delivery Refills by Source**

1/YYYY - 8/YYYY

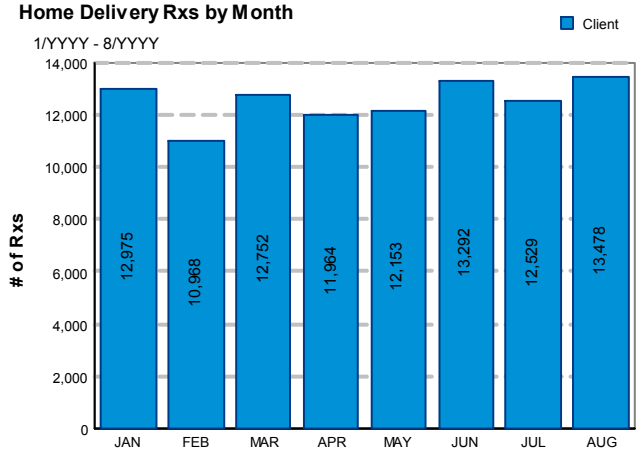
| | CUSTOMER SERVICE | FAX | IVR | POINT OF CARE | POSTAL | WEB |
|---|---|---|---|---|---|---|
| JAN YY | 1,107 | - | 2,963 | - | 273 | 2,740 |
| FEB YY | 889 | - | 2,715 | 4 | 309 | 2,220 |
| MAR YY | 919 | - | 2,949 | - | 346 | 2,768 |
| APR YY | 1,005 | - | 2,841 | - | 242 | 2,830 |
| MAY YY | 968 | - | 3,084 | - | 282 | 2,872 |
| JUN YY | 1,000 | - | 3,260 | - | 323 | 3,353 |
| JUL YY | 991 | - | 3,276 | - | 266 | 3,008 |
| AUG YY | 1,222 | 1 | 3,259 | - | 321 | 3,459 |

**Home Delivery New Fills by Source**

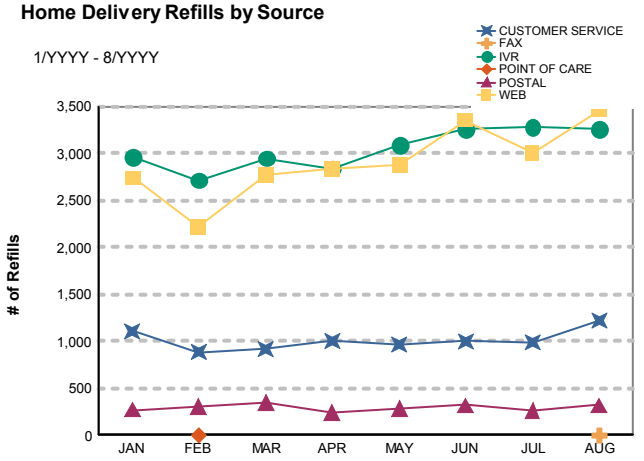
1/YYYY - 8/YYYY

| | Fax | Non-Fax |
|---|---|---|
| JAN YY | 1,058 | 4,834 |
| FEB YY | 931 | 3,900 |
| MAR YY | 986 | 4,784 |
| APR YY | 823 | 4,223 |
| MAY YY | 807 | 4,140 |
| JUN YY | 818 | 4,538 |
| JUL YY | 742 | 4,246 |
| AUG YY | 778 | 4,438 |

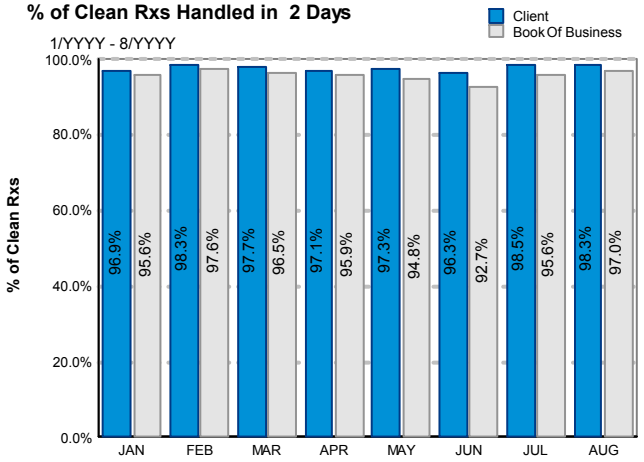
**Home Delivery Rxs by Month**



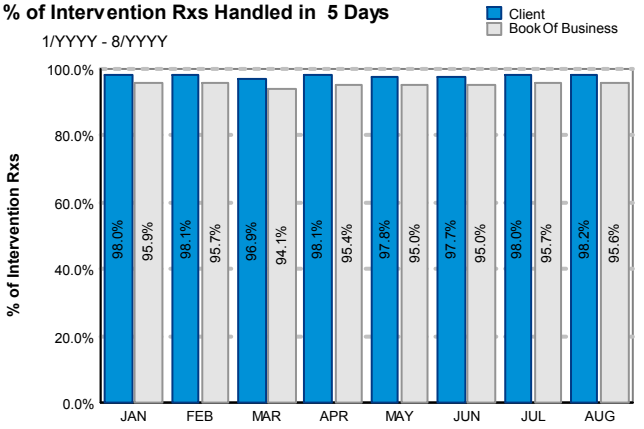

**Home Delivery Refills by Source**




**% of Clean Rxs Handled in 2 Days**




**% of Intervention Rxs Handled in 5 Days**

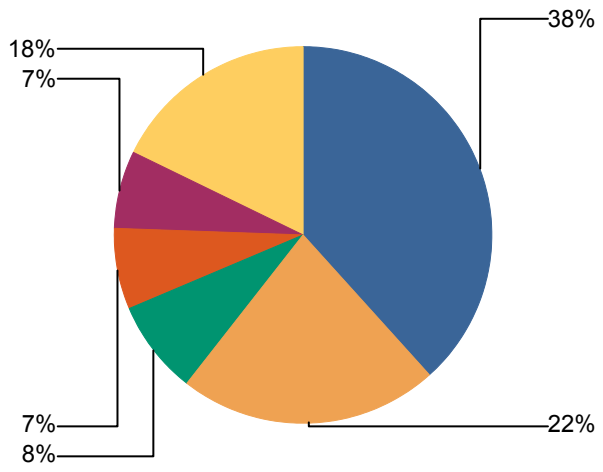


# Home Delivery

Express Scripts actively manages plan sponsors' benefits. Home Delivery interventions and rejections are a normal and important part of the Home Delivery process. Interventions occur for several reasons including safety checks, an invalid address or as the results of the benefit-plan design. The intervention/rejection process helps patients move from brand-name drugs to generics when possible. Please remember that not all rejects result in a member disruption. Depending upon the type of reject, the pharmacist may intervene on behalf of the patient to resolve the issue. Express Scripts always has the members' health and safety in mind and issues interventions and rejections when it is in the best interest of our members and plan sponsors.

**Client Top Reject Reasons**

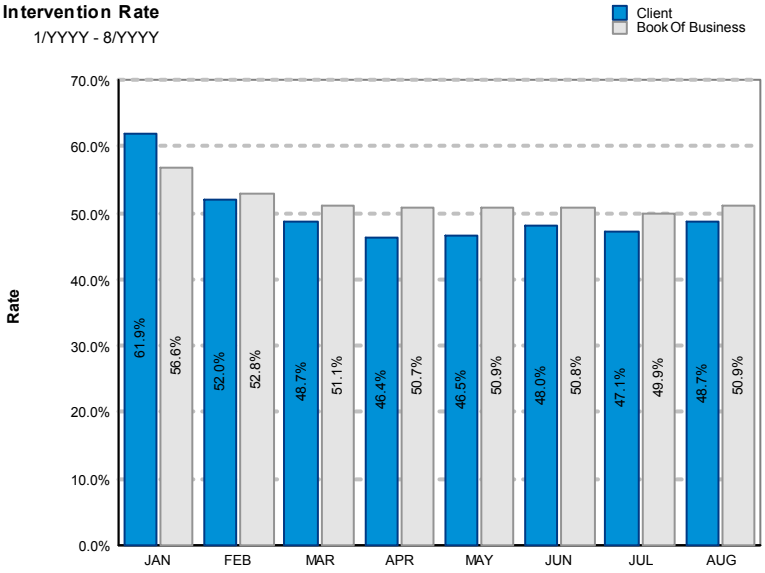
1/YYYY - 8/YYYY




| | |
|---|---|
| Provide Notice: Medicare Prescription Drug C | 38% |
| Prior Authorization Required | 22% |
| Product Not On Formulary | 8% |
| Plan Limitations Exceeded | 7% |
| M/I Cardholder ID | 7% |
| All Others | 18% |
| Total: | 100% |

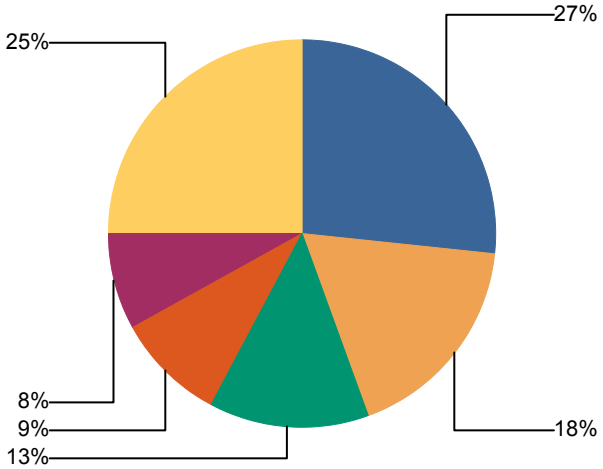
**Intervention Rate**

1/YYYY - 8/YYYY




**Book of Business Top Reject Reasons**

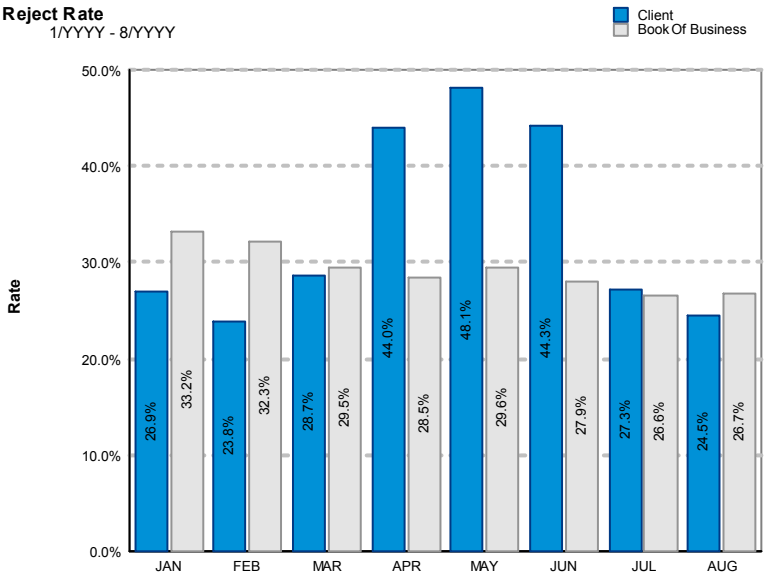
1/2016 - 8/2016




| | |
|---|---|
| Prior Authorization Required | 27% |
| Filled After Coverage Terminated | 18% |
| Product/Service Not Covered | 13% |
| Provide Notice: Medicare Prescription Drug C | 9% |
| Plan Limitations Exceeded | 8% |
| All Others | 25% |
| Total: | 100% |

**Reject Rate**

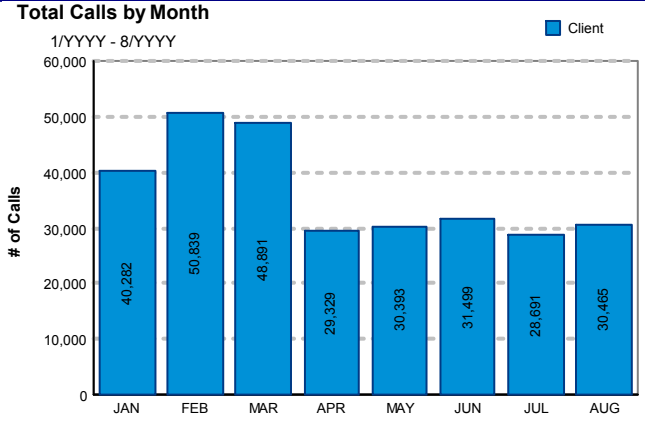
1/YYYY - 8/YYYY



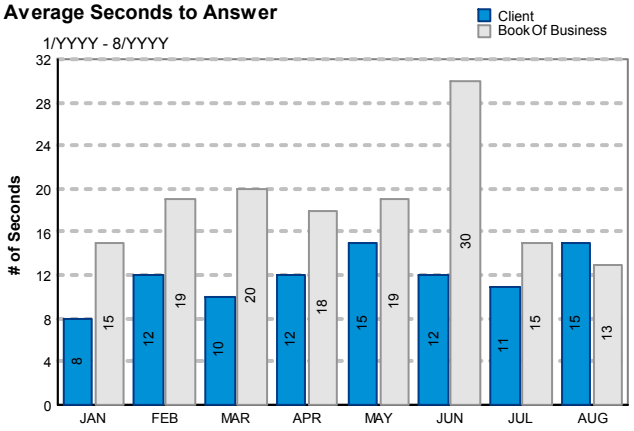
# Patient Care Contact Center

Patient and client satisfaction are at the center of all we do. That objective is clearly demonstrated at each Patient Care Contact Center. Patient Care Advocates are thoroughly trained to find solutions to patients' issues. In addition to ongoing training, patient calls are monitored to ensure the best service and optimal resolutions. Beyond the role of the Patient Care Advocate, there are multiple layers of quality assurance as well as call volume and resource management for consistency of excellence and efficiency. Callers get assistance from empowered advocates who identify potential savings and help patients switch to Home Delivery.

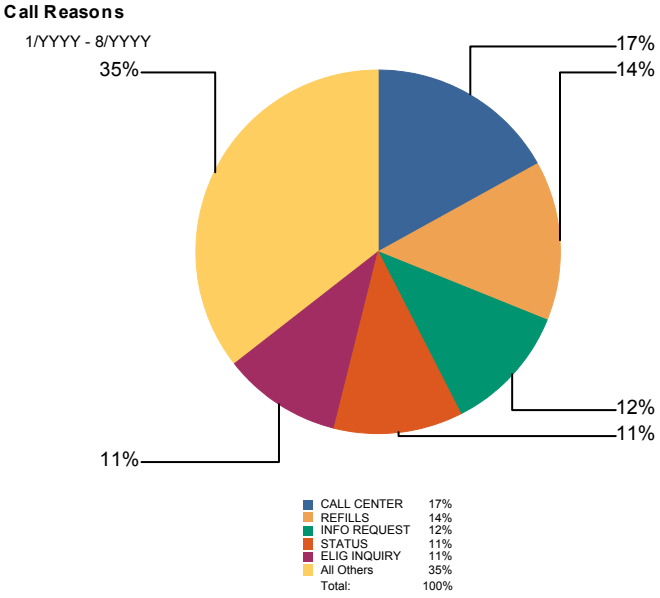
**Total Calls by Month**



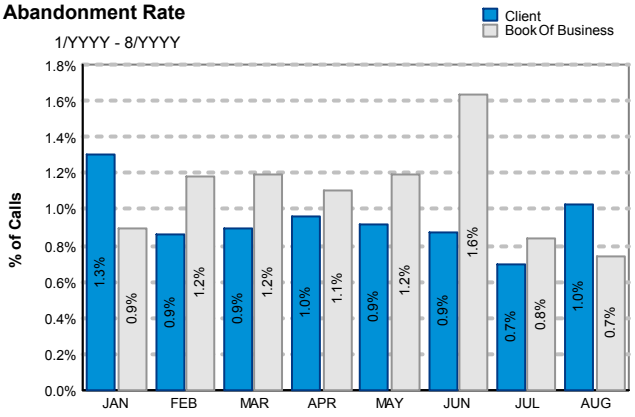

**Average Seconds to Answer**



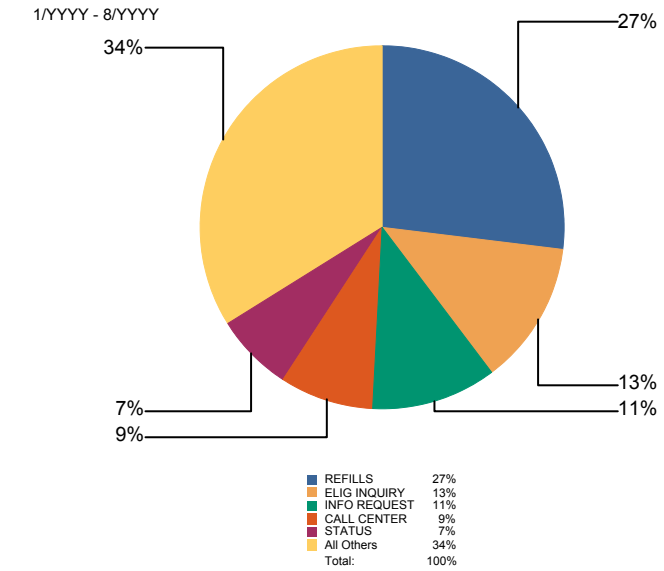

**Call Reasons**




**Abandonment Rate**




**Book of Business Call Reasons**



# Client Reported Requests

Client satisfaction is our top priority. To that end, we employ multiple layers of resources to ensure our objective is met. Using data from multiple areas at Express Scripts, we document and trend requests, issues,and turnaround times. This allows us to more effectively identify issue drivers and address root causes.

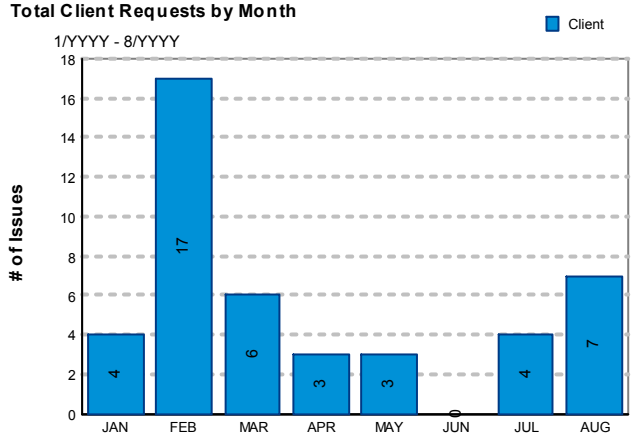
The Client Service Center (CSC) is a dedicated team of specialized associates who resolve escalated, member-specific issues for our clients. CSC's mission is to provide a convenient, effective, accurate, and timely process to assist Express Scripts' clients in resolving escalated member service issues, ensuring client satisfaction and retention. CSC is a first point of contact for member-specific issues.

PharmacoAnalytics (PhAn) is Express Scripts' reporting specialists team. PhAn provides best-in-class analytics by creating efficiencies, managing information, delivering innovative trend solutions, and establishing consultative excellence.

CD Clinical includes client-driven clinical requests.

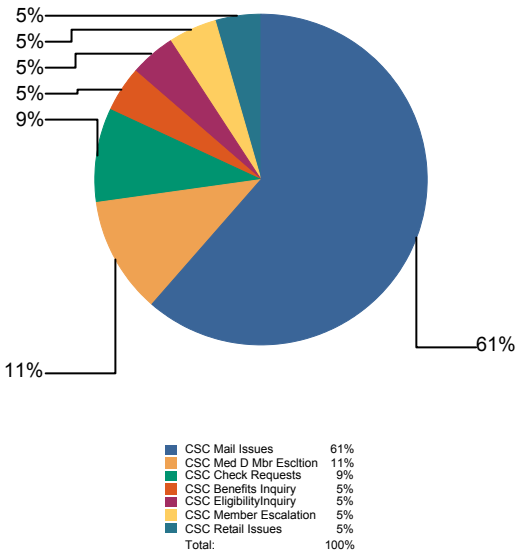
The Client Reported Requests data includes requests submitted by both the client and the Express Scripts account team.

**Total Client Requests by Month**




**Client Call Reasons**

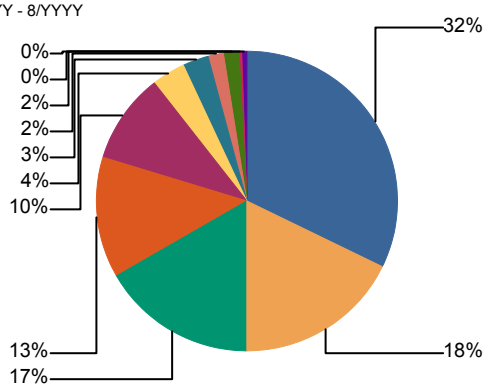
1/YYYY - 8/YYYY




| | |
|---|---|
| CSC Mail Issues | 61% |
| CSC Med D Mbr Escltion | 11% |
| CSC Check Requests | 9% |
| CSC Benefits Inquiry | 5% |
| CSC EligibilityInquiry | 5% |
| CSC Member Escalation | 5% |
| CSC Retail Issues | 5% |
| Total: | 100% |

**Book of Business Client Call Reasons**

1/YYYY - 8/YYYY



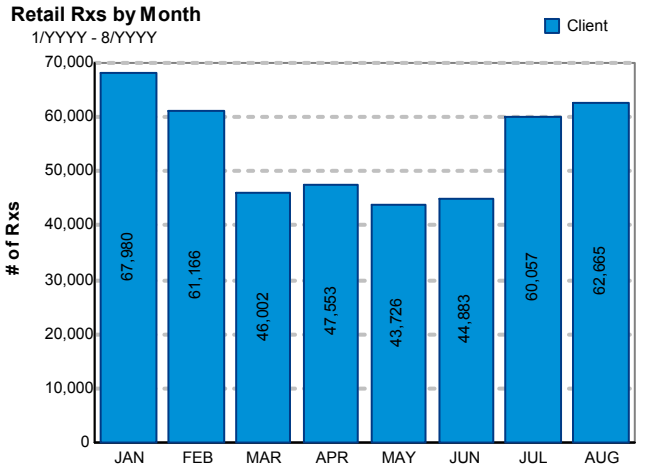

| | |
|---|---|
| CSC EligibilityInquiry | 32% |
| CSC Prior Approval | 18% |
| CSC Benefits Inquiry | 17% |
| CSC Retail Issues | 13% |
| CSC Mail Issues | 10% |
| CSC Adjustments | 4% |
| CSC Clms Process Req | 3% |
| CSC Check Requests | 2% |
| CSC Member Escalation | 2% |
| CSC Med D Adjustmnt | 0% |
| All Others | 0% |
| Total: | 100% |

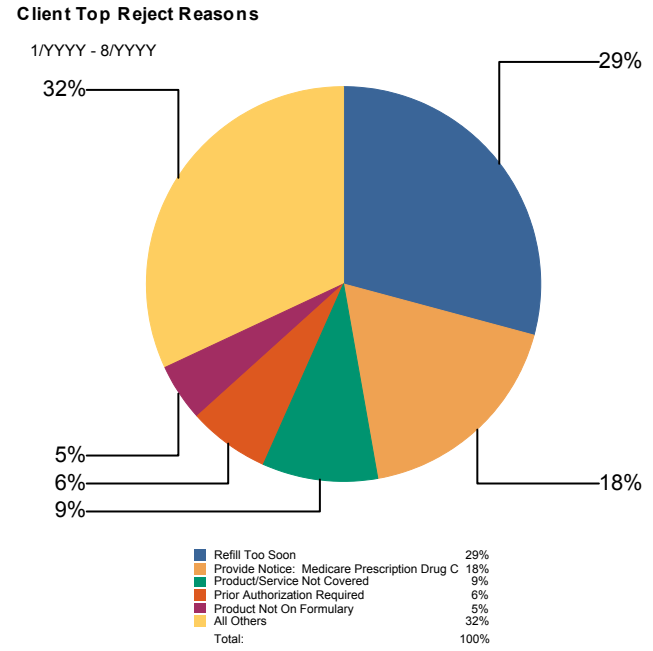
# Retail

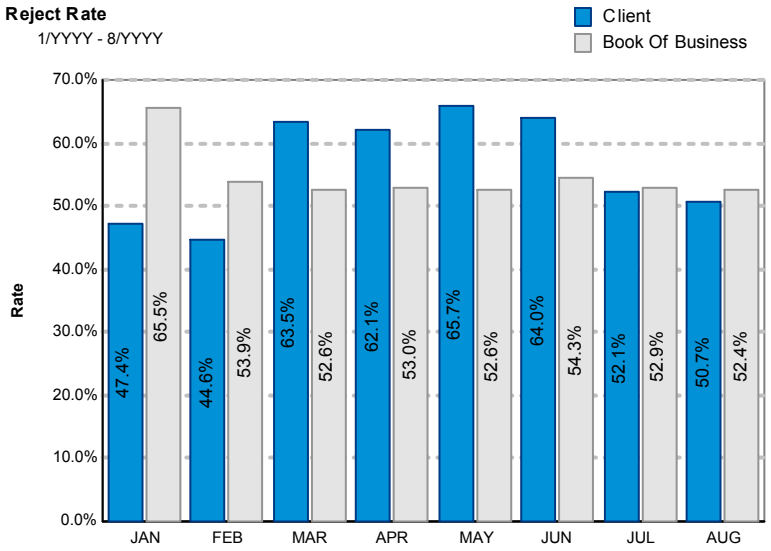
Express Scripts' services make prescription drug use safer and more affordable. And, our extensive pharmacy network allows patients to conveniently access medications at the retail level.Through our pharmacy audit program, we have several procedures to ensure patient safety. We monitor various State Board of Pharmacy websites to identify any pharmacies that have had actions taken against them,including those relating to quality of care. During on-site pharmacy audits, each auditor completes an observation documentation form that includes documenting any safety issues observed (e.g., proper drug storage, physical condition of facility, etc.).

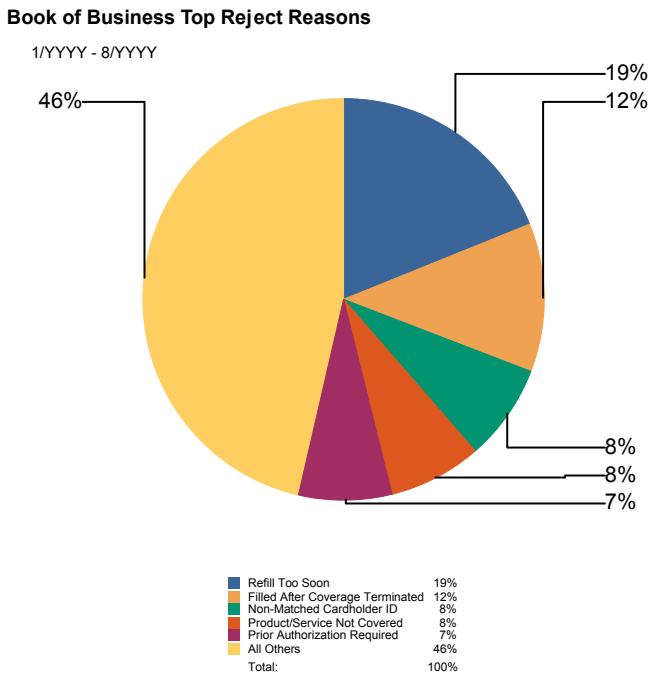
In addition, we also verify the following:

- Electronic patient profiles are properly used.
- Proper procedures are followed during the filling process, including the pharmacist's response to Express Scripts' DUR messaging.
- Proper counseling procedures are followed.
- All required safety inspection certifications are current and posted. (This is also part of our credentialing process.)
- Additional certification claimed by the pharmacist is documented and verified.
- All drugs, forms, strengths, and dosages are as prescribed.



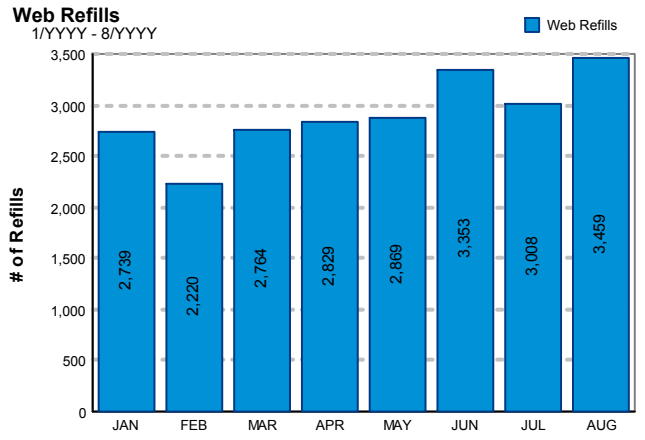
# Web

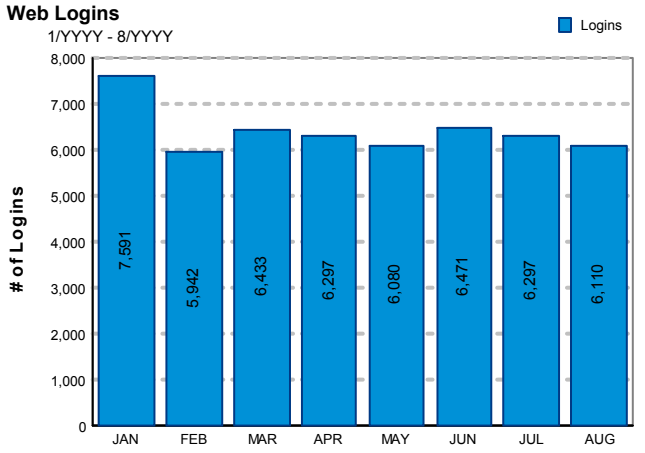
Our member portal provides access to features that help members get the most from their prescription-drug benefit.

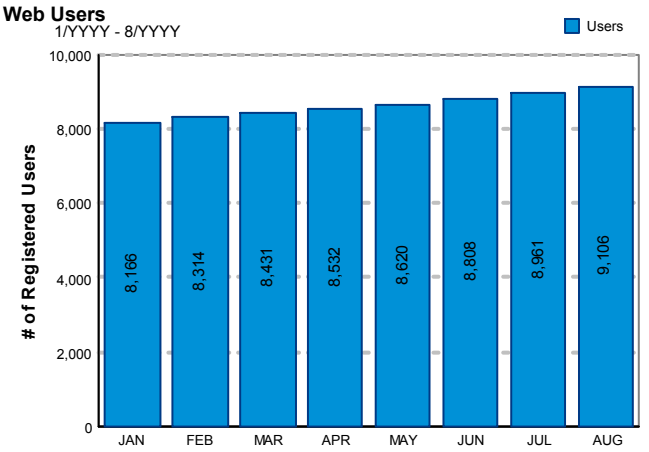
Member Portal Features 24/7 Access to:

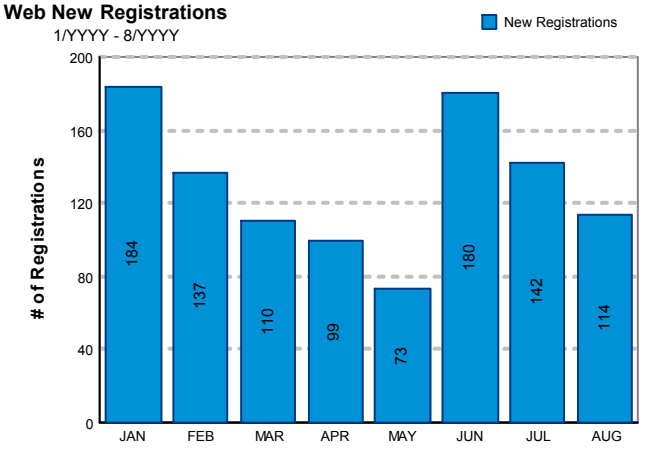
- Prescription Refills
- Out of pocket expenses with Price a Drug Prescription renewal requests
- Many ways to save on prescriptions, including Home Delivery Educational materials on generics, wellness, and disease management

In addition to the numerous member portal resources, the comprehensive Member Communications Catalog provides clients with letter templates, articles, e-mail campaign content, and buck slips that can be used to promote the use of Express-Scripts.com for members.



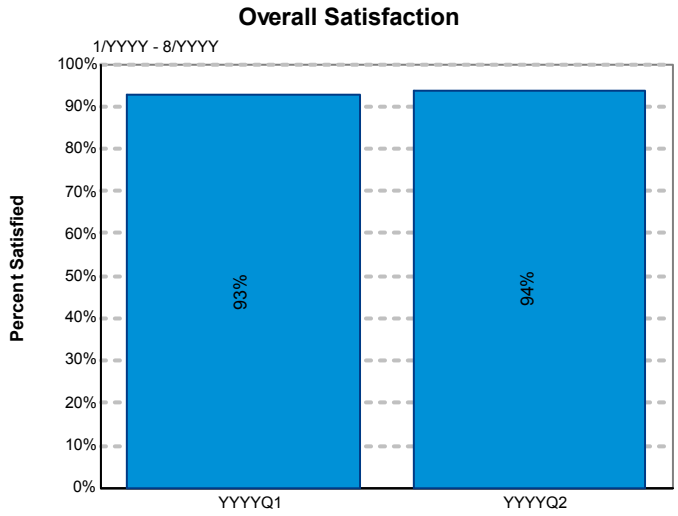



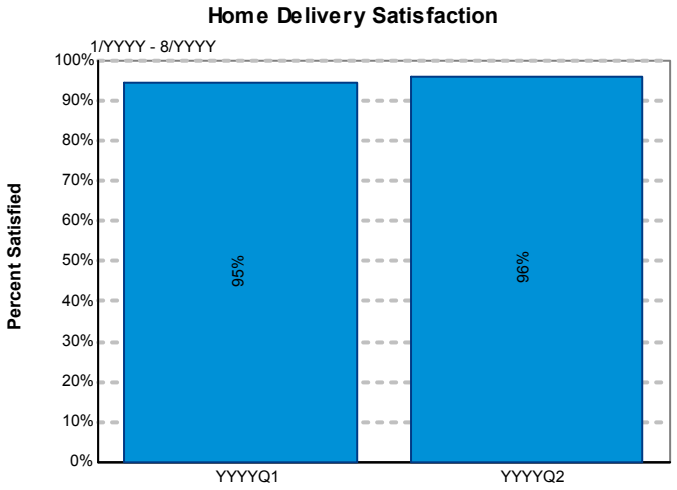



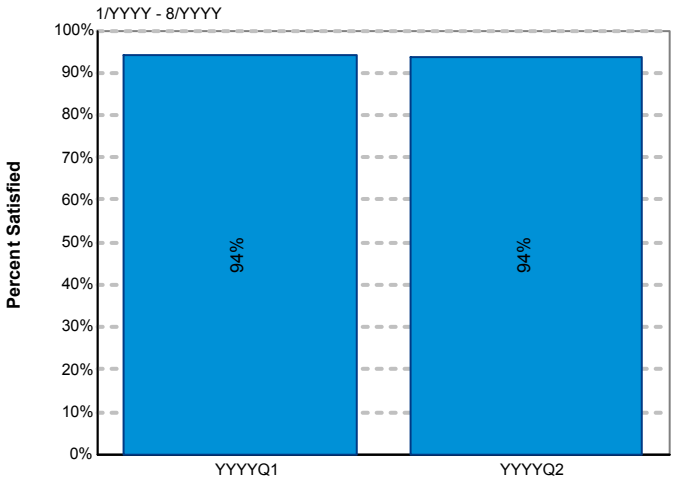
## Patient Satisfaction

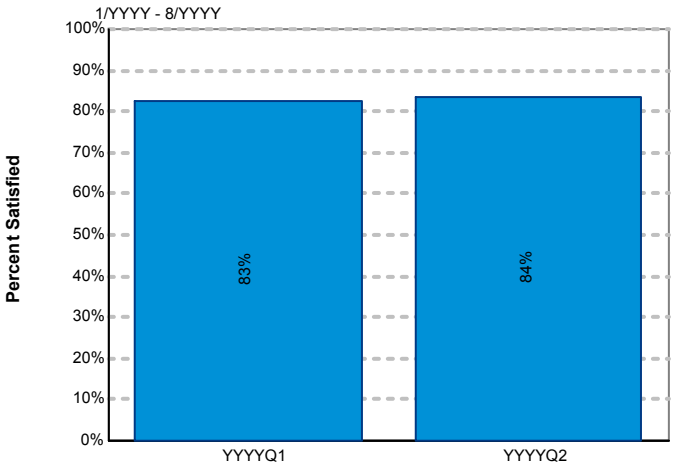
To measure member satisfaction, Express Scripts has an independent research firm conduct a monthly telephone survey of members randomly selected from the entire pool of Express Scripts clients. Members are interviewed about their satisfaction with Express Scripts overall service, home delivery service, retail pharmacy service, and our contact center service. Results from these surveys help Express Scripts identify improvement opportunities and truly gauge the voice of the customer.

The charts below show quarterly results from these surveys, with one chart for each of the following categories: Overall satisfaction with Express Scripts, satisfaction with home delivery service, satisfaction with retail pharmacies, and contact center satisfaction. Client specific results are not included as they may not be statistically significant.



# Home Delivery Metrics

*Detail Report*

*1/YYYY to 8/YYYY*

| | | # of Prescriptions Shipped | | | | Average Turn Around Time in business days | | | % of Prescriptions Shipped in X Days | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Clean Rx | | Intervention Rx | | | | | All Rx | | | | | | |
| | | Clean Rx | Intervention Rx | All Rx | Intervention Rate | Clean Rx | Intervention Rx | All Rx | 1 | 2 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 6 |
| YYYY | JAN | 4,939 | 8,036 | 12,975 | 62% | 0.65 | 1.29 | 1.05 | 83% | 97% | 67% | 87% | 93% | 97% | 98% | 73% | 91% | 96% | 98% | 99% | 99% |
| YYYY | FEB | 5,269 | 5,699 | 10,968 | 52% | 0.53 | 1.16 | 0.86 | 92% | 98% | 74% | 88% | 93% | 96% | 98% | 83% | 93% | 96% | 98% | 99% | 100% |
| YYYY | MAR | 6,544 | 6,208 | 12,752 | 49% | 0.85 | 1.41 | 1.12 | 80% | 98% | 65% | 86% | 92% | 96% | 97% | 72% | 92% | 96% | 98% | 98% | 99% |
| YYYY | APR | 6,416 | 5,548 | 11,964 | 46% | 0.64 | 1.21 | 0.91 | 89% | 97% | 72% | 88% | 93% | 96% | 98% | 81% | 93% | 96% | 98% | 99% | 100% |
| YYYY | MAY | 6,496 | 5,657 | 12,153 | 47% | 0.62 | 1.16 | 0.87 | 87% | 97% | 74% | 89% | 94% | 96% | 98% | 81% | 93% | 97% | 98% | 99% | 99% |
| YYYY | JUN | 6,917 | 6,375 | 13,292 | 48% | 1.08 | 1.49 | 1.28 | 71% | 96% | 60% | 87% | 93% | 97% | 98% | 65% | 92% | 96% | 98% | 99% | 99% |
| YYYY | JUL | 6,625 | 5,904 | 12,529 | 47% | 0.58 | 1.05 | 0.80 | 90% | 98% | 78% | 91% | 95% | 97% | 98% | 84% | 95% | 97% | 98% | 99% | 99% |
| YYYY | AUG | 6,919 | 6,559 | 13,478 | 49% | 0.51 | 0.96 | 0.73 | 93% | 98% | 80% | 92% | 96% | 97% | 98% | 87% | 95% | 98% | 98% | 99% | 99% |

Our Home Delivery process is designed to deliver medications to patients quickly and with incredible accuracy while assuring the greatest savings possible. With appropriate plan design, Home Delivery is a cost-effective solution for plan sponsors and members who use maintenance medications. On average, across Express Scripts' book of business, each prescription filled through Home Delivery costs up to 10% less than the same prescription filled at a local participating pharmacy.

Source: Pharmacy Benefit Guide. Drug Trend Report 2004. Express Scripts. June 2005.

**Definitions**

| | |
|---|---|
| Clean Rx | A prescription that requires no additional processing |
| Intervention Rx | A prescription that requires additional processing |
| Intervention Rate | The percentage of total prescriptions requiring additional processing |
| Turn Around Time | The number of business days between when a prescription is received and when it is shipped |
| % Rx Shipped in X Days | The percentage of prescriptions shipped within the given number of days from the date received |

*1/YYYY - 8/YYYY*

| | | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|---|
| Call Center | 17% | 17% | 19% | 18% | 16% | 15% | 16% | 17% | 18% |
| Transfers | 9.178 | 9.246 | 9.453 | 8.885 | 8.796 | 8.201 | 8.636 | 9.944 | 10.273 |
| Research Misc | 1.992 | 1.482 | 2.504 | 2.659 | 1.704 | 1.815 | 2.182 | 1.470 | 2.247 |
| Mbr Education | 1.594 | 2.172 | 1.920 | 1.876 | 1.382 | 1.516 | 1.034 | 1.200 | 1.238 |
| Mbr/Caller Prof | 1.144 | 1.497 | 1.503 | 1.505 | 1.335 | 0.574 | 0.804 | 0.833 | 0.803 |
| Rx Fax Req | 1.130 | 1.174 | 0.772 | 1.257 | 0.875 | 0.827 | 1.034 | 1.616 | 1.513 |
| Health Actn Pln | 1.125 | 0.514 | 1.565 | 0.866 | 1.359 | 1.241 | 1.240 | 1.151 | 1.399 |
| Returned Call | 0.282 | 0.382 | 0.438 | 0.247 | 0.322 | 0.207 | 0.138 | 0.147 | 0.298 |
| Communictn Scrn | 0.256 | 0.220 | 0.271 | 0.247 | 0.161 | 0.184 | 0.505 | 0.147 | 0.321 |
| Covg Inquiry | 0.113 | 0.073 | 0.230 | 0.124 | 0.230 | 0.046 | 0.046 | 0.049 | 0.115 |
| DCDP/Copay Inq | 0.034 | 0.073 | - | 0.062 | 0.046 | 0.023 | 0.023 | - | 0.023 |
| PA Inquiries | 0.008 | - | - | - | 0.023 | - | 0.023 | 0.024 | - |
| REFILLS | 14% | 12% | 14% | 14% | 15% | 15% | 14% | 15% | 17% |
| REFILL | 10.732 | 8.365 | 10.121 | 9.771 | 11.697 | 11.417 | 11.507 | 11.634 | 12.910 |
| RENEWALS | 2.374 | 2.319 | 2.671 | 2.659 | 2.257 | 2.228 | 1.746 | 2.376 | 2.706 |
| PEND RX | 0.482 | 0.367 | 0.605 | 0.598 | 0.576 | 0.368 | 0.459 | 0.392 | 0.527 |
| IVR/CSR REFILL | 0.274 | 0.279 | 0.188 | 0.392 | 0.184 | 0.368 | 0.230 | 0.367 | 0.183 |
| REFILL TOO SOON | 0.261 | 0.235 | 0.125 | 0.227 | 0.207 | 0.138 | 0.253 | 0.416 | 0.527 |
| LT/NT REC'D SLP | 0.005 | - | 0.042 | - | - | - | - | - | - |
| REF-OUT OF MED | 0.005 | - | - | - | 0.023 | 0.023 | - | - | - |
| #REFILL LEFT | 0.003 | - | - | - | 0.023 | - | - | - | - |
| PLA Required | 0.003 | - | - | - | - | - | - | 0.024 | - |
| REFILL EMAIL | 0.003 | 0.015 | - | - | - | - | - | - | - |
| Worry-free Fill | 0.003 | - | 0.021 | - | - | - | - | - | - |
| INFO REQUEST | 12% | 11% | 12% | 13% | 12% | 11% | 11% | 10% | 12% |
| PRICE QUOTE | 6.954 | 5.797 | 6.573 | 7.277 | 8.036 | 8.017 | 6.913 | 6.515 | 7.131 |
| INSTRUCTIONS | 3.001 | 4.124 | 4.299 | 3.484 | 2.993 | 1.585 | 2.159 | 1.935 | 2.545 |
| BENEFIT OVRVIEW | 1.238 | 1.174 | 0.981 | 1.299 | 0.829 | 1.149 | 1.194 | 1.102 | 2.224 |
| DRUG COVERAGE | 0.134 | 0.117 | 0.146 | 0.268 | 0.115 | 0.161 | 0.092 | 0.098 | 0.069 |
| PPO LOOKUP | 0.090 | 0.117 | 0.104 | 0.144 | 0.069 | 0.069 | 0.092 | 0.049 | 0.046 |
| FEEDBACK RCVD | 0.069 | 0.044 | 0.063 | 0.021 | 0.069 | 0.046 | 0.092 | 0.196 | 0.046 |
| MEDD EOB INQ | 0.066 | 0.088 | 0.063 | 0.041 | 0.046 | 0.184 | 0.046 | - | 0.046 |
| PRIOR AUTH LIST | 0.003 | - | - | - | 0.023 | - | - | - | - |
| SWITCH INQ | 0.003 | 0.015 | - | - | - | - | - | - | - |
| STATUS | 11% | 13% | 14% | 13% | 11% | 10% | 9% | 10% | 9% |
| ORDER STATUS | 11.196 | 12.489 | 13.836 | 13.441 | 10.845 | 9.993 | 9.049 | 9.650 | 8.920 |
| STATUS FAX RX | 0.013 | 0.015 | - | 0.021 | 0.023 | 0.046 | - | - | - |
| 15-21 DAYS | 0.003 | - | 0.021 | - | - | - | - | - | - |
| ELIG INQUIRY | 11% | 9% | 12% | 12% | 11% | 13% | 11% | 8% | 10% |
| ELIG INQ/INFO | 10.738 | 9.172 | 12.417 | 11.750 | 11.121 | 12.773 | 11.231 | 8.205 | 9.677 |
| RETAIL CLAIMS | 9% | 16% | 7% | 9% | 6% | 8% | 7% | 5% | 6% |
| CLAIM STATUS | 7.934 | 15.351 | 6.323 | 8.514 | 5.342 | 7.489 | 6.339 | 4.433 | 5.366 |
| CLAIM REJECTED | 0.456 | 0.440 | 0.522 | 0.289 | 0.599 | 0.505 | 0.436 | 0.490 | 0.390 |
| CLAIM ENTERED | 0.311 | 0.176 | 0.396 | 0.515 | 0.484 | 0.391 | 0.207 | 0.122 | 0.229 |
| CLAIM REVERSED | 0.008 | - | - | - | 0.069 | - | - | - | - |
| BILLING | 7% | 7% | 7% | 8% | 7% | 6% | 6% | 6% | 6% |
| BILLING | 3.128 | 3.552 | 3.422 | 3.958 | 3.339 | 2.757 | 2.435 | 2.964 | 2.224 |
| CREDIT CARD | 2.195 | 2.319 | 2.692 | 2.556 | 2.141 | 1.930 | 1.929 | 1.886 | 1.926 |
| DED/CAP/OOP | 1.178 | 1.145 | 1.210 | 1.299 | 1.036 | 0.850 | 1.148 | 1.372 | 1.376 |
| CREDIT | 0.034 | 0.059 | - | - | - | - | 0.115 | 0.098 | - |
| Patient Advct | 5% | 0% | 0% | 0% | 6% | 9% | 11% | 10% | 4% |
| Pat Adv Dashbd | 4.590 | 0.029 | - | - | 6.401 | 9.442 | 10.519 | 10.311 | 3.944 |
| MEDICATION | 4% | 3% | 3% | 3% | 4% | 3% | 5% | 6% | 5% |
| RPH INQUIRY | 1.383 | 1.145 | 0.981 | 1.361 | 1.888 | 1.562 | 1.562 | 1.347 | 1.399 |
| eSD STCXL Rx | 0.904 | 0.851 | 0.814 | 0.928 | 1.105 | 0.804 | 0.850 | 0.955 | 0.963 |
| QUICK START | 0.806 | 0.279 | 0.313 | 0.392 | 0.368 | 0.368 | 1.079 | 2.915 | 1.261 |
| MANAGED CARE | 0.456 | 0.367 | 0.543 | 0.330 | 0.276 | 0.414 | 0.620 | 0.612 | 0.550 |
| MEDICATION | 0.090 | 0.073 | 0.083 | 0.124 | 0.092 | 0.046 | 0.115 | 0.098 | 0.092 |
| Recode for Qty | 0.055 | - | - | 0.041 | 0.046 | 0.069 | 0.115 | 0.073 | 0.138 |
| Recode to Brnd | 0.047 | - | 0.021 | 0.041 | - | 0.092 | 0.138 | 0.098 | 0.023 |
| FAX REQUEST | 0.029 | 0.044 | - | 0.021 | - | - | 0.069 | 0.049 | 0.046 |
| INCOMING DRCALL | 0.029 | 0.029 | - | 0.082 | 0.023 | - | 0.023 | 0.024 | 0.046 |
| OUTGOING PTCALL | 0.016 | 0.044 | - | 0.021 | 0.046 | - | - | - | - |
| Dmgd-Dmgs | 0.013 | 0.015 | - | 0.021 | - | - | - | 0.049 | 0.023 |
| REQ TO STCXL RX | 0.008 | - | 0.021 | 0.041 | - | - | - | - | - |
| Dmgd-Tmp Sens | 0.005 | - | - | - | - | - | - | 0.024 | 0.023 |
| PROTOCOL | 0.005 | 0.015 | - | - | - | - | - | 0.024 | - |
| Recode to Gnrc | 0.005 | - | - | - | - | - | 0.023 | - | 0.023 |
| RX CLARIFICATN | 0.005 | - | - | - | - | - | 0.023 | 0.024 | - |
| DISP LIMIT | 0.003 | - | - | - | 0.023 | - | - | - | - |
| VARIABLE FILL | 0.003 | - | - | 0.021 | - | - | - | - | - |
| MISCELLANEOUS | 4% | 3% | 3% | 3% | 2% | 4% | 4% | 5% | 6% |
| Personal Addrs | 1.051 | 0.264 | 0.271 | 0.186 | 0.207 | 1.011 | 1.746 | 2.523 | 2.912 |
| ADDRESSOVERRIDE | 1.030 | 0.881 | 0.876 | 1.010 | 0.599 | 1.746 | 1.286 | 0.882 | 1.055 |
| Opps Initiated | 0.343 | 0.382 | 0.584 | 0.350 | 0.322 | 0.253 | 0.299 | 0.343 | 0.161 |
| Cancel Rx | 0.237 | 0.264 | 0.271 | 0.186 | 0.345 | 0.161 | 0.184 | 0.220 | 0.252 |
| Temp Addr | 0.235 | 0.411 | 0.376 | 0.206 | 0.207 | 0.138 | 0.092 | 0.098 | 0.229 |
| Med D Adjustmen | 0.206 | 0.161 | 0.167 | 0.186 | 0.253 | 0.138 | 0.230 | 0.171 | 0.367 |
| ORDR RSCH | 0.105 | 0.323 | 0.063 | 0.041 | 0.138 | 0.023 | 0.046 | 0.073 | 0.023 |
| IVR ASSIST | 0.097 | 0.044 | 0.104 | 0.165 | 0.092 | 0.092 | 0.046 | 0.171 | 0.092 |
| Other | 0.092 | 0.073 | 0.063 | 0.165 | 0.046 | 0.046 | 0.115 | 0.049 | 0.183 |
| Cust. Service | 0.047 | 0.044 | 0.021 | 0.082 | 0.046 | 0.069 | 0.046 | - | 0.069 |
| Billing Addr | 0.045 | 0.044 | 0.021 | 0.062 | 0.046 | 0.069 | - | 0.073 | 0.046 |
| Dependency Ver | 0.037 | 0.044 | 0.125 | 0.021 | - | - | 0.023 | - | 0.069 |
| Outbound Cont | 0.026 | - | - | - | 0.046 | 0.046 | 0.046 | 0.024 | 0.069 |
| Conf/Privacy | 0.024 | 0.015 | 0.125 | 0.021 | - | - | - | - | 0.023 |
| Rcon Eventshort | 0.016 | 0.015 | 0.021 | - | 0.023 | - | 0.046 | - | 0.023 |
| Debit Card | 0.008 | - | - | - | 0.023 | - | 0.023 | - | 0.023 |

*1/YYYY - 8/YYYY*

| | | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|---|
| OUTBOUND MSSG | 0.008 | - | - | 0.021 | 0.023 | - | - | 0.024 | - |
| eSD BE CXL Rx | 0.005 | 0.015 | - | - | - | - | 0.023 | - | - |
| Language Pref | 0.005 | - | - | - | - | - | 0.046 | - | - |
| Rcon Event list | 0.005 | - | - | - | 0.023 | - | - | 0.024 | - |
| Declines | 0.003 | - | - | - | - | 0.023 | - | - | - |
| Free Fm Fax Rqs | 0.003 | - | - | - | 0.023 | - | - | - | - |
| HR RPH CONSULT | 0.003 | - | - | - | 0.023 | - | - | - | - |
| THANK YOU | 0.003 | - | - | - | - | - | 0.023 | - | - |
| TransitionSply | 0.003 | - | - | - | - | - | - | 0.024 | - |
| **BROADVISION** | **3%** | **3%** | **2%** | **2%** | **4%** | **3%** | **4%** | **4%** | **4%** |
| WEB REGISTRATN | 2.224 | 1.996 | 1.419 | 1.381 | 2.694 | 1.792 | 3.101 | 2.964 | 2.798 |
| SPECIALTY DRUG | 0.577 | 0.675 | 0.584 | 0.371 | 0.691 | 0.597 | 0.482 | 0.637 | 0.550 |
| WEB PROFILE UPD | 0.203 | 0.235 | 0.271 | 0.124 | 0.230 | 0.115 | 0.207 | 0.294 | 0.138 |
| WEB SESSION | 0.079 | 0.059 | 0.083 | 0.103 | 0.069 | 0.069 | 0.092 | 0.073 | 0.092 |
| **INTERNET** | **1%** | **1%** | **2%** | **2%** | **2%** | **1%** | **0%** | **1%** | **1%** |
| PASSWORD RESET | 0.661 | 0.778 | 1.002 | 0.989 | 0.921 | 0.391 | 0.276 | 0.245 | 0.527 |
| ANY RX AT MAIL | 0.137 | 0.132 | 0.396 | 0.103 | 0.138 | 0.092 | 0.023 | 0.147 | 0.046 |
| MISC. RESEARCH | 0.126 | 0.117 | 0.063 | 0.309 | 0.276 | 0.092 | 0.046 | 0.073 | 0.023 |
| INTERNET | 0.090 | 0.117 | 0.125 | 0.103 | 0.115 | 0.069 | 0.046 | 0.073 | 0.046 |
| NEW RX-CONFIRM | 0.084 | 0.103 | 0.125 | 0.144 | 0.069 | 0.115 | 0.023 | 0.024 | 0.046 |
| **SUPERVISOR** | **1%** | **2%** | **1%** | **0%** | **1%** | **0%** | **0%** | **0%** | **0%** |
| SUPV INTER | 0.611 | 1.923 | 0.835 | 0.371 | 0.829 | 0.046 | 0.023 | 0.024 | 0.069 |
| **SUPPLIES** | **0%** | **1%** | **1%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| SOA/EOB | 0.306 | 0.851 | 0.647 | 0.247 | 0.023 | 0.184 | 0.023 | - | 0.115 |
| BR & ENV RQST | 0.013 | 0.059 | - | - | - | 0.023 | - | - | - |
| **Managed Care** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| TRC Call | 0.132 | 0.015 | 0.146 | 0.206 | 0.207 | 0.023 | 0.092 | 0.049 | 0.367 |
| **HIPAA** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| PRVCY SUP XFER | 0.119 | 0.249 | 0.104 | - | - | - | - | 0.441 | 0.115 |
| **How to use Home** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| How to Use Home | 0.071 | 0.015 | 0.063 | 0.021 | 0.069 | 0.092 | 0.207 | 0.147 | - |
| MailToLocation | 0.013 | - | - | - | 0.046 | 0.046 | 0.023 | - | - |
| NewRxDelvryProc | 0.003 | - | 0.021 | - | - | - | - | - | - |
| **EMAIL STATUS** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **1%** |
| EZ REGISTRATION | 0.079 | - | - | - | - | - | - | 0.073 | 0.619 |
| REGSTRTN UPGRDE | 0.003 | - | 0.021 | - | - | - | - | - | - |
| **Prof Prac** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| ENC Resolved | 0.079 | 0.044 | 0.104 | 0.186 | 0.023 | 0.092 | 0.046 | 0.073 | 0.069 |
| ENC Confirmed | 0.003 | - | - | - | - | - | - | 0.024 | - |
| **YOUR RX** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| MISDIRECTD CALL | 0.021 | 0.015 | - | 0.041 | 0.046 | 0.023 | - | - | 0.046 |
| **Card Benefit** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Card Benefit | 0.008 | - | - | - | 0.046 | - | - | - | 0.023 |
| Card-Co-payment | 0.005 | - | - | - | - | 0.046 | - | - | - |
| Card-DaysSupply | 0.003 | - | - | - | - | 0.023 | - | - | - |
| CardGroupRefill | 0.003 | - | - | - | - | - | - | 0.024 | - |
| **Home Dlvry Bnft** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Home Dlvry Bnft | 0.013 | - | - | 0.062 | 0.023 | - | - | 0.024 | - |
| HomeCopayPlus | 0.003 | - | 0.021 | - | - | - | - | - | - |
| **QUANTITY** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| SHRT CNT-NOCTRL | 0.008 | 0.044 | - | - | - | - | - | - | - |
| QTY DISPUTE | 0.003 | - | - | - | - | - | 0.023 | - | - |
| **Benefit Elig** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Benefit Elig | 0.005 | - | - | - | - | - | - | 0.024 | 0.023 |
| MedD Benefit | 0.003 | - | - | - | - | - | 0.023 | - | - |
| **PACKAGING** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| NON-SAFE CAPS | 0.008 | - | - | - | - | - | - | 0.024 | 0.046 |
| **PRIOR AUTH** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| PRIOR AUTH | 0.008 | - | 0.021 | 0.021 | 0.023 | - | - | - | - |
| **Hot Topics** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Specialty Pharm | 0.005 | - | - | - | 0.023 | - | - | - | 0.023 |
| **CAP/OOP/DED** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Deductible | 0.003 | 0.015 | - | - | - | - | - | - | - |
| **CDP** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| CLOSED FORM | 0.003 | - | - | - | 0.023 | - | - | - | - |
| **PHARMACY CONTACT** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| OUT OF STOCK | 0.003 | - | - | 0.021 | - | - | - | - | - |
| **RETAIL PHARMACIES** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| ENROLLMENT | 0.003 | - | - | - | 0.023 | - | - | - | - |
| **RX DIRECT** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| DR DIRECT RX | 0.003 | 0.015 | - | - | - | - | - | - | - |
| **Specialty** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| RefRxHome | 0.003 | - | - | - | - | - | - | - | 0.023 |
| **Others** | **2%** | **2%** | **3%** | **3%** | **2%** | **2%** | **2%** | **2%** | **3%** |

*1/YYYY - 8/YYYY*

**MAIL**

| | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|
| Provide Notice: Medicare Prescription Drug Coverage and Your Rights | 35.628% | 34.638% | 37.147% | 41.615% | 40.034% | 39.741% | 38.741% | 37.728% |
| Prior Authorization Required | 22.180% | 22.065% | 24.222% | 22.314% | 20.331% | 22.685% | 18.721% | 25.659% |
| Product Not On Formulary | 5.067% | 5.412% | 6.798% | 13.644% | 9.210% | 6.389% | 9.427% | 5.544% |
| Plan Limitations Exceeded | 5.609% | 4.038% | 4.548% | 5.173% | 9.980% | 9.598% | 10.093% | 5.105% |
| M/I Cardholder ID | 6.055% | 6.619% | 7.180% | 5.316% | 7.129% | 7.656% | 4.997% | 8.418% |
| Product/Service Not Covered | 5.003% | 5.371% | 3.159% | 2.729% | 2.481% | 3.349% | 2.365% | 4.361% |
| Prescriber Data Base Not Able to Verify Active State License with Prescriptive Authority for Prescriber ID Submitted | 8.158% | 6.953% | 5.457% | 0.682% | 0.000% | 3.012% | 0.999% | 1.082% |
| Claim Not Processed | 1.912% | 4.704% | 3.638% | 2.302% | 1.682% | 2.167% | 2.199% | 2.705% |
| M/I Prescriber ID | 3.410% | 1.749% | 1.532% | 0.483% | 0.228% | 0.478% | 2.831% | 0.541% |
| Date Written Is After Date Filled | 0.637% | 2.040% | 1.628% | 1.535% | 2.566% | 0.225% | 0.633% | 1.487% |
| Pharmacy Must Notify Beneficiary: Claim Not Covered Due to Failure to Meet Medicare Part D Active, Valid Prescriber NPI Requirements | 0.000% | 0.000% | 0.000% | 0.000% | 1.027% | 0.478% | 2.831% | 1.386% |
| Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired | 1.562% | 0.333% | 0.000% | 0.000% | 0.741% | 0.000% | 0.000% | 0.778% |
| Product/Service ID Qualifier Does Not Precede Product/Service ID | 0.096% | 1.166% | 0.527% | 0.227% | 0.456% | 0.169% | 0.167% | 0.642% |
| M/I Request Claim Segment | 0.096% | 1.166% | 0.527% | 0.227% | 0.456% | 0.169% | 0.167% | 0.642% |
| M/I Product/Service ID Qualifier | 0.096% | 1.166% | 0.527% | 0.227% | 0.456% | 0.169% | 0.167% | 0.642% |
| Patient Is Not Covered | 0.382% | 0.000% | 0.527% | 0.000% | 0.029% | 0.844% | 0.966% | 0.000% |
| Scheduled Downtime | 0.096% | 0.167% | 0.431% | 0.625% | 0.114% | 0.507% | 0.300% | 0.270% |
| Discontinued Product/Service ID Number | 0.064% | 0.208% | 0.574% | 0.000% | 0.542% | 0.000% | 0.766% | 0.000% |
| Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found | 0.223% | 0.167% | 0.287% | 0.483% | 0.143% | 0.535% | 0.067% | 0.000% |
| Product May Be Covered Under Hospice - Medicare A | 0.542% | 0.333% | 0.000% | 0.000% | 0.000% | 0.000% | 0.733% | 0.000% |
| M/I Group ID | 0.000% | 0.000% | 0.335% | 0.000% | 0.000% | 0.000% | 0.799% | 0.135% |
| Days Supply Exceeds Plan Limitation | 0.000% | 0.000% | 0.000% | 0.881% | 0.114% | 0.000% | 0.000% | 0.000% |
| Product Not FDA/NSDE Listed | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.845% |
| Non-Matched Cardholder ID | 0.605% | 0.250% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| Filled After Coverage Terminated | 0.223% | 0.000% | 0.096% | 0.142% | 0.029% | 0.000% | 0.000% | 0.000% |
| Not Covered Under Part D Law | 0.159% | 0.208% | 0.000% | 0.085% | 0.000% | 0.000% | 0.000% | 0.000% |
| Must Fill Through Specialty Pharmacy | 0.000% | 0.000% | 0.000% | 0.085% | 0.143% | 0.000% | 0.000% | 0.000% |
| M/I Date Prescription Written | 0.064% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |

1/YYYY - 8/YYYY

| | | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|---|
| | Other | 2.135% | 1.249% | 0.862% | 1.222% | 2.110% | 1.829% | 2.032% | 2.028% |
| **RETAIL** | | | | | | | | | |
| | Refill Too Soon | 24.412% | 27.570% | 28.023% | 27.094% | 27.930% | 28.189% | 33.702% | 35.794% |
| | Provide Notice: Medicare Prescription Drug Coverage and Your Rights | 15.289% | 17.741% | 19.291% | 20.024% | 19.840% | 20.433% | 16.646% | 15.971% |
| | Product/Service Not Covered | 9.157% | 10.059% | 10.398% | 9.087% | 9.668% | 9.808% | 8.518% | 9.328% |
| | Prior Authorization Required | 5.151% | 6.049% | 6.719% | 6.878% | 6.783% | 7.951% | 6.615% | 5.835% |
| | Product Not On Formulary | 3.201% | 4.013% | 4.811% | 6.590% | 6.240% | 6.076% | 4.142% | 4.787% |
| | DUR Reject Error | 4.878% | 5.720% | 5.334% | 4.841% | 5.298% | 4.497% | 4.069% | 4.091% |
| | M/I Processor Control Number | 5.996% | 3.830% | 3.416% | 3.674% | 3.355% | 2.828% | 2.597% | 2.552% |
| | M/I Cardholder ID | 6.496% | 3.091% | 2.499% | 2.324% | 1.909% | 1.582% | 1.718% | 1.366% |
| | Plan Limitations Exceeded | 1.490% | 1.864% | 2.103% | 2.848% | 2.906% | 2.713% | 2.322% | 1.939% |
| | Not Covered Under Part D Law | 1.525% | 1.717% | 1.894% | 1.570% | 1.321% | 1.461% | 0.297% | 0.000% |
| | Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found | 1.829% | 1.615% | 0.574% | 0.717% | 0.779% | 0.932% | 0.652% | 0.916% |
| | Prescriber Data Base Not Able to Verify Active State License with Prescriptive Authority for Prescriber ID Submitted | 3.388% | 2.098% | 0.161% | 0.210% | 0.104% | 0.296% | 0.629% | 0.393% |
| | M/I Group ID | 1.487% | 0.754% | 0.660% | 1.113% | 0.984% | 0.793% | 0.680% | 0.799% |
| | M/I Professional Service Code | 0.028% | 0.234% | 0.096% | 0.051% | 0.097% | 0.056% | 2.788% | 1.973% |
| | M/I Result Of Service Code | 0.028% | 0.084% | 0.133% | 0.061% | 0.090% | 0.045% | 2.756% | 2.020% |
| | Submission Clarification Code Not Supported | 2.388% | 1.410% | 0.226% | 0.139% | 0.101% | 0.083% | 0.089% | 0.359% |
| | Submit Bill To Other Processor Or Primary Payer | 0.727% | 0.363% | 0.564% | 0.179% | 0.751% | 0.654% | 0.428% | 0.573% |
| | Patient Is Not Covered | 0.596% | 0.637% | 0.503% | 0.697% | 0.177% | 0.591% | 0.192% | 0.223% |
| | The Packaging Methodology Or Dispensing Frequency Is Missing Or Inappropriate For LTC Short Cycle | 0.208% | 0.381% | 0.332% | 0.379% | 0.567% | 0.442% | 0.393% | 0.374% |
| | Days Supply Exceeds Plan Limitation | 0.376% | 0.267% | 0.486% | 0.152% | 0.316% | 0.310% | 0.153% | 0.132% |
| | Multiple Transactions Not Supported | 0.183% | 0.106% | 0.677% | 0.254% | 0.163% | 0.153% | 0.172% | 0.154% |
| | M/I Prescriber Last Name | 0.171% | 0.154% | 0.209% | 0.257% | 0.146% | 0.264% | 0.150% | 0.264% |
| | Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired | 1.214% | 0.059% | 0.000% | 0.000% | 0.000% | 0.000% | 0.006% | 0.000% |
| | M/I Submission Clarification Code | 0.118% | 0.165% | 0.106% | 0.173% | 0.222% | 0.191% | 0.195% | 0.183% |
| | Product May Be Covered Under Hospice - Medicare A | 0.068% | 0.066% | 0.106% | 0.125% | 0.108% | 0.282% | 0.093% | 0.129% |
| | Non-Matched Product/Service ID Number | 0.056% | 0.128% | 0.082% | 0.115% | 0.111% | 0.122% | 0.195% | 0.104% |
| | Scheduled Downtime | 0.149% | 0.121% | 0.055% | 0.135% | 0.191% | 0.070% | 0.096% | 0.041% |

*1/YYYY - 8/YYYY*

| | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|
| Claim Too Old | 0.050% | 0.183% | 0.144% | 0.085% | 0.003% | 0.003% | 0.134% | 0.195% |
| Quantity Does Not Match Dispensing Unit | 0.121% | 0.081% | 0.075% | 0.152% | 0.129% | 0.003% | 0.022% | 0.031% |
| Product Not FDA/NSDE Listed | 0.003% | 0.011% | 0.048% | 0.020% | 0.028% | 0.003% | 0.000% | 0.428% |
| Claim Not Processed | 0.062% | 0.040% | 0.034% | 0.014% | 0.049% | 0.017% | 0.256% | 0.041% |
| Duplicate Refills | 0.050% | 0.011% | 0.038% | 0.271% | 0.028% | 0.056% | 0.022% | 0.016% |
| M/I Special Packaging Indicator | 0.043% | 0.022% | 0.065% | 0.051% | 0.066% | 0.094% | 0.048% | 0.072% |
| Non-Matched Cardholder ID | 0.043% | 0.007% | 0.174% | 0.017% | 0.143% | 0.017% | 0.013% | 0.003% |
| Pharmacy Not Contracted in Long Term Care Network | 0.000% | 0.000% | 0.356% | 0.027% | 0.000% | 0.000% | 0.000% | 0.000% |
| Pharmacy Not Contracted in 90 Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 90 days supply of drugs) | 0.047% | 0.037% | 0.072% | 0.014% | 0.042% | 0.042% | 0.064% | 0.031% |
| Discontinued Product/Service ID Number | 0.043% | 0.059% | 0.051% | 0.054% | 0.021% | 0.083% | 0.019% | 0.013% |
| M/I Bin Number | 0.081% | 0.176% | 0.072% | 0.000% | 0.014% | 0.000% | 0.003% | 0.000% |
| Pharmacy Not Contracted With Plan On Date Of Service | 0.031% | 0.022% | 0.024% | 0.037% | 0.066% | 0.077% | 0.045% | 0.000% |
| Patient Relationship Code Not Supported | 0.043% | 0.000% | 0.017% | 0.003% | 0.007% | 0.003% | 0.172% | 0.038% |
| M/I Prior Authorization Number Submitted | 0.012% | 0.018% | 0.082% | 0.020% | 0.010% | 0.077% | 0.006% | 0.035% |
| M/I Prescriber ID | 0.047% | 0.059% | 0.027% | 0.003% | 0.000% | 0.014% | 0.061% | 0.019% |
| M/I Patient Relationship Code | 0.043% | 0.000% | 0.010% | 0.000% | 0.000% | 0.003% | 0.150% | 0.000% |
| M/I Date of Service | 0.078% | 0.018% | 0.021% | 0.030% | 0.021% | 0.017% | 0.019% | 0.006% |
| Filled After Coverage Terminated | 0.019% | 0.084% | 0.034% | 0.010% | 0.017% | 0.014% | 0.003% | 0.031% |
| M/I Route of Administration | 0.000% | 0.018% | 0.000% | 0.054% | 0.038% | 0.017% | 0.019% | 0.025% |
| M/I Prescription Origin Code | 0.040% | 0.022% | 0.034% | 0.010% | 0.010% | 0.003% | 0.013% | 0.025% |
| Non-Matched Pharmacy Number | 0.019% | 0.007% | 0.007% | 0.000% | 0.003% | 0.003% | 0.022% | 0.082% |
| Non-Matched Group ID | 0.000% | 0.000% | 0.130% | 0.007% | 0.007% | 0.003% | 0.000% | 0.000% |
| M/I Date Prescription Written | 0.000% | 0.033% | 0.014% | 0.017% | 0.000% | 0.000% | 0.048% | 0.031% |
| M/I DUR/PPS Level Of Effort | 0.003% | 0.007% | 0.024% | 0.058% | 0.000% | 0.000% | 0.029% | 0.009% |
| M/I Pharmacy Service Type | 0.012% | 0.000% | 0.000% | 0.000% | 0.035% | 0.003% | 0.013% | 0.060% |
| Pharmacy Must Notify Beneficiary: Claim Not Covered Due to Failure to Meet Medicare Part D Active, Valid Prescriber NPI Requirements | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.014% | 0.067% | 0.019% |
| M/I Prior Authorization Type Code | 0.000% | 0.015% | 0.024% | 0.000% | 0.010% | 0.014% | 0.013% | 0.013% |
| Date Written Is After Date Filled | 0.003% | 0.000% | 0.014% | 0.010% | 0.000% | 0.003% | 0.032% | 0.006% |

1/YYYY - 8/YYYY

| | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|
| Patient Residence not supported by plan | 0.000% | 0.007% | 0.014% | 0.037% | 0.003% | 0.000% | 0.000% | 0.000% |
| Compounds Not Covered | 0.016% | 0.000% | 0.003% | 0.007% | 0.003% | 0.003% | 0.016% | 0.006% |
| M/I Reason For Service Code | 0.003% | 0.000% | 0.044% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| M/I Request Coordination Of Benefits/Other Payments Segment | 0.003% | 0.004% | 0.007% | 0.000% | 0.000% | 0.000% | 0.000% | 0.031% |
| Use Prior Authorization Code Provided For Emergency Fill | 0.000% | 0.026% | 0.003% | 0.000% | 0.000% | 0.003% | 0.010% | 0.003% |
| Duplicate Paid/Captured Claim | 0.000% | 0.000% | 0.007% | 0.000% | 0.017% | 0.014% | 0.000% | 0.000% |
| Plans Prescriber Database Indicates the Associated DEA to Submitted Prescriber ID is Inactive | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.028% |
| Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.028% |
| Filled Before Coverage Effective | 0.000% | 0.022% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.006% |
| Diagnosis Code Qualifier Submitted Not Covered | 0.012% | 0.004% | 0.000% | 0.000% | 0.007% | 0.003% | 0.003% | 0.000% |
| M/I Other Payer ID | 0.003% | 0.015% | 0.007% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% |
| Reversal Request Outside Processor Reversal Window | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.019% | 0.000% |
| M/I Product/Service ID Qualifier | 0.000% | 0.000% | 0.010% | 0.000% | 0.007% | 0.000% | 0.000% | 0.006% |
| M/I Other Payer ID Qualifier | 0.003% | 0.015% | 0.007% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Intermediary Authorization Type ID | 0.000% | 0.000% | 0.003% | 0.003% | 0.000% | 0.003% | 0.000% | 0.013% |
| Product Not Covered Non-Participating Manufacturer | 0.000% | 0.018% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% |
| M/I Person Code | 0.009% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.006% |
| Repackaged Product Not Covered By the Contract | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.009% |
| M/I Days Supply | 0.012% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| Refills Are Not Covered | 0.000% | 0.011% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| Quantity Dispensed Exceeds Maximum Allowed | 0.000% | 0.000% | 0.000% | 0.000% | 0.010% | 0.000% | 0.000% | 0.000% |
| Product/Service ID Qualifier Value Not Supported | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.010% | 0.000% |
| M/I Usual And Customary Charge | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.009% |
| M/I Prescriber State/Province Address | 0.009% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| Future Date Prescription Written Not Allowed | 0.003% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% |
| Value In Gross Amount Due Does Not Follow Pricing Formulae | 0.000% | 0.000% | 0.007% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Product/Service ID | 0.000% | 0.000% | 0.000% | 0.000% | 0.007% | 0.000% | 0.000% | 0.000% |
| M/I Intermediary Authorization ID | 0.000% | 0.000% | 0.000% | 0.007% | 0.000% | 0.000% | 0.000% | 0.000% |

*1/YYYY - 8/YYYY*

| | YYYY JAN | YYYY FEB | YYYY MAR | YYYY APR | YYYY MAY | YYYY JUN | YYYY JUL | YYYY AUG |
|---|---|---|---|---|---|---|---|---|
| M/I Dispense As Written (DAW)/Product Selection Code | 0.000% | 0.000% | 0.000% | 0.003% | 0.003% | 0.000% | 0.000% | 0.000% |
| Refills Exceed allowable Refills | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% |
| Other Payer ID Qualifier Not Supported | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| M/I Unit Of Measure | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Quantity Dispensed | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Primary Care Provider ID | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Prescriber ID Qualifier | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| M/I Other Payer Reject Count | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% |
| M/I Ingredient Cost Submitted | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| M/I Gross Amount Due | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| M/I Diagnosis Code Qualifier | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% |
| M/I Basis Of Cost Determination | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% | 0.000% | 0.000% |
| Compound Segment Required For Adjudication | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| Compound Segment Present On A Non-Compound Claim | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| Compound Requires Two Or More Ingredients | 0.000% | 0.000% | 0.000% | 0.000% | 0.003% | 0.000% | 0.000% | 0.000% |
| Other | 8.424% | 8.653% | 8.818% | 9.293% | 9.007% | 8.559% | 8.346% | 8.311% |

## Glossary of Terms - Operational Performance Report

| | |
|---|---|
| **Abandonment Rate** | The percentage of calls where a caller hangs up after waiting 30 seconds, or longer, for their call to be answered by a patient care advocate. |
| **Average Seconds to Answer** | The average amount of time, in seconds, a caller waits to have their call answered, includes callers handled by IVR (where applicable). |
| **Call Reason** | The reason(s) a call was initiated to ESI, as identified by the patient care or client service center advocate. |
| **Call Service Level** | The percentage of calls answered within 60 seconds. |
| **% Clean Rx Handled In 2 days** | The percentage of Clean prescriptions shipped within 2 Business days of receipt at ESI. |
| **Clean Script (Rx)** | Prescription containing complete information requiring no intervention before processing. |
| **Home Delivery Rxs by Month** | The total number of prescriptions filled and shipped from an ESI home delivery pharmacy. |
| **Intervention Rate** | The percentage of total prescriptions shipped requiring manual intervention, via outreach to a physician or member, to complete processing. |
| **% Intervention Rx Handled in 5 days** | The percentage of Intervention scripts shipped within 5 Business days of receipt at ESI. |
| **Intervention Script (Rx)** | Prescription requiring outreach to a physician or member to complete processing. |
| **IVR** | Interactive Voice Response system available 24 hours a day, 365 days a year. |
| **Refills by Source** | The number of home delivery prescriptions shipped from each of eight possible sources: Customer Service, Fax, IVR, Point of Care,Web,Rx Direct,Postal and Others. |
| **Reiect Rate** | The percentage of total prescriptions which were not successfully filled. |
| **Reiect Reason** | Why a prescription was not filled at either a mail or retail pharmacy. |
| **Retail Rxs by Month** | The count of prescriptions filled at a retail pharmacy. |
| **Total Calls by Month** | The number of member calls logged by the patient care advocates. |
| **Total Client Issues by Month** | The number of client reported issues logged by the Client Service Center (CSC). |
| **Web Logins** | The number of times a member successfully logs into the ESI web site. |
| **Web New Registrations** | The count of new registered ESI web site users during the reporting period. |
| **Web Refills** | The number of refills requested through the ESI web site. Patients must be registered on the site before a refill can be submitted. |
| **Web Users** | The cumulative count of the patients registered to use the ESI web site. |
| ***** | Indicates the Section is grouped on Group ID level |

# Summary Report

PROGRAM: ELG0830B EXPRESS SCRIPTS HOLDING COMPANY. DATE: MM/DD/YY
REPORT : RPT0830A ELIGIBILITY PRE-EDIT ENROLLMENT STATISTICS TIME: 06:50
RUN-ID : 7108-13210-01 FIELD EDIT / SUSPENSE SUMMARY REPORT PAGE: 1

R E C O R D T O T A L S

**********

| | |
|---|---|
| RECORDS READ ON CLIENT INPUT FILE . . . . . | 214 |
| RECORDS WRITTEN TO GROUP SUSPENSE FILE . . . . . (-) | 1 |
| RECORDS WRITTEN TO USER GROUP SUSPENSE FILE . . . . . (-) | 0 |
| RECORDS WRITTEN TO LOCATOR SUSPENSE . . . . . (-) | 0 |
| RECORDS WRITTEN TO FINANCIAL HOLD FILE . . . . . (-) | 0 |
| RECORDS BYPASSED DUE TO INVALID DATA WITH SUSPENSE ERROR (-) | 0 |
| RECORDS BYPASSED DUE TO INVALID DATA . . . . . (-) | 0 |
| RECORDS BYPASSED DUE TO REFORMAT ERRORS. . . . . (-) | 0 |
| RECORDS WRITTEN TO PAID TRANSACTION FILE . . . . . | 213 |

G R O U P T O T A L S

**********

| | |
|---|---|
| NUMBER OF GROUPS ON INPUT FILE . . . . . | 14 |
| NUMBER OF GROUPS ON SUSPENSE . . . . . (-) | 0 |
| ======== | |
| NUMBER OF GROUPS ON CLIENT PROFILE . . . . . | 14 |

# Statistical Report

PROGRAM: ELGWRP7B EXPRESS SCRIPTS HOLDING COMPANY. DATE: MM/DD/YY

REPORT : ELGWRP7B ELIGIBILITY PRE-EDIT ENROLLMENT STATISTICS TIME: 06:51

RUN-ID : 7108-13210-01 STATISTICAL REPORT PAGE: 1

| INT GROUP # / CLIENT GROUP # | M/D | ADDS REGULAR (+) | ADDS FUTURE TERMS (+) | ADDS WITH TERMS (+) | CHANGES REGULAR (+) | CHANGES FUTURE TERMS (+) | CHANGES WITH TERMS (+) | TERMED PERSONS (+) | RE-INSTATE (+) | GEN-RATED TERMS (+) | RE-JECTED TERMS (X) | DUP. RECS (+) | CARDS (+) | RECORDS MULTI REC (+) | NUM OF WITH NO CHANGES (+) | INPUT TRANS (=) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ZXS00001AAA | M | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | D | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| CHS L1: | | L2: | | L3: | | | | | | | | | | | | |
| CHS L4: | | L5: | | L6: | | | | | | | | | | | | |
| ZXS00001AAA | M | 3 | 0 | 0 | 1 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |
| | D | 2 | 0 | 0 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| TOTALS | M | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| | D | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |

# Sample Rebate Summary Report: Filled Month

**Summary Report**
**Sample Client**

| | | | |
|---|---|---|---|
| Period From: | MM/DD/YYYY | Activity: | Integrated |
| Period To: | MM/DD/YYYY | Carrier: | ABCD |
| Period: | 1QYY | | |

**Carrier Summary**

| Fill Month | Net Rebates Reporting Period | Additional Rebates Prior Period | Net Rebates Total |
|---|---|---|---|
| Month YYYY | $0.00 | $6,200.00 | $6,200.00 |
| Month YYYY | $0.00 | $10,000.00 | $10,000.00 |
| Month YYYY | $0.00 | $30,000.00 | $30,000.00 |
| Month YYYY | $1,291,000.00 | $0.00 | $1,291,000.00 |
| Month YYYY | $1,400,000.00 | $0.00 | $1,400,000.00 |
| Month YYYY | $1,000,000.00 | $0.00 | $1,000,000.00 |
| **Total for Carrier ABCD** | **$3,691,000.00** | **$46,200.00** | **$3,737,200.00** |
| Adjustment: Reason Given | | | -$24,000.00 |
| Adjustment: Reason Given | | | -$2,000.00 |
| **Grand Totals** | **$3,691,000.00** | **$46,200.00** | **$3,711,200.00** |

## Not all clients receive all reports

# Sample Rebate Summary Report: Therapeutic Description


Therapeutic Description Summary Report

Company Name

| | | | |
|---|---|---|---|
| Period From: | MM/DD/YYYY | Activity: | Retail |
| Period To: | MM/DD/YYYY | Carrier: | 1234 |
| Period: | 1QYY | | |

| Carrier | Therapeutic Description | Total Rx | Total Brand Rx | Net Rebates Reporting Period | Additional Rebates Prior Period | Net Rebates Total |
|---|---|---|---|---|---|---|
| 1234 | Vitamins | 46 | 14 | $8.00 | $0.00 | $8.00 |
| 1234 | Ear, Nose and Throat Medications | 105 | 65 | $14.00 | $4.00 | $18.00 |
| 1234 | Anti-Infectives | 6 | 5 | $16.00 | $12.00 | $28.00 |
| Total | | 157 | 84 | $38.00 | $16.00 | $54.00 |

## Not all clients receive all reports

# Sample Rebate Summary Report: Per Rx–Formulary

**PER Rx SUMMARY REPORT**

**Client Name**

Integrated Summary

Carrier ABCD

Period From: MM/DD/YYYY

Period To: MM/DD/YYYY

Period: 3QYY

| Formulary ID-Name | Filled Date Range | Channel | Rxs/Brand Rxs/Invoiced Rxs | Rate | Amount Due |
|---|---|---|---|---|---|
| 393- ESI National Preferred | MM/DD/YY - MM/DD/YY | Retail | 10 | $20.00 | $200.00 |
| 393- ESI National Preferred | MM/DD/YY - MM/DD/YY | Mail | 3 | $60.00 | $180.00 |
| 617- ESI High Performance | MM/DD/YY - MM/DD/YY | Retail | 3450 | $26.00 | $89,700.00 |
| 617- ESI High Performance | MM/DD/YY - MM/DD/YY | Mail | 1650 | $72.00 | $118,800.00 |
| **Total** | | | **5113** | | **$208,880.00** |

Adjustment: reason given -$24,000.00

Adjustment: reason given -$2,000.00

Clients must have a Per Rx arrangement to receive this report

| A1 | ORG ID | CARRIER | ACCOUNT | CONTRAC | CONTRAC | BPL # | BPL NAME | ESI GROU | EXTERNA | GROUP N. | FORMULA | FORMULA | RETAIL/M. | SUBSIDY | SPECIALT | FILLED M | SHARE AM | AVERAGE | TOTAL DA | SUM OF B | SUM OF B | SUM OF A | PER RX R | PER RX C | FIELD3 | FIELD4 | FIELD5 | FIELD6 | FIELD7 | FIELD8 | FIELD9 | FIELD10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| D1 | | | | | | | | | | | | Unknown | R | | NO | NO | 2015-04 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| D1 | | | | | | | | | | | | Unknown | R | | NO | NO | 2015-05 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| A1 | ORG ID | CARRIER | ACCOUNT | CONTRAC | CONTRAC | BPL # | BPL NAME | ESI GROU | EXTERNA | GROUP N | FORMULA | FORMULA | RETAIL/M | SUBSIDY | SPECIALT | FILLED M | SHARE AM | FIELD1 | FIELD2 | SUM OF B | SUM OF B | SUM OF A | PER RX R | PER RX C | PERCENT | REBATES | PERCENT | ADMIN FE | FIELD7 | FIELD8 | FIELD9 | FIELD10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| D1 | | | | | | | | | | | 2225 | Incentive | M | YES | NO | 2014-01 | 7.62 | 0 | 0 | 0 | 0 | 0 | 74.67 | 0 | 1 | 7.62 | 1 | 0 | 0 | 0 | 0 | 0 |
| D1 | | | | | | | | | | | 2225 | Incentive | R | YES | NO | 2014-01 | 0 | 0 | 0 | 0 | 0 | 0 | 16.42 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| D1 | | | | | | | | | | | 2225 | Incentive | M | YES | NO | 2014-01 | 0.72 | 0 | 0 | 0 | 0 | 0 | 74.67 | 0 | 1 | 0.72 | 1 | 0 | 0 | 0 | 0 | 0 |

| A1 | ORG ID | CARRIER | CONTRAC | BPL | GROUP | FILLED MC | MANUFAC | REBATE | ADMIN | FIELD1 | TOTAL REBATES |
|---|---|---|---|---|---|---|---|---|---|---|---|
| D1 | | | | | | YYYY-MM | ESI Sanofi- | 7.62 | 0 | 0 | 7.62 |
| D1 | | | | | | YYYY-MM | ESI Sanofi- | 0.72 | 0 | 0 | 0.72 |
| D1 | | | | | | YYYY-MM | ESI Astra Z | 0.1 | 0 | 0 | 0.1 |

# APPENDIX P

## FUNDING, PAYMENT AND ACCOUNTING METHODOLOGY DEVIATIONS AND REQUIREMENTS INTERROGATORIES

# APPENDIX P
# FUNDING, PAYMENT AND ACCOUNTING METHODOLOGY DEVIATIONS AND REQUIREMENTS INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answer **for both the HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. If the responses specific to the HealthSelect PDP are different than those of the HealthSelect Medicare Rx PDP, Respondent shall describe those differences. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal (**Appendix Q**).

**Deviations to RFP Sections IX.A.1. – IX.C.1. are not permissible and will not be accepted by ERS.**

## A. Deviations – Scope of Work - *Funding, Payment and Accounting Methodology and* Requirements

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Funding, Payment and Accounting Methodology and Requirements*** described in RFP Sections IX.D.1. – IX.D.1.c.ii.

☒ Affirm ☐ Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of any Deviations between Respondent's response and these requirements:
Respondent's requested Deviations detail:

Not applicable.

## B. Interrogatories – Reimbursement of Claims

B.1. The PDP's payment and claims reimbursement methodology is described in RFP Section IX.B. Respondent shall describe its experience and capabilities with a reimbursement process with claims paid in arrears. The initial funding of the reimbursement process will be determined and agreed upon by both parties during the implementation process.

Express Scripts has extensive experience in managing these types of claims with a client of nine million lives. We have established a system for accepting these claims via online portal for processing against the benefit and reimbursement to members for any overage out-of-pocket amounts.

**HealthSelect PDP:**

B.2. Describe in detail Respondent's claims reimbursement methodology.

When a pharmacy fills a prescription for a cash-paying customer, the pharmacy charges a retail price. This cost is called a Usual and Customary (U&C) fee. In some cases for very competitive products, the U&C fee may be set close to — or even less than — the actual product cost.

The pharmacy charges the same price as charged to a customer who did not have a pharmacy benefit and had to pay out of pocket for the medication. Please note that the pharmacy never charges the member more than it would charge a cash-paying customer.

Claims below or equal to the copayment amount are paid 100% by the member and are not funded by a plan in any way. On these claims, the pharmacy is the sole provider of the benefit.

B.3. Describe in detail Respondent's administrative fee reimbursement methodology.

**The billing package includes a claims invoice for claim charges, as well as a billing detail report detailing the claim costs and dispensing fees. In exchange for our services, Express Scripts charges an administrative fee for all claims successfully adjudicated and billed to ERS. We do not charge an administrative fee for rejected claims. Applicable billing packages also include an additional administrative fee invoice that outlines clinical program fees and charges for any additional services performed by Express Scripts as requested by the client.**

**HealthSelect Medicare Rx PDP:**

B.4. Regarding Respondent's claims reimbursement methodology, select one (1) of the following options:

☒ Confirm same response as provided in Section B.2. above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the

B.5. Regarding Respondent's administrative fee reimbursement methodology, select one (1) of the following options:

☒ Confirm same response as provided in Section B.3. above for the HealthSelect PDP.
☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP.

## C. Interrogatories – Federal Employer Identification Number Submission Requirements (Informational Only)

C.1. Respondent agrees to provide Respondent's 147C Verification Letter if selected as a Finalist during the Finalists Review Phase.

☒ Will provide ☐ If unable to provide or if this is not applicable, check here and explain.

C.2. Respondent shall confirm that it has a Texas identification number or will confirm that it will submit an application for a Texas identification number should it be awarded the Contract if it does not already have one.

☒ Confirm

The application for a Texas identification number may be obtained by contacting ERS' Accounts Payable Department at: ap@ers.texas.gov.

## D. Interrogatories – Financial Stability Requirements

**Note:** ERS will rely on the financial statements provided by Respondent in its Minimum Requirements Questionnaire.

**Financial Support**

D.1. If applicable, specify the name and address of any sponsoring or parent-corporation or others who provide financial support to Respondent.

**Express Scripts, Inc. is a wholly owned subsidiary of Evernorth Health, Inc, which is a wholly owned subsidiary of Cigna Corporation, a publicly traded entity under NYSE symbol CI.**

**The address for Evernorth headquarters is:**

**One Express Way**
**St. Louis, MO 63121**

The address for Cigna Corporate Headquarters is:
900 Cottage Grove Road
Bloomfield, CT 06002

D.1.a. If applicable, describe all areas of remuneration provided to Respondent from pharmaceutical manufacturers including, but not limited to, rebates, administrative fees, data compilation fees and promotional grants directly related to ERS utilization.

Express Scripts discloses to our clients our principal sources of revenue derived from pharmaceutical manufacturers, wholesale distributors, and network pharmacies. Express Scripts receives rebates and administrative fees directly related to ERS utilization from pharmaceutical manufacturers, but does not receive data compilation fees or promotional grants from pharmaceutical manufacturers directly related to ERS utilization. Express Scripts has committed to passing through certain revenues received by Express Scripts, directly attributable to ERS eligible utilization, as described elsewhere in the RFP response.

D.1.b. If applicable, describe any understandings, legal relationships or financial agreements with respect to sponsorship or other financial support of Respondent with any other entity (i.e., guarantees, letters of credit, etc.).

Not applicable.

D.1.c. For each sponsoring or parent corporation or others who provide financial support to Respondent, what are the maximum limits of financial support?

Not applicable.

D.1.d. Provide documentation of the limits of financial support provided by Respondent's sponsoring or parent corporation or any entity that will provide financial support to Respondent for purposes of the Contract.
☐ Provided ☒ If unable to provide, or if this is not applicable, check here and explain.

Not applicable. As part of the Minimum Requirements, Express Scripts has provided Cigna's 2021 Annual Report, which notes Express Scripts' as a line item within that document. We are not relying on our parent company for further financial support.

**Independent Auditors**

D.2. Identify Respondent's independent auditor responsible for auditing the annual audited financial statements by providing the following information. If there are different independent auditors for Respondent's commercial PDP business and Respondent's Medicare Rx PDP business, Respondent shall provide information for each programs' auditors:
Express Scripts considers this response to be proprietary and confidential.

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

D.2.a. Identify the independent auditor for Respondent's sponsoring or parent corporation, if applicable, by providing the following information:
Express Scripts considers this response to be proprietary and confidential.

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Ownership Information**

D.3. If Respondent's company is a subsidiary or affiliate of another company, provide a full disclosure of all direct or indirect ownership.

Express Scripts, Inc. is a wholly owned subsidiary of Evernorth Health, Inc, which is a wholly owned subsidiary of Cigna Corporation, a publicly traded entity under NYSE symbol CI. As of January 31, 2022, no owners held over 10% of the outstanding shares of the organization. Our financial information, including Securities and Exchange Commission (SEC) filings, governance, and stock information, is available online at cigna.com via Cigna's Investor Relations page.

**Financial Ratings**

D.4. **Ratings**. Provide copies of ratings and reports on Respondent issued by independent rating organizations or similar entities, such as those issued by A.M. Best's, Moody's, Dun & Bradstreet, and Standard and Poor's.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

D.5. Describe Respondent's procedure on how it handles participant and pharmacy stale dated checks, tracking and reporting, notifications, etc.

All checks issued by Express Scripts will be issued on our pre-existing bank accounts as part of our overall book-of-business.

Express Scripts tracks unclaimed member balances. If a member credit balance or outstanding check remains unclaimed after 6 months, it is presumed abandoned and must be reported and delivered to the custody of the state's unclaimed property administrator. Unclaimed property is remitted to the state in which the owner was last known to reside. If the address is unknown, the unclaimed property is remitted to the state of Delaware, where Express Scripts is incorporated. Unclaimed property is remitted annually based on the requirements of each individual state.

A due diligence letter is mailed to the member based upon each individual state's dormancy periods and minimum unclaimed property dollar amount thresholds. The letter notifies the member of the unclaimed credit balance or outstanding check. If the property is reclaimed, a check is issued to the payee.

D.6. **Insurance Coverage Limits.** Describe the various types of insurance coverage provided to protect ERS, the GBP, the Participants, and the State. The response should include, but not be limited to, the information in the table below for each type of insurance coverage:
Express Scripts considers this response to be proprietary and confidential.

**HealthSelect PDP:**

| | |
|---|---|
| Risks covered: | |
| Name of insurance carrier: | |
| Levels and limits: | |
| Deductibles: | - |

**HealthSelect Medicare Rx PDP:**

☒ Confirm same response as provided above for the HealthSelect PDP.

☐ Unable to confirm; Respondent shall provide a description of the differences for the HealthSelect Medicare Rx PDP by duplicating the table above for each coverage.

During the Finalists Review Phase, Finalists will be required to provide proof of the insurance coverages provided in this section.

**Confirmed.**

D.7. With regard to the insurance requirements (including professional, general liability, malpractice, and fidelity) for each type of pharmacy in Respondent's network, including Respondent's EDS, mail order, specialty, and retail pharmacies, answer the following:
Express Scripts considers this response to be proprietary and confidential.

D.7.a. What are Respondent's minimum insurance coverages required of each individual pharmacy or pharmacy group?
Express Scripts considers this response to be proprietary and confidential.

D.7.b. If the process differs by type of pharmacy (i.e., independent vs. chains), indicate such and describe separately.

**Not applicable.**

D.7.c. Does Respondent's mail order, specialty pharmacy and retail pharmacies maintain malpractice and/or fidelity insurance? ☒ Yes ☐ No

dun & bradstreet

# Supplier Qualifier Report

Print this Report



ATTN: **Name1**

Report Printed: NOV 12 2019
**In Date**

## BUSINESS INFORMATION

**EXPRESS SCRIPTS HOLDING COMPANY**
(SUBSIDIARY OF CIGNA CORPORATION, BLOOMFIELD, CT)
**1 Express Way**
**Saint Louis, MO 63121**

**Rating Change**

This is a **headquarters (subsidiary)** location.
Branch(es) or division(s) exist.

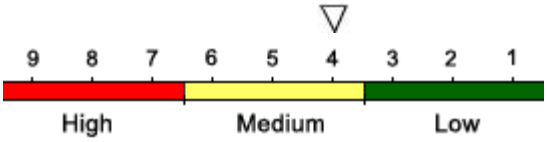
| | |
|---|---|
| **Telephone:** | 314 996-0900 |
| **Chief executive:** | TIMOTHY WENTWORTH, PRES-CEO |
| **Year started:** | 1986 |
| **Employs:** | 26,600 (4 here) |

All amounts are displayed in local currency.

| | |
|---|---|
| **Financial statement date:** | SEP 30 2018 |
| **Net worth F:** | 18,125,300,000 |
| **Gross revenue F:** | 100,064,600,000 |
| **History:** | CLEAR |
| **Financial condition:** | GOOD |

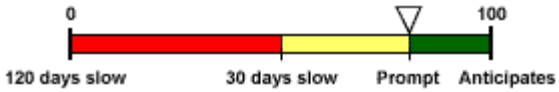
| | |
|---|---|
| **D-U-N-S® Number:** | 07-846-1979 |
| **Parent D-U-N-S®:** | 08-116-1936 |
| **D&B Rating:** | **5A3**<br>Formerly<br>5A2 |
| **Financial strength:** | 5A is **$50 million and over**. |
| **Composite credit appraisal:** | 3 is **fair**. |
| **D&B Supplier Risk:** | **4** |

**SUPPLIER EVALUATION RISK (SER) RATING FOR THIS FIRM : 4**




## D&B PAYDEX®

**D&B PAYDEX: 80**
When weighted by dollar amount, payments to suppliers average generally within terms.




Based on up to 24 months of trade.

## SUMMARY ANALYSIS

| | |
|---|---|
| **D&B Rating:** | **5A3** |
| **Financial strength:** | 5A indicates **$50 million and over**. |
| **Composite credit appraisal:** | 3 is **fair**. |

The Rating was changed on October 29, 2019 because of changes in financial information, payment information, or other information about this business. This credit rating was assigned because of D&B's assessment of the company's financial ratios and its cash flow. For more information, see the D&B Rating Key.

Below is an overview of the company's rating history since 06/06/12:

| D&B Rating | Date Applied |
|---|---|
| 5A3 | 10/29/19 |
| 5A2 | 01/16/19 |
| 5A3 | 04/03/18 |
| 5A2 | 03/02/18 |
| 5A3 | 09/21/15 |
| 5A2 | 03/10/14 |
| 5A3 | 06/06/12 |

The Summary Analysis section reflects information in D&B's file as of November 11, 2019.

## RISK SCORE ANALYSIS

**SER COMMENTARY:**
- Proportion of slow payment experiences to total number of payment experiences reported.
- Change in net worth.
- Total Liabilities to Net Worth influencing the score.
- Business belongs to an industry with above average risk of ceasing operations or becoming inactive.

## PROBABILITY OF CEASED OPERATIONS/BECOMING INACTIVE

**SUPPLIER EVALUATION RISK RATING: 4**

The probability of ceased operations/becoming inactive indicates what percent of U.S. businesses is expected to cease operations or become inactive over next 12 months.

| | |
|---|---|
| **Probability of Supplier Ceased Operations/Becoming Inactive :** | 3.7% (370 PER 10,000) |
| **Percentage of US business with same SER score :** | 13% (1,300 PER 10,000) |
| **Average Probability of Supplier Ceased Operations/Becoming Inactive :** | 0.48% (48 PER 10,000)<br>- Average of Businesses in D&B's Supplier Database |
| **CREDIT DELINQUENCY SCORE:** | 556 |

## SPECIAL EVENTS

10/22/2019
**MERGER/ACQUISITION:** According to published reports, Verity Solutions, DUNS 004579288, (Kirkland, WA) announced that it was snapped up by Express Scripts, DUNS 078461979, (Saint Louis, MO). Financial details of the deal were not disclosed.

## CUSTOMER SERVICE

If you have questions about this report, please call our Customer Resource Center at 1.800.234.3867 from anywhere within the U.S. If you are outside the U.S. contact your local D&B office.

*** Additional Decision Support Available ***

Additional D&B products, monitoring services and specialized investigations are available to help you evaluate this company or its industry. Call Dun & Bradstreet's Customer Resource Center at 1.800.234.3867 from anywhere within the U.S. or visit our website at www.dnb.com.

## HISTORY

The following information was reported **10/29/2019**:

**Officer(s):**

TIMOTHY WENTWORTH, PRES-CEO
NEAL SAMPLE, EXEC V PRES-COO
JAMES HAVEL, EXEC V PRES-CFO
STEVEN MILLER, SR V PRES-CHIEF MEDICAL OFFICER
MARTIN AKINS, SR V PRES-GENERAL COUNSEL-CORPORATE SECRETARY
BRADLEY PHILLIPS, CHIEF ACCOUNTING OFFICER-CORPORATE CONTROLLER
CHRISTINE HOUSTON, EXEC V PRES
EVERETT NEVILLE, EXEC V PRES
PHYLLIS ANDERSON, SR V PRES-CHIEF MARKETING OFFICER
GLEN SEIZ, CHIEF INNOVATION OFFICER
SARA WADE, SR V PRES-CHIEF INNOVATION OFFICER

THE OFFICER(S)

The Delaware Secretary of State's business registrations file showed that Express Scripts Holding Company was registered as a Corporation on July 15, 2011, under the file registration number 5011101.

Business started 1986. 100% of capital stock is owned by parent company.

Express Scripts, Inc. (ESI) was incorporated in Missouri in September 1986, and was reincorporated in Delaware in March 1992. Aristotle Holding, Inc. was incorporated in Delaware in July 2011. On April 2, 2012, ESI consummated a merger (the Merger) with Medco Health Solutions, Inc. (Medco) and both ESI and Medco became wholly-owned subsidiaries of Aristotle Holding, Inc. Aristotle Holding, Inc. was renamed Express Scripts Holding Company (the company or Express Scripts) concurrently with the consummation of the Merger.

The company's common stock has previously traded on the NASDAQ Global Select Market under the symbol "ESRX".

Business started 1986. Present control succeeded Dec 2018.

**CONTROL CHANGE:**

On January 15, 2019, sources stated that Halfmoon Parent, Inc., Bloomfield, CT, has acquired Cigna Corporation, Bloomfield, CT, and Express Scripts Holding Company, Saint Louis, MO, on December 20, 2018. With the acquisition, Cigna Corporation and Express Scripts Holding Company will now operate as wholly-owned subsidiaries of Halfmoon Parent, Inc. At the Effective Time, each issued and outstanding share of Express Scripts Holding Company common stock, par value $0.01 per share other than shares of Express Scripts Holding Company common stock held by Express Scripts Holding Company as treasury shares, owned by Cigna Corporation or by direct or indirect wholly owned subsidiaries of Express Scripts Holding Company or Cigna Corporation including Halfmoon Parent, Inc. or with respect to which appraisal rights were properly exercised and not withdrawn, was converted automatically into 0.2434 of a share of Halfmoon Parent, Inc. common stock and the right to receive $48.75 in cash, without interest, subject to applicable withholding taxes. Employees and management were retained. Further details are unavailable.

RECENT EVENTS.

On October 29, 2019, sources stated that Express Scripts Holding Company, St. Louis, MO, has acquired Verity Solutions Group, Inc., Kirkland, WA, on October 17, 2019. With the acquisition, Verity Solutions Group, Inc., will now operate as a subsidiary of Express Scripts Holding Company. Employees and management were retained. Terms of the deal were not disclosed. Further details are unavailable.

In December 2017, the company sold United BioSource Holdings, Inc. (UBC) for approximately $150.0 million.

In December 2017, the company completed the acquisition of CareCore National Group, LLC and its affiliates d/b/a eviCore healthcare (eviCore) for approximately $3.6 billion.

In May 2017, the company completed the acquisition of myMatrixx Holdings, Inc. (myMatrixx) for approximately $250.0 million.

TIMOTHY WENTWORTH. Director since 2015. He has served as the company's CEO since 2016 and President since 2014. He previously served as Senior Vice President and President, Sales and Account Management from April 2012 to February 2014. He joined the company when it merged with Medco in April 2012. At Medco, he served as Group President, National and Key Accounts from October 2008 to April 2012.

NEAL SAMPLE. He was named as the company's Executive Vice President and Chief Operations Officer (COO) in January 2018 and previously served as Senior Vice President and Chief Information Officer (CIO) from February 2016 to January 2018. Prior to joining Express Scripts, he served as President, Enterprise Growth at American Express, a global services, payments and travel company, from August 2014 to February 2016, and as CIO, Enterprise Growth at American Express, from April 2012 to August 2014. He served in various roles of increasing responsibility at eBay Inc. from 2010 to 2012.

JAMES HAVEL. He has served as the company's Executive Vice President and CFO since 2017. He previously served as

the company's Executive Vice President and interim CFO from January to September 2015, and then as Senior Vice President, Finance, through March 2016. Prior to re-joining the company, he served as COO of Vatterott Education Centers, from April through November 2016. From April 2012 to December 2014, he served as CFO of Major Brands Holdings. He owned and operated Havel Associates, LLC from July 2010 to April 2012.

STEVEN MILLER. He has served as the company's Senior Vice President and Chief Medical Officer (CMO) since 2007. He joined the company in April 2005 as Vice President, Research and Product.

MARTIN AKINS. He has served as the company's Senior Vice President, General Counsel since 2015 and Corporate Secretary since 2013. He also served as Vice President and Deputy General Counsel from February 2010 to October 2015 and as Vice President and Associate General Counsel from December 2008 to February 2010.

BRADLEY PHILLIPS. He has served as the company's Vice President, CAO and Corporate Controller since 2017. Prior to joining the company, he served as Senior Vice President and CAO at Peabody Energy from September 2015 to June 2017, as Senior Vice President of Finance-Americas from July 2013 to August 2015 and Senior Vice President Finance and Administration-Australia from January 2010 to June 2013.

CHRISTINE HOUSTON. Ms. Houston was named Executive Vice President and Chief Operations Officer in December 2016 and served as our Chief Operations Officer until January 2018, when the Company announced her retirement and plan to continue in her capacity as Executive Vice President for a period to be determined to conclude several key initiatives. Ms. Houston previously served as Senior Vice President, Operations from February 2014 to December 2016. From February 2012 to February 2014, she served as Senior Vice President, Pharma and Retail Relations, and from January 2009 to February 2012, she served as Vice President/General Manager, Operations. Ms. Houston joined Express Scripts in September 1997 and has served in various leadership positions in Information Technology and Operations.

EVERETT NEVILLE. Mr. Neville was named Executive Vice President, Strategy, Supply Chain & Specialty in January 2018 and previously served as Senior Vice President, Strategy, Supply Chain & Specialty from November 2016 to January 2018. From March 2015 to November 2016, he served as Senior Vice President, Supply Chain, and from March 2009 to March 2015 he served as Vice President, Pharma Strategy and Contracting. Mr. Neville has been with the Company for over 19 years. Prior to joining Express Scripts, Mr. Neville served in multiple clinical settings, including hospital and managed care, as a benefit consultant, pharmacist and pharmacy director.

PHYLLIS ANDERSON. Ms. Anderson was named the Companys Chief Marketing Officer in December 2013 and has also served as a Senior Vice President since October 2015. Prior to joining Express Scripts, Ms. Anderson served as Vice President, Marketing at Humana Insurance Company from March 2005 to October 2013. Ms. Anderson also served as Vice President, Strategic Initiatives - Consumer Real Estate at Bank of America and Director, Market Brand and Strategy at Duke Energy Corporation.

GLEN SEIZ. Mr. Seiz was named Senior Vice President, Specialty, in January 2018, and has served as President of our Accredo specialty pharmacy since November 2016. From March 2015 to November 2016, he served as Vice President and General Manager of Accredo. From April 2012 to March 2015, he served as Vice President of Clinical and Trend Programs for Express Scripts. Mr. Seiz has been with the Company for 13 years in diverse leadership positions in the areas of clinical product development, formulary and utilization management, specialty and Medicare. Prior to joining the Company, Mr. Seiz was Assistant Professor of Pharmacy Practice at St. Louis College of Pharmacy.

SARA WADE. Ms. Wade was named Senior Vice President and Chief Human Resources Officer in December 2010 and previously served as Vice President, Compensation and Benefits from June 2009 to December 2010. Prior to joining Express Scripts, she served at Coca Cola Enterprises as Corporate Vice President, Compensation and Benefits from April 2008 to June 2009 and at Patriot Coal Corporation as Senior Vice President, Human Resources from November 2007 to April 2008.

## BUSINESS REGISTRATION

CORPORATE AND BUSINESS REGISTRATIONS REPORTED BY THE SECRETARY OF STATE OR OTHER OFFICIAL SOURCE AS OF JUN 12 2015:

| | |
|---|---|
| **Registered Name:** | EXPRESS SCRIPTS HOLDING COMPANY |
| **Business type:** | CORPORATION |
| **Corporation type:** | NOT AVAILABLE |
| **Date incorporated:** | JUL 15 2011 |
| **State of incorporation:** | DELAWARE |
| **Filing date:** | JUL 15 2011 |
| **Registration ID:** | 5011101 |
| **Status:** | STATUS NOT AVAILABLE |
| **Where filed:** | SECRETARY OF STATE/CORPORATIONS DIVISION, DOVER, DE |

**Registered agent:** CORPORATION SERVICE COMPANY, 2711 CENTERVILLE RD SUITE 400, WILMINGTON, DE, 198080000

## OPERATIONS

10/29/2019

**Description:** Subsidiary of Cigna Corporation, Bloomfield, CT started 2018 which operates as a provider of hospital or medical service plan. Parent company owns 100% of capital stock.

As noted, this company is a subsidiary of Cigna Corporation. DUNS number 081161936, and reference is made to that report for background information on the parent company and its management.

The company operates as a pharmacy benefit management (PBM) company.

The company's PBM segment offers clinical solutions; and specialized pharmacy care, home delivery and specialty pharmacy, retail network pharmacy administration, benefit design consultation, drug utilization review, drug formulary management, public exchange, administration of group purchasing organization, and digital consumer health and drug information services. This segment also provides Medicare, Medicaid, and health insurance marketplace products; Express Scripts SafeGuardRx, a suite of solutions targeting the therapy classes that pose clinical challenges and budgetary threat to its clients; and Inside Rx, a program that provide affordable access to medication for uninsured and underinsured individuals. Its Other Business Operations segment distributes specialty pharmaceuticals and medical supplies, including injectable and infusible pharmaceuticals and medications to treat specialty and rare/orphan diseases. This segment also provides medical benefit management solutions for radiology, cardiology, musculoskeletal disorders, sleep disorders, post-acute care, genetic lab, specialty pharmacy, and medical oncology.

TRADEMARK(S): EXPRESS SCRIPTS, MEDCO, ACCREDO, CURASCRIPTSD, MYMATRIXX, EVICORE HEALTHCARE, CONSUMEROLOGY, MY RX CHOICES, RATIONALMED, SCREENRX, EXPRESSALLIANCE, EXPRESS SCRIPTS MEDICARE, EXPRESS ADVANTAGE NETWORK, HEALTH DECISION SCIENCE, THERAPEUTIC RESOURCE CENTER, CONSTELLATION, EXPRESSPATH, MEDICUBE, CHOLESTEROL CARE VALUE PROGRAM, HEPATITIS CURE VALUE PROGRAM, EXPRESS SCRIPTS SAFEGUARDRX, MARKET EVENTS PROTECTION PROGRAM, ONCOLOGY CARE VALUE PROGRAM, DIABETES CARE VALUE PROGRAMSM, INFLAMMATORY CONDITIONS CARE VALUE PROGRAMSM, INFLATION PROTECTION PROGRAMSM, PULMONARY CARE VALUE PROGRAMSM, MULTIPLE SCLEROSIS CARE VALUE PROGRAMSM and INSIDE RXSM.

Terms are cash and Net 30 days. Sells to commercial concerns and general public. Territory : International.

Nonseasonal.

**Employees:** 26,600 which includes officer(s). 4 employed here.

**Facilities:** Occupies premises in a single story building.

**Branches:** This business has multiple branches, detailed branch/division information is available in Dun & Bradstreets linkage or family tree products.

**Subsidiaries:** The business has subsidiary(ies); detailed subsidiary information is available in Dun & Bradstreet's linkage or family tree products.

## FAMILY LINKAGE

**Parent Information:**

| | |
|---|---|
| D-U-N-S® #: | 08-116-1936 |
| Name: | CIGNA CORPORATION |
| Country: | US |
| Revenue: | N/A |

**Domestic Ultimate Parent Information:**

| | |
|---|---|
| D-U-N-S® #: | 08-116-1936 |
| Name: | CIGNA CORPORATION |
| Country: | US |
| Revenue: | N/A |

**Global Ultimate Parent Information:**

| | |
|---|---|
| D-U-N-S® #: | 08-116-1936 |
| Name: | CIGNA CORPORATION |
| Country: | US |
| Revenue: | N/A |

## UNSPSC

UNSPSC (United Nations Standard Product and Services Code) is a globally accepted commodity (Product and

Services) classification system. EXPRESS SCRIPTS HOLDING COMPANY offers the following product(s) and service(s):

**51000000 Drugs and Pharmaceutical Products**

## NAICS

Beginning in 1997, the **Standard Industrial Classification** (SIC) was replaced by the **North American Industry Classification System** (NAICS). This six digit code is a major revision that not only provides for newer industries, but also reorganizes the categories on a production/process-oriented basis. This new, uniform, industry-wide classification system has been designed as the index for statistical reporting of all economic activities of the U.S., Canada, and Mexico.

**446110 Pharmacies and Drug Stores**
**454110 Electronic Shopping and Mail-Order Houses**
**424210 Drugs and Druggists' Sundries Merchant Wholesalers**

## SIC

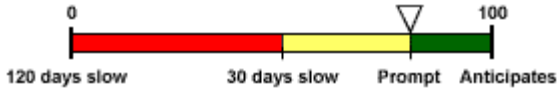
Based on information in our file, D&B has assigned this company an extended 8-digit SIC. D&B's use of 8-digit SICs enables us to be more specific to a company's operations than if we use the standard 4-digit code.

**59120000 Drug stores and proprietary stores**
**59619924 Pharmaceuticals, mail order**
**51220000 Drugs, proprietaries, and sundries**

## D&B PAYDEX

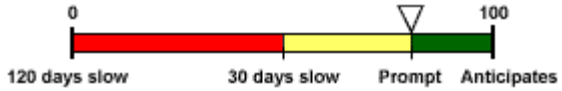
The D&B PAYDEX is a unique, dollar weighted indicator of payment performance based on up to 59 payment experiences as reported to D&B by trade references.

**3-Month D&B PAYDEX: 80**
When weighted by dollar amount, payments to suppliers average within terms.




Based on trade collected over last 3 months.

**D&B PAYDEX: 80**
When weighted by dollar amount, payments to suppliers average generally within terms.




Based on up to 24 months of trade.
When dollar amounts are not considered, then approximately 63% of the company's payments are within terms.

## PAYMENT SUMMARY

The Payment Summary section reflects payment information in D&B's file as of the date of this report.

Below is an overview of the company's dollar-weighted payments, segmented by its suppliers' primary industries:

| | Total Rcv'd (#) | Total Dollar Amts ($) | Largest High Credit ($) | Within Terms (%) | Days Slow <31 (%) | 31-60 (%) | 61-90 (%) | 90> (%) |
|---|---|---|---|---|---|---|---|---|
| **Top industries:** | | | | | | | | |
| Misc business credit | 8 | 7,039,000 | 7,000,000 | 100 | - | - | - | - |
| Nonclassified | 3 | 31,500 | 30,000 | - | 98 | - | 2 | - |
| Telephone communictns | 2 | 40,000 | 35,000 | 100 | - | - | - | - |
| Whol drugs/sundries | 1 | 4,000,000 | 4,000,000 | 100 | - | - | - | - |
| Lithographic printing | 1 | 500,000 | 500,000 | 100 | - | - | - | - |
| Trucking non-local | 1 | 95,000 | 95,000 | 100 | - | - | - | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Whol general grocery | 1 | 85,000 | 85,000 | 50 | 50 | - | - | - |
| Public finance | 1 | 65,000 | 65,000 | 100 | - | - | - | - |
| Facilities support | 1 | 35,000 | 35,000 | 50 | 50 | - | - | - |
| Detective/guard svcs | 1 | 25,000 | 25,000 | 100 | - | - | - | - |
| OTHER INDUSTRIES | 10 | 61,850 | 20,000 | 34 | 17 | 16 | 16 | 17 |
| **Other payment categories:** | | | | | | | | |
| Cash experiences | 24 | 2,300 | 250 | | | | | |
| Payment record unknown | 5 | 800,150 | 400,000 | | | | | |
| Unfavorable comments | 0 | 0 | 0 | | | | | |
| **Placed for collections:** | | | | | | | | |
| With D&B | 0 | 0 | | | | | | |
| Other | 0 | N/A | | | | | | |
| Total in D&B's file | 59 | 12,779,800 | 7,000,000 | | | | | |

The highest **Now Owes** on file is $6,000,000

The highest **Past Due** on file is $30,000

D&B receives over 600 million payment experiences each year. We enter these new and updated experiences into D&B Reports as this information is received.

## PAYMENT DETAILS

**Detailed payment history**

| Date Reported (mm/yy) | Paying Record | High Credit ($) | Now Owes ($) | Past Due ($) | Selling Terms | Last Sale Within (months) |
|---|---|---|---|---|---|---|
| 10/19 | Ppt | 7,000,000 | 6,000,000 | 0 | | 1 mo |
| | Ppt | 95,000 | 60,000 | 0 | | 1 mo |
| | Ppt | 20,000 | 20,000 | 5,000 | Lease Agreemnt | 1 mo |
| | Ppt | 1,000 | 1,000 | 0 | | 1 mo |
| | Ppt-Slow 30 | 5,000 | 2,500 | 0 | | 1 mo |
| | Ppt-Slow 60 | 7,500 | 2,500 | 0 | | 1 mo |
| | Ppt-Slow 90 | | 500 | 250 | | 1 mo |
| | Ppt-Slow 90 | | 1,000 | 1,000 | | 2-3 mos |
| | Ppt-Slow 90 | | 5,000 | 2,500 | | 1 mo |
| | Slow 15 | 1,000 | 100 | 0 | | 1 mo |
| | Slow 30-90 | | 20,000 | 15,000 | | 1 mo |
| | Slow 30-90 | | 0 | 0 | | 6-12 mos |
| | Slow 90 | 500 | 500 | 500 | | |
| | Slow 30-240+ | 20,000 | 2,500 | 2,500 | | 1 mo |
| 09/19 | Ppt | 4,000,000 | 1,000,000 | 0 | | 1 mo |
| | Ppt | 500,000 | 500,000 | 0 | | 1 mo |
| | Ppt | 35,000 | 30,000 | 0 | | 1 mo |
| | Ppt | 5,000 | 2,500 | 0 | | 1 mo |
| | Ppt-Slow 5 | 85,000 | 70,000 | 30,000 | | 1 mo |
| | (020) | 50 | | | Cash account | 1 mo |
| 08/19 | Ppt | 25,000 | 15,000 | 0 | | 1 mo |
| | Ppt-Slow 30 | 35,000 | 25,000 | 10,000 | | 1 mo |
| | (023) | 100 | 0 | 0 | Cash account | 6-12 mos |
| 06/19 | (024) | 400,000 | 0 | 0 | | 1 mo |
| | (025) | 400,000 | 0 | 0 | | 1 mo |

| | | | | | | |
|---|---|---|---|---|---|---|
| | (026) | 50 | 0 | 0 | | 1 mo |
| | (027) | 50 | 0 | 0 | | 1 mo |
| | (028) | 50 | 0 | 0 | | 2-3 mos |
| 03/19 | (029) | 100 | | | Cash account | 1 mo |
| | (030) | 100 | | | Cash account | 1 mo |
| 02/19 | (031) | 250 | | | Cash account | 1 mo |
| 01/19 | Slow 90+ | 250 | 0 | 0 | | 6-12 mos |
| 11/18 | Slow 30 | 30,000 | 0 | 0 | | |
| 08/18 | Ppt | 250 | 0 | 0 | | 6-12 mos |
| | Ppt | 0 | 0 | 0 | N30 | 6-12 mos |
| | (036) | 100 | | | | 1 mo |
| Â | Â Satisfactory. | | | | | |
| 07/18 | Slow 60-90 | 20,000 | 0 | 0 | | 6-12 mos |
| | (038) | 50 | | | Cash account | 1 mo |
| 06/18 | (039) | | | | Sales COD | 1 mo |
| | (040) | | | | Sales COD | 1 mo |
| | (041) | | | | Sales COD | 1 mo |
| | (042) | | | | Sales COD | 1 mo |
| 05/18 | (043) | 250 | | | Cash account | 1 mo |
| | (044) | 250 | | | Cash account | 1 mo |
| | (045) | 50 | | | Cash account | 1 mo |
| | (046) | 50 | | | Cash account | 1 mo |
| 04/18 | (047) | 50 | | | Cash account | 6-12 mos |
| | (048) | 50 | | | Cash account | 6-12 mos |
| | (049) | 50 | | | Cash account | 6-12 mos |
| 02/18 | Ppt | 65,000 | | | | 1 mo |
| | Slow 30 | 250 | 0 | 0 | N30 | 6-12 mos |
| | (052) | 250 | | | Cash account | 1 mo |
| | (053) | 50 | | | Cash account | 1 mo |
| 01/18 | (054) | | | | Cash account | 1 mo |
| | (055) | 250 | | | Cash account | 1 mo |
| | (056) | 250 | | | Cash account | 1 mo |
| | (057) | 50 | | | Cash account | 1 mo |
| 11/17 | Disc-Ppt | 0 | 0 | 0 | | 1 mo |
| | (059) | 50 | | | Cash account | 1 mo |

Payment experiences reflect how bills are met in relation to the terms granted. In some instances payment beyond terms can be the result of disputes over merchandise, skipped invoices etc.

Each experience shown is from a separate supplier. Updated trade experiences replace those previously reported.

## PAYMENT TRENDS

### SUPPLIER VERSUS INDUSTRY PAYDEX

| -> | PRIOR 4 QTRS | | CURRENT 12 MONTH TREND | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | --- | --- | --- | 2019 | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | DEC | MAR | JUN | SEP | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV |
| Supplier PAYDEX | 79 | 79 | 79 | 79 | 79 | 78 | 78 | 79 | 79 | 79 | 79 | 79 | 79 | 78 | 79 | 80 |
| **Industry PAYDEX (Based on 11 establishments in SIC 5912)** | | | | | | | | | | | | | | | | |
| UP QRT | 80 | 80 | 80 | 80 | 80 | | | 80 | | | 80 | | | 80 | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MEDIAN | 79 | 79 | 79 | 79 | 79 | | | 79 | | | 79 | | | 79 | | |
| LO QRT | 72 | 73 | 73 | 73 | 73 | | | 75 | | | 75 | | | 72 | | |

PAYDEX scores are updated daily and are based on upto 24 months of trade experiences from the Dun& Bradstreet trade file.

**All amounts displayed within this report are in local currency.**

## FINANCE

**09/23/2019**

**Three-year statement comparative:**

| | Fiscal Consolidated Dec 31 2015 (000s omitted) | Fiscal Consolidated Dec 31 2016 (000s omitted) | Fiscal Consolidated Dec 31 2017 (000s omitted) |
|---|---|---|---|
| Current Assets | 12,059,500 | 12,363,400 | 11,957,100 |
| Current Liabs | 17,155,300 | 16,428,100 | 17,846,400 |
| Current Ratio | 0.7 | 0.75 | 0.67 |
| Working Capital | (5,095,800) | (4,064,700) | (5,889,300) |
| Other Assets | 41,183,800 | 39,381,500 | 42,298,700 |
| Net Worth | 17,380,500 | 16,243,800 | 18,125,300 |
| Sales | 101,751,800 | 100,287,500 | 100,064,600 |
| Long Term Liab | 18,707,500 | 19,073,000 | 18,284,100 |
| Net Profit (Loss) | 2,499,500 | 3,427,600 | 4,531,700 |

**Interim Consolidated statement dated SEP 30 2018:**

| Assets | | Liabilities | |
|---|---|---|---|
| Cash | 3,705,700 | Accts Pay | 4,412,900 |
| Accts Rec | 7,824,100 | Claims & Rebates Payable | 10,190,200 |
| Inventory | 2,168,900 | Accruals | 2,067,000 |
| Prepaid Exps & Other Current Assets | 653,500 | Short-Term Debt & Long-Term Debt | 2,021,300 |
| **Curr Assets** | **14,352,200** | **Curr Liabs** | **18,691,400** |
| Fixt & Equip | 490,900 | Long-Term Debt | 12,974,200 |
| Computer Software-Net | 827,500 | Other Liabilities | 855,400 |
| Goodwill | 31,110,500 | L.T. Liab-Other | 2,347,800 |
| Other Intangible Assets-Net | 8,425,500 | COMMON STOCK | 8,700 |
| Other Assets | 235,000 | ADDIT. PD.-IN CAP | 23,826,800 |
| | | TREASURY STOCK | (22,153,800) |
| | | RETAINED EARNINGS | 18,890,700 |
| | | ADJUSTMENTS | 400 |
| **Total Assets** | **55,441,600** | **Total** | **55,441,600** |

From JAN 01 2018 to SEP 30 2018 sales $75,974,400,000; cost of goods sold $69,539,400,000. Gross profit $6,435,000,000; operating expenses $2,672,600,000. Operating income $3,762,400,000; other income $33,800,000; other expenses $456,300,000; net income before taxes $3,339,900,000; Federal income tax $760,800,000. Net income $2,579,100,000.

Statement obtained from Securities And Exchange Commission. Prepared from books without audit.

Accounts receivable shown net less $467,800,000 allowance.

**Explanations**
The net worth of this company includes intangibles; Adjustments consists of accumulated other comprehensive loss and non-controlling interest.

As of September 23, 2019, attempts to contact the management of this business have been unsuccessful. Inside and

outside sources confirmed operation and location.

## KEY BUSINESS RATIOS

**Statement date:** SEP 30 2018
**Based on this number of establishments:** 11

| Firm | | Industry Median | | Quartile Rank (Supplier) |
|---|---|---|---|---|
| Return of Sales: | 3.4 | Return of Sales: | 3.8 | N/A |
| Current Ratio: | 0.8 | Current Ratio: | 1.3 | 4 |
| Quick Ratio: | 0.6 | Quick Ratio: | 0.9 | 4 |
| Assets / Sales: | UN | Assets / Sales: | 130.6 | N/A |
| Total Liability / Net Worth: | UN | Total Liability / Net Worth: | 101.3 | N/A |

UN = Unavailable

## PUBLIC FILINGS

The following Public Filing data is for information purposes only and is not the official record. Certified copies can only be obtained from the official source.

## SUITS

**Status:** **Pending**
**DOCKET NO.:** 201800014059
**Plaintiff:** INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL, FORT WASHINGTON, PA
**Defendant:** EXPRESS SCRIPTS HOLDING COMPANY AND OTHERS
**Cause:** CIVIL ACTION
**Where filed:** MONTGOMERY COUNTY PROTHONOTARY, NORRISTOWN, PA

**Date status attained:** 05/25/2018
**Date filed:** 05/25/2018
**Latest Info Received:** 06/01/2018

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**Status:** **Pending**
**DOCKET NO.:** 201500008254
**Plaintiff:** ROTHMAN, BARRY M, COLLEGEVILLE, PA
**Defendant:** EXPRESS SCRIPTS HOLDING COMPANY AND OTHERS
**Where filed:** MONTGOMERY COUNTY PROTHONOTARY, NORRISTOWN, PA

**Date status attained:** 04/16/2015
**Date filed:** 04/16/2015
**Latest Info Received:** 04/24/2015

If it is indicated that there are defendants other than the report subject, the lawsuit may be an action to clear title to property and does not necessarily imply a claim for money against the subject.

## UCC FILINGS

**Collateral:** Account(s) and proceeds - Chattel paper and proceeds
**Type:** Original
**Sec. party:** LEASE SERVICING CENTER, INC., ALEXANDRIA, MN TCF EQUIPMENT FINANCE, A DIVISION OF TCF NATIONAL BANK, MINNETONKA, MN
**Debtor:** EXPRESS SCRIPTS HOLDING COMPANY
**Filing number:** 2018 7382167
**Filed with:** SECRETARY OF STATE/UCC DIVISION, DOVER, DE

**Date filed:** 10/24/2018
**Latest Info Received:** 11/20/2018

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**Collateral:** Account(s) and proceeds - Chattel paper and proceeds - Equipment and proceeds
**Type:** Original
**Sec. party:** LEASE SERVICING CENTER, INC., ALEXANDRIA, MN TCF EQUIPMENT FINANCE, A DIVISION OF TCF NATIONAL BANK, MINNETONKA, MN
**Debtor:** EXPRESS SCRIPTS HOLDING COMPANY
**Filing number:** 2018 7377712

**Filed with:** SECRETARY OF STATE/UCC DIVISION, DOVER, DE

**Date filed:** 10/24/2018
**Latest Info Received:** 11/20/2018

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**Collateral:** Account(s) and proceeds - Chattel paper and proceeds - General intangibles(s) and proceeds - Leased Computer equipment and proceeds - Leased Equipment and proceeds
**Type:** Original
**Sec. party:** PRODUCTION MAIL SOLUTIONS FINANCING, STAMFORD, CT
**Debtor:** EXPRESS SCRIPTS HOLDING COMPANY
**Filing number:** 2013 3325926
**Filed with:** SECRETARY OF STATE/UCC DIVISION, DOVER, DE

**Date filed:** 08/26/2013
**Latest Info Received:** 09/20/2013

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**Type:** Amendment
**Sec. party:** PRODUCTION MAIL SOLUTIONS FINANCING, CINCINNATI, OH
**Debtor:** EXPRESS SCRIPTS HOLDING COMPANY
**Filing number:** 2013 3966836
**Filed with:** SECRETARY OF STATE/UCC DIVISION, DOVER, DE

**Date filed:** 10/09/2013
**Latest Info Received:** 11/05/2013
**Original UCC filed date:** 08/26/2013
**Original filing no.:** 2013 3325926

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**Collateral:** Chattel paper including proceeds and products - Leased Computer equipment including proceeds and products - Leased Equipment including proceeds and products
**Type:** Original
**Sec. party:** CANON U.S.A., INC., MELVILLE, NY
**Debtor:** EXPRESS SCRIPTS HOLDING COMPANY
**Filing number:** 2013 2070259
**Filed with:** SECRETARY OF STATE/UCC DIVISION, DOVER, DE

**Date filed:** 05/31/2013
**Latest Info Received:** 06/20/2013

There are additional UCC's in D&B's file on this company available by contacting 1-800-234-3867.

The public record items contained in this report may have been paid, terminated, vacated or released prior to the date this report was printed.

## GOVERNMENT ACTIVITY

**Activity summary**
Congressional District: 01

The details provided in the Government Activity section are as reported to Dun & Bradstreet by the federal government and other sources.

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# Cigna Corporation

## And Insurance Operating Subsidiaries

**Full Rating Report**

### Ratings

| | |
|---|---|
| Long-Term IDR | BBB |
| Short-Term IDR | F3 |
| Senior Unsecured Notes | BBB |

**Subsidiaries**

| | |
|---|---|
| Insurer Financial Strength | A |

### Rating Outlook

Stable

### Financial Data

**Cigna Corporation**

| ($ Mil.) | 2018 | 6/30/19 |
|---|---|---|
| EBITDA | 4,774 | 3,100 |
| EBITDA/Revenue (%) | 9.8 | 8.1 |
| Net Income | 2,646 | 1,410 |
| Shareholders' Equity | 41,035 | 43,818 |
| Debt/EBITDA (x) | 3.6 | 3.3 |

Note: GAAP data.
Source: Fitch Ratings, S&P Global Market Intelligence.

### Related Research

Cigna Corporation. – Ratings Navigator (September 2019)

### Analysts

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## Key Rating Drivers

**Acquisition Changes Organization:** Cigna Corporation's acquisition of Express Scripts Holding Company for $52 billion closed in 4Q18. This transaction added size and scale in addition to differentiated capabilities and unregulated cash flows. Cigna's new structure gives it a platform to compete with other larger peers that have sizeable nonhealth insurance operations.

**Increased Financial Leverage:** Cigna's financial leverage and debt/EBITDA ratios peaked at 51% and 3.6x, respectively, at close of this transaction. The company is making strides to reduce leverage and publicly stated it will reduce its financial leverage ratio (FLR) below 40% within two years of closing. With over a half year of integration, Fitch Ratings believes management will likely meet its stated goal.

**Recovery Rating Assumption Changes:** Fitch upgraded Cigna's senior unsecured debt on Aug. 30, 2019, reflecting a change in applied recovery assumptions from those used for insurance holding companies ('RR5' or below average) to those used for nonregulated corporate entities ('RR4' or average). This recognizes the enhanced flexibility provided by sizeable nonregulated cash flows to the holding company from Cigna's Health Services segment, as insurance operating company dividends are limited by law.

**Corporate Methodology:** Given Fitch's movement to rate Cigna's debt based more on its *Corporate Rating Criteria*, short-term ratings could potentially move up given further deleveraging since the short-term rating sits at the 'F2'/'F3' cusp with an IDR of 'BBB'. At this time, the liquidity profile falls short of requirements to obtain the higher 'F2', but further deleveraging could result in improved liquidity.

**Very Strong Financial Performance:** Cigna continued to generate excellent operating results during 2018, reporting an 8% increase in EBITDA and a medical loss ratio of 78.9%. The company did experience sizeable one-time costs associated with its acquisition of Express Scripts, but Fitch notes that 1H19 results are performing in line with expectations.

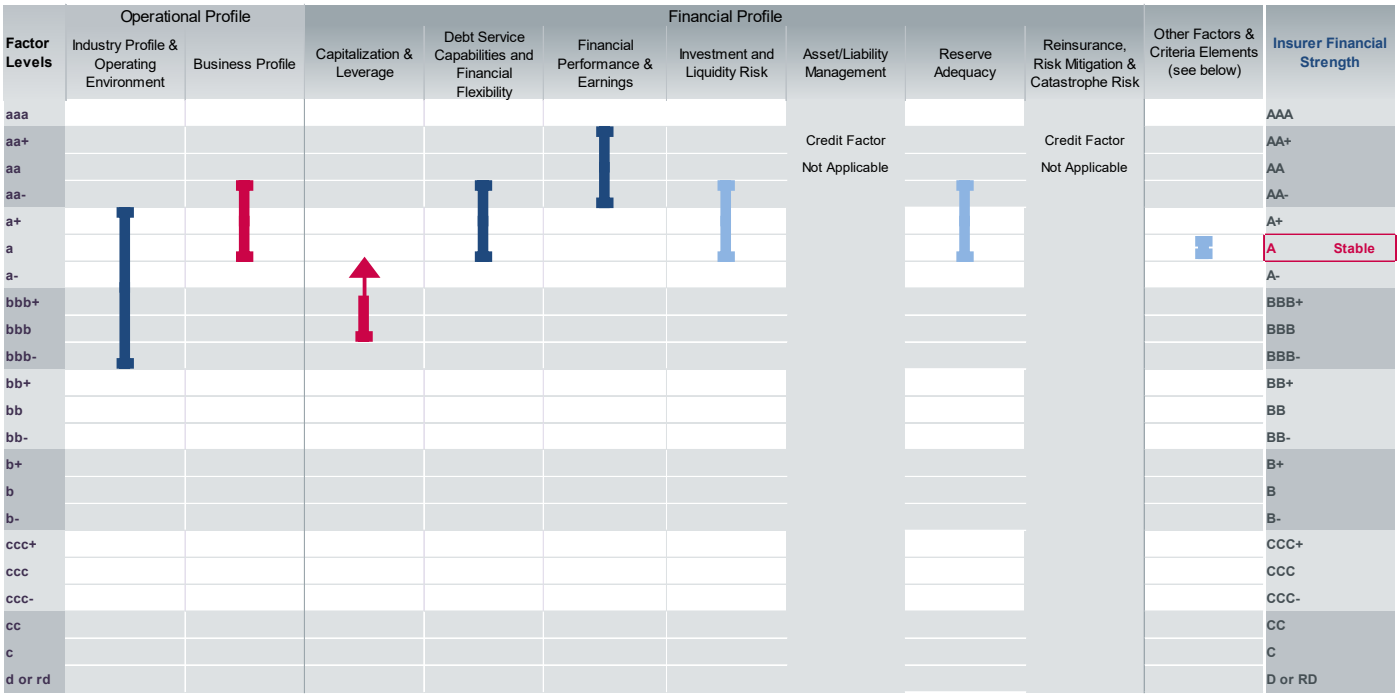
## Rating Sensitivities

**Integration Challenge and Opportunity:** Failure to successfully integrate Express Scripts as reflected by a material deviation in operating results relative to projections could result in a downgrade; however, successful integration could lead to an improvement in business profile and an upgrade.

**Leverage Metrics:** A sustained improvement in debt/EBITDA below 2.5x could lead to a ratings upgrade. Conversely, a sustained debt/EBITDA of 4.0x or higher could lead to a ratings downgrade.

**Short-Term Ratings:** Further deleveraging of the holding company would strengthen liquidity and the financial structure to withstand sensitivity testing for reductions in regulated cash flows, which could lead to an upgrade of short-term ratings.

## Cigna Corporation (Sept. 3, 2019)




| Other Factors & Criteria Elements | | | | |
|---|---|---|---|---|
| **Provisional Insurer Financial Strength** | | | | **A** |
| Non-Insurance Attributes | Positive | **Neutral** | Negative | +0 |
| Corporate Governance & Management | **Effective** | Some Weakness | Ineffective | +0 |
| Ownership | Positive | **Neutral** | Negative | +0 |
| Transfer & Convertibility / Country Ceiling | Yes | **No** | 0 | +0 |
| **Insurer Financial Strength (IFS)** | | | Final: | **A** |
| IFS Recovery Assumption | **Good** | | | -1 |
| **Issuer Default Rating (IDR)** | | | Final: | **n.a.** |

**Bar Chart Legend:**

Vertical Bars = Range of Rating Factor

Bar Colors = Relative Importance

- Higher Influence
- Moderate Influence
- Lower Influence

Bar Arrows = Rating Factor Outlook

- Positive
- Negative
- Evolving
- Stable

## ESG CONSIDERATIONS

Unless otherwise disclosed in this section, the highest level of ESG credit relevance is a score of 3 — ESG issues are credit neutral or have only a minimal credit impact on the entity, either due to their nature or the way in which they are being managed by the entity.

For more information on our ESG Relevance Scores, visit www.fitchratings.com/esg.

### Related Criteria

Insurance Rating Criteria (January 2019)

Corporate Rating Criteria (February 2019)

## Business Profile

### Favorable Business Profile

Fitch ranks Cigna's business profile as favorable compared with all other U.S. health insurers based on its competitive position, business risk profile and level of diversification. Given this ranking, Fitch scores the company's business profile as 'a+' under Fitch's *Insurance Rating Criteria* guidelines. A successful integration of Express Scripts would be a catalyst for a better business profile ranking.

#### *Most Favorable Competitive Positioning*

Competitive positioning is comprised of two subfactors: general and operating scale. For Cigna, these factors aggregate into a most favorable position. Cigna has a leading business franchise within the sector and strong competitive advantages. As of YE 2018, the company had revenues of $49 billion and medical membership of 17 million.

#### *Favorable Business Risk Profile*

Cigna's risk profile is better than the sector as a whole, and its ability to differentiate risks through analytics and pricing results in fairly stable operating performance. The company competes not only on price, but also on product offerings, provider network and customer service. The company operates in well-established products and markets.

#### *Most Favorable Diversification*

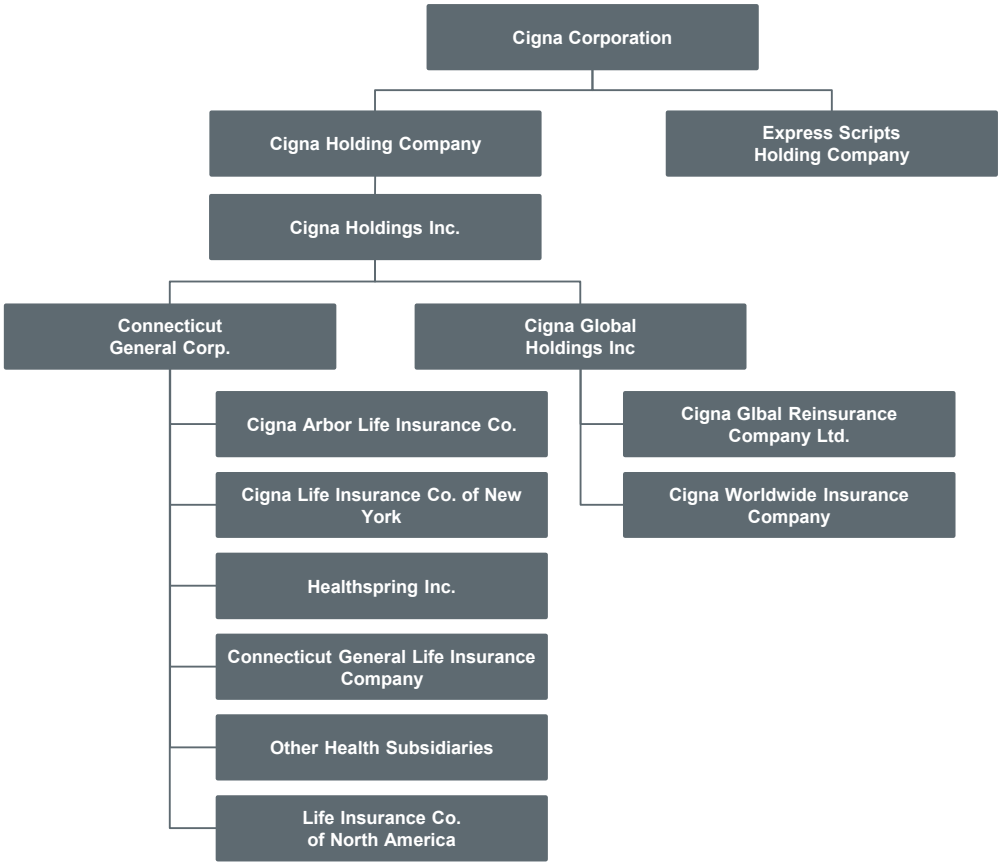
Cigna is a very highly diversified company that participates in over 30 different countries and offers a differentiated set of medical, pharmacy, behavioral, dental, disability, life and accident insurance products. Cigna distributes these products through multiple distribution channels, including brokers, agents, direct to consumers, affinity and bancassurance.

The acquisition of Express Scripts also offers Cigna additional capabilities, including a broader portfolio of specialty services, integrated behavioral, medical and pharmacy management services, leading specialty pharmacy services and advanced analytics.

## Ownership

Cigna's public ownership status is neutral to its ratings, with the benefits of financial flexibility and access to capital markets offsetting potential demands of capital efficiency from public shareholders.

### Simplified Organizational Chart — Cigna Corporation




Source: Fitch Ratings, Cigna Corporation.

## Capitalization and Leverage and Financial Flexibility

| | 2015 | 2016 | 2017 | 2018 | 1H19 | Fitch's Expectation |
|---|---|---|---|---|---|---|
| Debt/EBITDA[a] ($ Mil.) | 1.2 | 1.3 | 1.2 | 3.6 | 3.3 | Fitch anticipates the company will aggressively pay down debt such that financial leverage will be below 40% at YE 2020. |
| Financial Leverage Ratio (%) | 31 | 27 | 29 | 51 | 48 | |
| Total Financing and Commitment Ratio (x) | 0.4 | 0.4 | 0.5 | 1.0 | 0.9 | |
| Managed Care Premium/Equity (x) | 3.5 | 3.8 | 3.4 | 3.8 | 3.4 | |
| NAIC RBC (%) | 268 | 262 | 292 | 275 | N.A. | |

[a]Full-year 2018 uses Express Scripts 3Q EBITDA annualized and 1H19 is annualized. N.A. – Not available. Note: GAAP data.
Source: S&P Global Market Intelligence.

### Strong Capitalization

Overall Fitch view's the company's regulatory capital be strong and expects GAAP leverage metrics to improve from temporarily elevated levels as debt is repaid. Capitalization has a high influence on the rating.

#### *Acquisition Materially Increases Debt Load*

To fund the Express Scripts acquisition, Cigna raised approximately $24.5 billion in new debt, which comprised $20 billion in senior notes, $1.5 billion in CP and $3 billion from a term loan credit agreement. The remaining balance was funded by $3 billion cash on hand and $30.5 billion of newly issued equity. Additionally, Cigna assumed approximately $13 billion in Express Scripts debt, bringing the increase in debt to almost $38 billion.

#### *Holding Company Leverage Metrics Deteriorate*

The increased debt load caused significant deterioration in holding company leverage metrics to a level that exceeded previously established rating sensitivities. Fitch notes that Cigna's debt to- BITDA spiked at YE 2018 on a reported basis as the company's reported EBITDA only included roughly 11 days of Express Scripts operations against the entire amount of debt used to fund the acquisition.

For purposes of the debt/EBITDA calculations shown above, the 1H19 metric of 3.3x is calculated from annualized EBITDA, while the 3.6x in 2018 uses Express Scripts' EBITDA that is annualized for the first three quarters and was added to Cigna's full-year results. Further, the 2018 ratio had several one-time adjustments related to the acquisition. Results for 1H19 also better reflect the loss of revenue associated with the termination of Express Scripts' pharmacy benefits management contract with Anthem Inc.

Cigna continues its share repurchase plan while the company is also actively paying down debt. The company anticipates it will purchase $1.5 billion in stock in 2019, and through July 2019, it already deployed $1.1 billion. Absent the share repurchase program, Cigna would reach its target financial leverage ratio of 40% earlier than YE 2020.

#### *Insurance Operating Company Metrics Remain Strong*

In contrast to the deterioration of capital metrics at the holding company level, the insurance operating companies continue to remain strongly capitalized. Fitch will continue to monitor operating company capital levels to determine if the debt can be serviced without extraordinary dividends from the insurance operating companies.

## Debt Service Capabilities and Financial Flexibility

| | 2015 | 2016 | 2017 | 2018 | 1H19 | Fitch's Expectation |
|---|---|---|---|---|---|---|
| Interest Expense ($ Mil.) | 252 | 251 | 252 | 498 | 880 | Fitch anticipates that metrics will improve as the company actively reduces financial leverage, but will take until 2020–2021 for metrics to stabilize. |
| Operating EBITDA/Interest Expense (x) | 16.3 | 14.6 | 16.6 | 9.7 | 7.1 | |
| Maximum Dividend/Interest Expense (x) | 4.0 | 6.0 | 6.4 | 4.2 | 2.4[a] | |

[a]Estimate. Note: GAAP data.
Source: S&P Global Market Intelligence.

## Holding Company Debt Maturities

($ Mil., as of Dec. 31, 2018)

| | |
|---|---|
| 2019 | 2,995 |
| 2020 | 4,684 |
| 2021 | 7,397 |
| 2022 | 2,225 |
| 2023 | 4,858 |
| Thereafter | 17,404 |

Source: Company financial statements.

## Strong Financial Flexibility and Debt Service Capabilities

Overall, Fitch view's the company's debt service capabilities and financial flexibility to be strong with a moderate influence on the rating.

### *Strong Interest Coverage*

Historically, Cigna had strong operating EBITDA interest coverage that decreased in 2018 with the sizeable debt load undertaken to finance the Express Scripts acquisition. Absent the increased leverage, Cigna would have continued to produce interest coverage in the midteens. Fitch believes it will take two to three years for this ratio to stabilize as the company continues to reduce leverage while various acquisition costs are fully absorbed and synergies are realized.

### *Financial Flexibility Is Very Strong*

Fitch believes Cigna's financial flexibility is very strong, and its potential liquidity and capital needs are limited and generally met through operations. The company maintains a liquid investment portfolio that is a multiple of the company's insurance obligations. Additionally, Cigna continues to generate sufficient operating cash flow to fund its ongoing needs.

All of Express Scripts cash flows are available without restriction to the holding company while the insurance companies could dividend $2.1 billion without regulatory approval in 2019. Given this mix of cash flow available to the holding company, Fitch is using a combination of its *Corporate Rating Criteria* and *Insurance Rating Criteria* to determine holding company ratings.

Fitch estimates that approximately 50%–70% of the consolidated cash flows will originate outside of the insurance operations going forward.

## Financial Performance and Earnings

| ($ Mil.) | 2015 | 2016 | 2017 | 2018 | 1H19 | Fitch's Expectation |
|---|---|---|---|---|---|---|
| Revenue | 37,876 | 39,668 | 42,043 | 48,569 | 76,765 | Fitch expects profitability will approximate current levels. While some level of volatility is incorporated in the rating overall, the expectation is for an underwriting profit. |
| Medical Loss Ratio (%) | 80.9 | 81.6 | 81.0 | 78.9 | 81.6 | |
| EBITDA | 4,164 | 3,840 | 4,424 | 11,672[a] | 6,237 | |
| EBITDA/Revenues (%) | 11.0 | 9.7 | 10.5 | 9.8 | 8.1 | |
| Net Income | 2,077 | 1,843 | 2,232 | 2,646 | 2,782 | |
| Net Income/Average Capital (%) | 12.9 | 10.5 | 12.0 | 5.2 | 6.7 | |

[a]Full-year 2018 uses Express Scripts third-quarter EBITDA annualized; however, EBITDA/revenues is based on historical health insurance figures for YE 2018.
Note: GAAP data.
Source: S&P Global Market Intelligence.

## Very Strong Financial Performance

Overall, Fitch view's the company's financial performance and earnings to be very strong with a moderate influence on the rating.

### *Very Strong Profitability*

Cigna's pretax adjusted income from operations increased in 2018, reflecting improved margins in individual business and strong ongoing performance in commercial business, including increased contributions from specialty products. The medical loss ratio decreased, reflecting the resumption of the health insurance industry tax and improvement from individual business. The expense ratio also increased, reflecting resumption of the health insurance industry tax and ongoing investments in growth and innovation that were partially offset by higher revenues.

### *Acquisition Brings New Segments*

The acquisition, along with some recent accounting changes, resulted in a change in Cigna's reporting segments effective YE 2018. The largest of the new segments is Integrated Medical, accounting for almost 70% of total revenues. The integrated medical segment consists of a commercial operating segment that includes employer-sponsored medical coverage and a government operating segment, which includes Medicare offerings for seniors and individual insurance offerings to nonseniors both on and off the health insurance exchanges.

The Health Services segment consists of Express Scripts PBM business and Cigna's legacy home delivery operations. YE 2018 results for this segment include only 11 days of operations from Express Scripts. Going forward, this segment will be closely watched to see how the integrated operations perform.

Overall, Fitch anticipates that the company will generate approximately $8 billion in cash flows from operation in 2019 on approximately $136 billion in revenues. The company revised revenues from its original estimates up by approximately $3 billion to reflect higher contributions from its prescription benefit management business.

### *Margins Better than Peers*

EBITDA margins continue to exceed Fitch's median guideline for the current rating category of 7% and compare favorably with peer national health insurers. Fitch expects this trend to continue over the near to intermediate term and possibly accelerate depending on the success of the integration of Express Scripts and any potential synergies.

## Investments and Liquidity

| ($ Mil.) | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Cash and Invested Assets | 25,762 | 26,681 | 30,000 | 31,591 | 32,829 |
| Risky Asset Ratio (%) | 19 | 18 | 22 | 23 | 7 |
| Net Investment Income (NII) | 1,166 | 1,153 | 1,147 | 1,226 | 1,480 |
| NII/Average Cash and Invested Assets (%) | 4.6 | 4.4 | 4.0 | 4.0 | 4.6 |
| Cash and Invested Assets/MCL (x) | 11.8 | 11.3 | 11.8 | 13.1 | 12.2 |

MCL – Medical claim liabilities. Note: GAAP data.
Source: S&P Global Market Intelligence.

**Fitch's Expectation**

Fitch expects asset quality to remain fairly stable at current levels. Portfolio liquidity is expected to remain strong.

### Strong Investments and Adequate Liquidity

Fitch views the company's investments and liquidity as strong with a low influence on the current rating.

#### *Quality Fixed-Income Portfolio*

Cigna's fixed-income portfolio exhibits acceptable credit quality with 90% being investment grade at YE 2018. The fixed-income portfolio was $23 billion, or 79% of total invested assets, as of YE 2018.

The largest allocation was to corporate bonds, accounting for 80% of total fixed-income securities, which exhibited good diversification, with the largest allocations to consumer, financial and basic industry sectors at 21%, 21% and 18% of corporate bonds, respectively.

#### *Commercial Mortgage Exposure*

Performance measures were positive as the average loan to value of all commercial mortgages ranged from 60% to 70% at YE 2018 with positive debt service coverage. Commercial mortgage loans amounted to $1.9 billion, or approximately 6% of total cash and invested assets, at YE 2018. The commercial mortgage portfolio is a good duration match for Cigna's disability income and life insurance reserves. The portfolio consists of approximately 66 loans, almost all senior interests, with all the loans in good standing as of YE 2018.

#### *Manageable Market Scenario Sensitivity*

Potential loss in fair value of Cigna's investment portfolio under various market scenarios appeared manageable at Dec. 31, 2018. A 100bp increase in interest rates was estimated to result in a $1.6 billion loss in fair value, which was in line with prior year but very moderate relative to the overall portfolio. Cigna's long-duration life insurance reserves would be favorably affected by an increase in interest rates.

A 10% strengthening of the U.S. dollar relative to foreign currencies was estimated to result in a $400 million decline in the fair value of investments, which again is slightly better than the prior year's results. Cigna holds foreign currency assets as a natural hedge against liabilities in its foreign subsidiaries, mostly in South Korean won.

## Reserve Adequacy

| | 2014 | 2015 | 2016 | 2017 | 2018 | Fitch's Expectation |
|---|---|---|---|---|---|---|
| MCL ($ Mil.) | 2,180 | 2,355 | 2,532 | 2,420 | 2,697 | Fitch expects reserve development to be modest and the number of days in claims payable to remain fairly stable at approximately 40 days. |
| Growth Rate in MCL (%) | 6 | 8 | 8 | (4) | 11 | |
| Reserve Development/MCL (%) | (3) | (6) | 8 | (4) | (7) | |
| Days Claims Payable | 39 | 39 | 39 | 36 | 37 | |

MCL – Medical claim liabilities. Note: GAAP data.
Source: S&P Global Market Intelligence.

### Reserves Viewed as Adequate and Predictable

Fitch views the company's reserve adequacy as strong with a low influence on the current rating.

#### *Longer Duration Life Reserves*

Due to longer duration reserves associated primarily with its group life insurance business, which brings higher reserve risk relative to medical insurance, Cigna's reserve structure is different from many health insurance peers. Details of Cigna's reserves can be seen in the table below.

## Reserves by Line of Business

| ($ Mil., As of Dec. 31, 2018) | Current | Noncurrent | Total |
|---|---|---|---|
| Contractholder Deposit Funds | 641 | 7,365 | 8,006 |
| Future Policy Benefits | 740 | 8,981 | 9,721 |
| Unpaid Claims and Claim Expenses | | | |
| Integrated Medical | 2,678 | 19 | 2,697 |
| Other Segments | 2,394 | 3,230 | 5,624 |
| Unearned Premiums | 348 | 379 | 727 |
| **Total Insurance and Contractholder Liabilities** | **6,801** | **19,974** | **26,775** |

Source: Cigna Corporation10-K.

#### *Days in Claims Payable Remains Strong*

Reserves for health insurance benefits are typically of shorter duration, making them easier to project and less volatile than life or non-life insurance reserves. Further, reserve adequacy is typically a rating strength for health insurers and is generally less of a differentiating factor between health insurers' ratings compared with the ratings of life and non-life insurance companies. Fitch measures reserve adequacy using a days in claims payable ratio and reserve development trends.

Days in claims payable, measured by the number of days a company could pay its average daily medical claims or benefits by liquidating its reserves, was steady over past several years and Fitch does not anticipate any material changes going forward.

## Reinsurance and Risk Management

### Reinsurance Agreement with Berkshire Hathaway

Cigna effectively eliminated a source of potential volatility from its earnings and capital by reinsuring its variable annuity reinsurance business, which was in runoff since 2000. The reinsurance agreement with Berkshire Hathaway Inc. closed in 2013 and is subject to an overall limit, with approximately $3.4 billion remaining as YE 2018. The reinsurance recoverable associated with this transaction amounted to approximately $893 million as of YE 2018. These variable annuity liabilities are long term and include both guaranteed minimum death benefits and guaranteed minimum income benefits exposure.

#### *Large Reinsurance Recoverable from Divestitures*

The 2004 sale of Cigna's retirement benefits business to Prudential Retirement Insurance and Annuity Company was primarily implemented via a reinsurance arrangement. Cigna's reinsurance recoverable balance from this transaction totaled $787 million at YE 2018 and is fully secured by assets held in trust.

Similarly, in 1998, Cigna sold its individual life insurance and annuity business to The Lincoln National Life Insurance Company and Lincoln Life & Annuity Company of New York through indemnity reinsurance arrangements, resulting in a reinsurance receivable balance of $3.3 billion at YE 2018. Both companies maintained sufficient credit or financial strength ratings to avoid fully securing the outstanding reinsurance recoverable balance.

## Appendix A: Industry Profile and Operating Environment

This section discusses the U.S. health insurance sector. Fitch's Insurer Financial Strength (IFS) ratings on health insurers range from 'AA–' to 'BBB+', with the concentration in the 'A' category.

### Regulatory Oversight

Fitch views U.S. insurance regulation as very developed, relatively transparent and effective. Insurance regulation is conducted primarily at the state level, focused on protecting policyholders and promoting insurance company solvency. State regulators have broad authority over insurers domiciled in their state with respect to, among other things, standards of solvency, financial reporting, pricing, investments, market conduct and licensing.

Health insurers are subject to U.S. federal regulation associated with legislation, such as the Affordable Care Act, the Employee Retirement Income Security Act of 1974, and the Health Insurance Portability and Accountability Act of 1996, among others. Compliance with such legislation is primarily enforced by the Centers for Medicare & Medicaid Services and the U.S. Department of Labor.

### Technical Sophistication of Insurance Market; Diversity and Breadth

The U.S. health insurance and managed care sector has become quite technically sophisticated over the past two decades through advances in information technology, coupled with a growing volume of increasingly detailed claims data that feeds sophisticated predictive modeling capabilities. These capabilities drove the development of more tailored, flexible product offerings greatly improved pricing accuracy and care management, and have reduced margin volatility within the sector. Generally speaking, the level of sophistication is highly correlated with the size of the organization, as larger companies have greater resources and tend to offer more products in more regions, providing more comprehensive claims data.

### Competitive Profile

Fitch considers the U.S. health insurance industry to be mature and highly competitive, with high barriers to entry given the need to develop provider networks and administrative scale. Competition is based heavily on pricing as product differentiation is difficult to develop and maintain, and is limited by competitors and government influence. Competition is also generally local, allowing entrenched smaller local insurers with strong provider networks to effectively compete against much larger national scale insurers despite their smaller administrative scale.

### Financial Markets Development

The U.S. has the largest and most developed financial markets in the world. The markets are very deep, robust and highly liquid, which provides insurers the ability to maintain diversified asset portfolios, manage interest rate and credit risk exposures, and invest new cash flows with favorable trade execution. While the U.S. financial markets exhibit enormous strength in almost all economic environments, they have experienced stress during extreme conditions.

### Country Risk

Insurers' ratings are unconstrained by sovereign risk issues as Fitch maintains a 'AAA' country rating with a Stable Outlook on the U.S. The rating is supported by structural strengths, including the size of the economy, high per-capita income, strong institutions, dynamic business environment and the world's pre-eminent reserve currency. Partially offsetting this are concerns tied to government spending and financing activity, particularly growth in government deficits and the ability to meet long-term obligations, such as retirement and healthcare entitlements.

## Customers by Line of Business

(000 of Lives, as of YE 2018)

| | |
|---|---|
| Commercial | 13,982 |
| Government | 1,407 |
| International | 1,572 |
| **Total Medical** | **16,961** |
| Pharmacy | 73,230 |
| Behavioral | 27,215 |
| Dental | 16,544 |
| Medicare Part D | 3,295 |
| International Markets | 12,569 |
| Group Disability and Life | 14,800 |
| **Total Customer Relationships** | **164,614** |

Source: Cigna Corporation financial supplement.

## Appendix B: Peer Analysis

### Better Margins than Peers

Cigna's financial leverage metrics are currently much higher than peers, but Fitch anticipates that they will migrate over time to be in line with rated peers.

Cigna's profitability, measured primarily by the EBITDA margin, historically has been somewhat superior to its peers, and the company's diversified product offerings and large proportion of administrative services-only business are favorable characteristics in light of regulatory uncertainties in the industry. It is possible that Cigna can widen this lead with the successful execution of Express Scripts.

## Peer Comparison

($ Mil., As of Dec. 31, 2018)

| Company | IFS Rating | Membership (Mil.) | Total Revenue ($ Mil) | EBITDA ($ Mil | EBITDA Margin (%) | Shareholders' Equity ($ Mil.) | Debt/ Capital (%) | Debt to EBITDA (x) | EBITDA/Int. Expense (x) |
|---|---|---|---|---|---|---|---|---|---|
| Cigna | A | 17.0 | 48,569 | 4,774 | 9.8 | 41,035 | 51 | 3.6 | 9.7 |
| Aetna | A | 22.1 | 61,650[a] | 5,979[a] | 9.7[a] | 18,563[a] | 31[a] | 1.4[a] | 17.4[a] |
| UnitedHealth | AA– | 49.1 | 226,247 | 19,772 | 8.7 | 54,319 | 40 | 1.8 | 14.1 |
| Anthem | A+ | 39.9 | 92,105 | 6,953 | 7.5 | 28,541 | 40 | 2.8 | 9.5 |

[a]Fitch's estimate. IFS – Insurer Financial Strength. Int. – Interest.
Source: S&P Global Market Intelligence.

## Complete IFS Ratings List

| | |
|---|---|
| Connecticut General Life Insurance Co. | |
| Life Insurance Company of North America. | |
| CIGNA Worldwide Insurance Co. | |
| CIGNA Life Insurance Co. of New York. | |
| Insurer Financial Strength Rating | A |

## Appendix C: Other Ratings Considerations

Below is a summary of additional ratings considerations that are part of Fitch's ratings criteria.

### Group IFS Rating Approach

Fitch has applied a group rating approach when assigning a 'A' IFS ratings to Cigna's insurance company subsidiaries. The agency considers these subsidiaries to be Core based on their contribution to the group's overall premium and capital bases. Only normal regulatory barriers exist with regard to the movement of dividends and interest payments to the parent. Fitch believes Cigna has ample resources and willingness to support its operating subsidiaries

### Notching

Under Fitch's *Insurance Rating Criteria*, IFS ratings are typically assigned to insurance operating companies and serve as the initial "anchor" rating. Operating company IDRs are notched from the IFS ratings and holding company IDRs are notched from the operating company IDRs. As non-insurance operations provide more of the cash flow to service debt, the holding company ratings are expected to be less directly tied to Cigna's insurance company ratings over time. All of Cigna's new holding company debt, legacy holding company debt and Express Scripts debt is cross-guaranteed and is cross-defaulted.

For notching purposes, the U.S. regulatory environment is assessed by Fitch as being Effective and classified as following a Ring-Fencing approach.

## Notching Summary

| |
|---|
| **IFS Ratings** |
| A baseline recovery assumption of Good applies to Cigna's insurance company subsidiaries' IFS "anchor" ratings, and standard notching between the subsidiaries' IFS ratings and implied IDR was used. |
| **Operating Company Debt** |
| Not applicable. |
| **Holding Company IDR** |
| Widened notching between Cigna's insurance subsidiaries' implied IDR and Cigna holding company IDR was used to adjustment for high financial leverage following the acquisition financing. |
| **Holding Company Debt** |
| A baseline recovery assumption of Average was applied to Cigna's senior unsecured debt. Standard notching relative to the IDR was used. The Average assumption is consistent with corporate methodology at investment-grade levels. Traditional insurance methodology would utilize Below Average resulting in holding company ratings one notch below the IDR. |
| **Hybrids** |
| Not applicable. |
| IFS – Insurer Financial Strength. IDR – Issuer Default Rating. |

### Short-Term Ratings

Cigna maintains a $4.25 billion revolving credit facility to support the company's $1.5 billion CP program. The short-term IDR was notched from Cigna's holding company IDR. Under Fitch's criteria, CP programs with issuers that have a 'BBB' IDR are at a cusp where the default rating is 'F3' but may reach an 'F2' rating provided that the company has a minimum financial flexibility factor of 'bbb+' or higher and a minimum financial structure factor of 'bbb–' or higher. When doing sensitivity analysis for Cigna's regulated cash flows, the financial structure was not supportive of the 'F2' rating at this time. Fitch recognizes this may change as the company further deleverages.

### Corporate Governance and Management

Corporate governance and management are adequate and neutral to the rating.

## Transfer and Convertibility Risk (Country Ceiling)

None.

## Criteria Variations

None.

## Appendix D: Debt Issuance

($ Mil.)

| Short-term Debt | Issuer | 2018 | 2017 |
|---|---|---|---|
| Current Maturities: $1,000, 2.25% Senior Notes | Express Scripts | 995 | — |
| Current Maturities: $337, 7.25% Senior Notes | Express Scripts | 343 | — |
| CP | Legacy Cigna | 1,500 | 100 |
| Current Maturities: $131, 6.35% Notes | Legacy Cigna | — | 131 |
| Other, Including Capital Leases | Various | 117 | 9 |
| **Total Short-Term Debt** | **—** | **2,955** | **240** |
| | | | |
| **Long-Term Uncollateralized Debt** | | | |
| **Cigna Debt (Issued to Finance Acquisition)** | | | |
| $1,000, Floating-Rate Notes due 2020 | Cigna | 997 | — |
| $1,750, 3.200% Notes due 2020 | Cigna | 1,743 | — |
| $1,000, Floating-Rate Notes due 2021 | Cigna | 996 | — |
| $1,250, 3.40% Notes due 2021 | Cigna | 1,245 | — |
| $3,000 million, Floating-Rate Term Loan due 2021 | Cigna | 2,997 | — |
| $700 million, Floating-Rate Notes due 2023 | Cigna | 697 | — |
| $3,100, 3.75% Notes due 2023 | Cigna | 3,085 | — |
| $2,200, 4.125% Notes due 2025 | Cigna | 2,187 | — |
| $3,800, 4.375% Notes due 2028 | Cigna | 3,774 | — |
| $2,200, 4.800% Notes due 2038 | Cigna | 2,178 | — |
| $3,000, 4.900% Notes due 2048 | Cigna | 2,964 | — |
| | | | |
| **Express Scripts Debt (Assumed in Acquisition)** | | | |
| $500, 4.125% Senior Notes due 2020 | Medco | 506 | — |
| $500, 2.600% Senior Notes due 2020 | Express Scripts | 493 | — |
| $400, Floating-Rate Senior Notes due 2020 | Express Scripts | 399 | — |
| $500, 3.300% Senior Notes due 2021 | Express Scripts | 499 | — |
| $1,250, 4.750% Senior Notes due 2021 | Express Scripts | 1,285 | — |
| $1,000, 3.900% Senior Notes due 2022 | Express Scripts | 998 | — |
| $500, 3.050% Senior Notes due 2022 | Express Scripts | 481 | — |
| $1,000, 3.000% Senior Notes due 2023 | Express Scripts | 959 | — |
| $1,000, 3.500% Senior Notes due 2024 | Express Scripts | 966 | — |
| $1,500, 4.500% Senior Notes due 2026 | Express Scripts | 1,508 | — |
| $1,500, 3.400% Senior Notes due 2027 | Express Scripts | 1,386 | — |
| $449, 6.125% Senior Notes due 2041 | Express Scripts | 493 | — |
| $1,500, 4.800% Senior Notes due 2046 | Express Scripts | 1,465 | — |
| | | | |
| **Legacy Cigna Debt (Pre-Acquisition)** | | | |
| $250, 4.375% Notes due 2020 | Legacy Cigna | 248 | 249 |
| $300, 5.125% Notes due 2020 | Legacy Cigna | 298 | 299 |
| $78, 6.370% Notes due 2021 | Legacy Cigna | 78 | 78 |
| $300, 4.500% Notes due 2021 | Legacy Cigna | 297 | 299 |
| $750, 4.000% Notes due 2022 | Legacy Cigna | 746 | 745 |
| $100, 7.650% Notes due 2023 | Legacy Cigna | 100 | 100 |
| $17, 8.300% Notes due 2023 | Legacy Cigna | 17 | 17 |
| $900, 3.250% Notes due 2025 | Legacy Cigna | 895 | 894 |
| $600, 3.050% Notes due 2017 | Legacy Cigna | 595 | 594 |
| $259, 7.875% Debentures due 2027 | Legacy Cigna | 259 | 258 |
| $45, 8.300% Step Down Notes due 2033 | Legacy Cigna | 45 | 45 |
| $191, 6.150% Notes due 2036 | Legacy Cigna | 190 | 190 |
| $121, 5.875% Notes due 2041 | Legacy Cigna | 119 | 119 |
| $317, 5.375% Notes due 2042 | Legacy Cigna | 315 | 315 |
| $1,000, 3.875% Notes due 2047 | Legacy Cigna | 988 | 988 |
| Other, Including Capital Leases | Other | 32 | 9 |
| **Total Long-Term Debt** | **—** | **39,523** | **5,199** |

Source: Cigna Corporation.

The ratings above were solicited and assigned or maintained at the request of the rated entity/issuer or a related third party. Any exceptions follow below.

MOODY'S INVESTORS SERVICE

CREDIT OPINION
7 November 2019

Update

Rate this Research

RATINGS

**Cigna Corporation**

| | |
|---|---|
| Domicile | Bloomfield, Connecticut, United States |
| Long Term Rating | Baa2 |
| Type | Senior Unsecured - Dom Curr |
| Outlook | Stable |

*Please see the ratings section at the end of this report for more information. The ratings and outlook shown reflect information as of the publication date.*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| Japan | 81-3-5408-4100 |
| EMEA | 44-20-7772-5454 |


# Cigna Corporation

## Update to Credit Analysis


## Summary

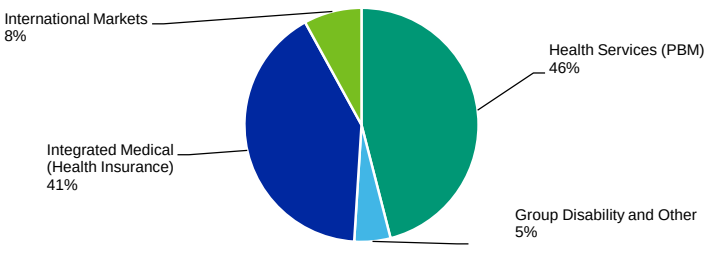
Moody's Baa2 senior debt rating and stable outlook of Cigna Corporation (Cigna) is based on the strong market position, relatively low underwriting risk and strong capital position of its health insurance operating subsidiaries. It also reflects the significantly enhanced diversification and large increase in unregulated revenues attained through the acquisition of Express Scripts Holding Company (ESI), a leading pharmacy benefit manager (PBM), last December. The international and group disability businesses provide additional diversification.

These strengths are mitigated by the high leverage incurred in financing the ESI acquisition. Leverage, as measured by debt-to-capital or debt-to-EBITDA are above the threshold typical for investment grade issuers. Our rating is predicated on Cigna significantly de-levering by the end of 2020. While we project sufficient operating results to accommodate de-levering, capital expenditures and capital requirements at the operating insurance subsidiaries, any material shortfall in operating results would put pressure on cash flow. The rating also reflects the significant integration risks of such a large acquisition.

In late September 2019 Cigna initiated an obligor exchange, in which over 80% of certain legacy Cigna Holding Company, Express Scripts and Medco bonds were exchanged for bonds of Cigna Corporation, the ultimate parent. The exchange did not impact leverage and we assigned Baa2 ratings to the new Cigna Corporation and affirmed the legacy debt, also at Baa2.


Exhibit 1

**Pre-tax adjusted income (loss) from operations by segment (ex. Corporate segment)**
**September 30, 2019**




*Source: Moody's Investors Service; Company Filings*

## Credit strengths

» Leading position in both health insurance and PBM

» Low risk profile healthcare membership highlighted by a low percentage of full risk membership

» Over half of cash flow to parent now from non-regulated sources

## Credit challenges

» Successfully managing the de-levering and integration processes of the ESI acquisition

» Successfully implementing its strategy to penetrate deeper into local markets and further expand into international markets

» Recovering momentum in Medicare Advantage now that the Center for Medicaid and Medicare Services (CMS) has removed sanctions on the business line

» Political risk related to Medicare for all and rising exposure to regulatory changes in the PBM industry.

## Outlook

The stable outlook reflects a balance between the integration risk inherent is such a large acquisition (i.e. ESI) and the significant deleveraging requirements through 2021 with the benefits of greater diversification and the addition of significant non-regulated cash flows that will be available to the parent company.

## Factors that could lead to an upgrade

» Leverage as measured by debt-to-capital falls below 40% and debt/EBITDA moves to 2.5x or below (both measures considering Moody's adjustments)

» EBITDA growth of the consolidated company is 4% or higher in 2019 and flat to positive in 2020 and 2021 (reflecting the loss of the Anthem account at ESI)

» The integration of ESI's operations proceeds according to Moody's expectations

» A successful integration of ESI, resulting in the generation of strong levels of unregulated and diversified cash flows available to the parent company, accompanied by deleveraging, could lead to tighter debt notching at the parent, as compared with the current 3-notch gap between Cigna's A2 IFS ratings and the parent company's Baa2 senior debt ratings.

## Factors that could lead to a downgrade

» EBITDA and cash flow fall short of Moody's projections in 2019 -- 2021

» Debt-to-capital remains above 45% by year-end 2020 and Debt/EBITDA above 3.0x (both with Moody's adjustments)

» The integration with ESI does not proceed as anticipated

## Key indicators table

| Cigna Corporation [1][2] | 2018 | 2017 | 2016 | 2015 | 2014 |
|---|---|---|---|---|---|
| **As Reported (US Dollar Millions)** | | | | | |
| Total Assets | 153,226 | 61,759 | 59,360 | 57,088 | 55,870 |
| Total Shareholders' Equity | 41,072 | 13,760 | 13,785 | 12,113 | 10,879 |
| Total Revenue | 48,569 | 42,043 | 39,668 | 37,876 | 34,914 |
| Net income (loss) attributable to common shareholders | 2,637 | 2,237 | 1,867 | 2,094 | 2,102 |
| Total Medical Membership (excl Standalone PDP)('000) | 16,961 | 16,377 | 15,197 | 14,999 | 14,456 |
| **Moody's Adjusted Ratios** | | | | | |
| Organic membership growth | 3.6% | 7.8% | 1.3% | 3.8% | 2.7% |
| Operating Income (EBITDA) Margin | 12.3% | 12.4% | 10.9% | 12.2% | 12.9% |
| Medical Loss Ratio | 78.9% | 81.0% | 81.6% | 80.9% | 80.6% |
| Financial Leverage - Debt to Capital | 51.6% | 33.0% | 32.2% | 35.9% | 38.6% |
| Financial Leverage -Debt to EBITDA | 7.4x | 1.3x | 1.5x | 1.5x | 1.5x |
| EBITDA Interest Coverage | 10.8x | 17.4x | 14.0x | 15.1x | 14.0x |
| Cash Flow Interest Coverage | 3.1x | 5.1x | 5.1x | 4.1x | 3.5x |
| Consolidated NAIC Risk-Based Capital (CAL) | 323% | 329% | 323% | 330% | 344% |
| Goodwill & Intangibles % Shareholders' Equity | 210.4% | 63.8% | 65.5% | 74.6% | 82.8% |
| Full risk membership % | 28.8% | 27.9% | 20.7% | 20.5% | 21.1% |

[1]Information based both on statutory/regulatory and US GAAP financial statements as of Fiscal YE December 31. [2]Certain items may have been relabeled and/or reclassified for global consistency.
*Source: Moody's Investors Service, company filings*

## Profile

Cigna Corporation (Cigna) is a global health care services organization headquartered in Connecticut in the US. Through its subsidiaries, the company provides health care and related benefits, with the majority offered through employers and other groups such as unions and associations. Its key product lines include medical coverage, including Medicare and Medicaid products, and related specialty health care products and services such as pharmacy benefit management services, behavioral health, dental and disease management care, as well as group disability, life and accident insurance. In addition, the company has international operations that offer supplemental health, life and accident insurance products, expatriate benefits and international health care coverage to businesses, government and non-government organizations and individuals in selected markets.

The company's corporate structure changed with the acquisition of ESI in December 2018. Cigna Corporation, which was originally formed in September 2018 as Halfmoon Parent, Inc. to issue $20 billion in debt to partly finance the ESI acquisition, is the ultimate parent. Legacy Cigna Corporation, formerly the ultimate parent, is now Cigna Holding Company, a wholly-owned subsidiary of the newly renamed Cigna Corporation and ESI is also a wholly-owned subsidiary of Cigna Corporation. In late September Cigna commenced an obligor exchange, in which debt holders of Cigna Holding Company and ESI and Medco (a subsidiary of ESI) were incentivized to exchange their debt for Cigna Corporation debt. As a result, outstanding legacy bonds declined from $16.8 billion to $4.2 billion.

With the acquisition of ESI, Cigna Corporation is also a leader in the pharmacy benefits management space. ESI has more than 2,500 clients, 75 million customers, processes 1.2 billion prescriptions annually with an 86.7% generic fill rate. The goal of this merger is to better control health care spending growth. The combination of Cigna and ESI will allow for the holistic management of medical and pharmacy costs and particularly specialty pharmacy. This is becoming more important as pharmacy is fast growing component of health care spend. Furthermore, the addition of ESI increases the percentage of non-regulated cash flow to the parent from a relatively small percent to over half, which reduces regulatory risk.

Cigna reports earnings four main operating segments, in addition to corporate. As shown in Exhibit 1, Integrated Medical and Health Services, both discussed below, contributed approximately 41% and 46% of 2019 Q3 pre-tax adjusted operating income (excluding corporate).

**Integrated Medical – Health Insurance**

Click here for more information about Cigna's health insurance operations.

Cigna's A2 IFS ratings for its operating health insurance subsidiaries are based primarily on the group's strong business profile, driven by its national presence and brand name, large membership base and its broad range of group benefits products. The ratings also consider the group's relatively low business risk profile -- as 78% of its members (excluding international) are in administrative services only, its strong profitability (adjusted pre-tax margin of 11.9% in H1 2019) and its strong capital levels (RBC CAL ratio of 323%). These strengths are partly mitigated by sluggish performance in Medicare Advantage as the company has mostly HMO plans (more prevalent for lower income populations), which is not the most attractive product for its target market.

Results through the first nine months of 2019 in the Integrated Medical segment (the insurance operations) were solid. Pre-tax operating earnings were up 9% year-over-year. Although overall membership growth was modest year-over-year, the Select segment (employers with 50 – 500 employees) continues to grow and was up 12% year-over-year and comprises approximately 14% of total membership. While the medical cost ratio remains among the best, it increased 200bps in third quarter 2019 to 80.3%, reflecting the suspension of the health insurance fee (HIF), more normalized losses in the individual market and the addition of ESI's part D business.

**Health Services – Pharmacy Benefit Management**

Click here for more information about Express Scripts.

Express Scripts (ESI) Baa2 rating (stable outlook) is largely driven by the rating of Cigna Corporation, the parent company. However, the rating also reflects operating conditions at ESI, which was rated Baa2 prior to being acquired. ESI, which now comprises Cigna's Health Services segment, is the second largest PBM in the U.S. It serves over 2,500 clients and 75 thousand customers. Therefore, the rating also reflects its leading market position. Furthermore, ESI achieved a record low 0.4% drug trend for commercial clients and a negative 0.3% trend for Medicare clients. Another credit strength is its leading position in specialty pharmacy.

ESI also has several credit challenges. The loss of its largest client is the most significant challenge. Anthem, Inc., which comprised approximately 20% of revenue and over 30% of EBITDA in recent years, is in the midst of transitioning its clients to own PBM, IngenioRx, a process that should be complete by the end of 2019. During the first nine months of 2019, Cigna's Health Services segment reported adjusted pre-tax operating income of $3,555 million, which excluded $1,589 million from clients transitioning to Anthem.

A second challenge relates to the Anthem lawsuit. Anthem is suing ESI for $14.8 billion, asserting breach of contract. In addition, there are sector-wide challenges including political risks (i.e. eliminating rebates), fewer generic drug introductions, softening mail order growth trends and an evolving competitive environment (i.e. IngenioRx). Finally, there is integration risk and the question of whether ESI's combination with Cigna will impact retention. So far, aside from Anthem, retention has remained very high at 98.5% for 2019.

In July, the Trump administration pulled its proposal to prohibit drug manufacturers from paying rebates to PBMs in government programs. Still, it is likely that political pressure on rebates, which are blamed for creating higher list prices for brand-name drugs, will continue. A full elimination of rebates would represent a change in the way the PBM industry operates, especially if commercial plans followed suit, and PBMs would have to seek new ways to price their services and offer value.

**Financial Flexibility: Financial leverage substantially higher following acquisition**

Cigna's financial flexibility, which we assess solely on a consolidated basis, has been adversely impacted by the ESI acquisition. Prior to the acquisition, Cigna's leverage and coverage ratios were among the best of its peers.

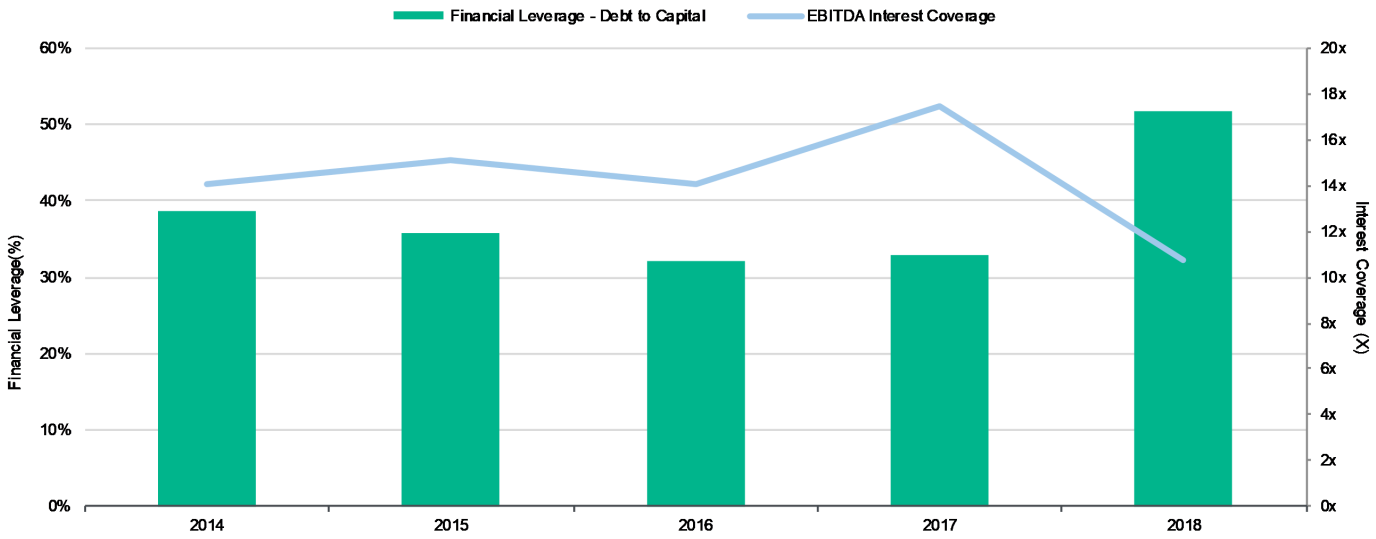
Cigna paid $3.7 billion in debt through third quarter 2019 helping debt-to-capital with Moody's adjustments to improve to 47.3% from 51.6% as of year-end 2018. Cigna plans to reduce outstanding debt by at least $4.2 billion overall in 2019. Pro-forma debt-to-EBITDA (last 12 months) was 3.5x as of September 30, 2019.

In addition, we forecast that EBITDA coverage of interest expense, which has been consistently been in the mid-teens historically, should fall to below 10x in 2019, due to the significant increase in interest expense. If Cigna meets its deleveraging targets, (the company reduced debt by approximately $2 billion in Q1 2019) we estimate that adjusted debt-to-capital ratio will fall below 40% by the end of 2020 and debt-to-EBITDA will improve to approximately 2.5x.

Cigna's earnings and subsidiary dividend capacity have remained strong and we note that liquidity is supported by a $3.25 billion credit facility, a $1.0 billion 364-day revolving credit agreement, and if necessary, potential access to the public debt and equity markets. As discussed below, given Cigna's aggressive debt repayment objectives through 2021, debt repayment requirements will be high relative to projected cash flow.

Exhibit 3

**ESI acquisition increased leverage, decreased EBITDA coverage**




*Source: Moody's Investors Service; Company Filings*

## Liquidity analysis

Cigna Corporation, the parent company, is dependent on dividends and administrative expense reimbursements from its subsidiaries, most of which, historically had been subject to regulatory restrictions. With the acquisition of ESI, Cigna Corp will be receiving more than half of its cash flow from ESI, which is generally unregulated. In addition to the $3.7 billion of debt Cigna already repaid in 2019, Cigna has debt maturities of approximately $4.7 billion through 2020. We forecast that consolidated cash flow in 2019 and 2020 are sufficient cover debt payments plus capex and subsidiary capital growth. However, the cushion appears smaller in 2020 and 2021. Any significant (unanticipated) shortfall versus expected results could require Cigna to stretch beyond operating cash flows to meet scheduled debt repayment. In this case, management does have additional levers to pull.

In addition, Cigna also has a three-year $3.0 billion term loan agreement that was used to finance the merger, repay existing indebtedness of ESI and pay related fees and expenses. Through September 30, 2019 $1.0 billion remains outstanding on the term loan. There is no remaining amount available for borrowing.

Supplementing its operating cash flow, Cigna also has the ability to borrow approximately $1.1 billion from its affiliates without prior regulatory approval. At September 30, 2019, there was approximately $1.1 billion in cash and short-term investments available at the parent company level or subsidiaries with no regulatory restrictions on transferring cash to the parent.

Cigna's cash flow could be impacted by two unrelated pending lawsuits involving Anthem, Inc (Baa2 stable), posing uncertainty. In short, the companies are suing each other for as much as $14.8 billion. In the first suit, Cigna is suing Anthem for approximately 14.8 billion (and Anthem is counter-suing) related to the cancellation of the proposed merger between the two companies in 2017. In the other unrelated case Anthem is suing ESI, also for approximately $14.8 billion. An initial ruling on the first suit is expected in Q1 2020 and the second suit possibly by late 2020. Our ratings do not incorporate a material adverse (or beneficial) impact from these lawsuits.

Cigna also has a $3.25 billion bank line of credit, with no MAC clause, which serves as a backup for Cigna's commercial paper program and as an available line of credit. The facility expires in April 2023 and includes an option to increase the commitment by $500 million

and extend the term for additional one year periods. In October 2019 Cigna also executed a $1.0 billion 364-day revolving credit agreement with 23 banks that matures in October 2020.

The company utilizes its commercial paper program to provide liquidity and to facilitate the investment process. As of September 30, 2019, Cigna had $1.1 billion outstanding under its commercial paper program. There were no borrowings outstanding under the credit facility and the company had $21 million of letters of credit outstanding.

Cigna's share repurchase program is discretionary and may be discontinued at any time; and following the agreement to acquire ESI, Cigna had suspended its share repurchase program. In the first quarter of 2019 Cigna resumed share repurchases. Through the first nine months of 2019, 9.3 million shares were repurchased for approximately $1.5 billion.

## ESG Considerations

Like its health insurance peers, Cigna has elevated social risks related to its integral role in society and position as the front line for most people in managing their health care costs, and being regarded as at least partly responsible for the cost structure and access to health care for most Americans.

## Structural considerations

The three notch difference between Cigna's Baa2 senior unsecured debt rating and A2 IFS ratings on Cigna's operating subsidiaries is consistent with other highly rated life and health insurers. This standard notching represents the priority of claims of policyholders versus debt holders and also standard and potential extraordinary regulatory restrictions on the payment of dividends to the parent company from the insurance subsidiaries. The increase in unregulated cash flows that will ensue from the ESI acquisition could potentially result in narrower notching between senior debt and the IFS rating; i.e. moving to two notches from three.

Originally, the new debt issued by the ultimate parent and the legacy debt issued by the subsidiaries were supported by both upstream and downstream guarantees, subject to “fall away” provisions, meaning that the guarantees would be released when the aggregate legacy debt would fall below 20% of the total consolidated outstanding debt. In late September Cigna implemented a obligor exchange, incentivizing legacy debt bond holders to exchange that debt for new Cigna Corporation debt. With the results of the obligor exchange, the aggregate debt is now below 20% of consolidated debt and, therefore, the guarantees are released.

Despite the release of the guarantees, Moody’s is not differentiating between debt ratings of Cigna Corporation and Cigna Holding Company, its downstream subsidiary, because Cigna Holding Company is now minimal with its remaining debt now below 4% of total outstanding debt. We plan to continue rating the Cigna Holding Company debt.

On October 4, Moody’s affirmed the legacy ESI (including Medco debt) debt at Baa2 with a stable outlook but stated that if the exchange offer concludes with a substantial portion of legacy debt being exchanged (82% was exchanged as of October 9), it would anticipate withdrawing those ratings.

## Moody's related publications

### Sector research

» Healthcare Quarterly, October 2019

» Healthcare - US: Public health insurance proposals would cut into industry margins, with single-payer posing the deepest threat, October 2019

» Financial Institutions - US: Individual health insurance market stability after individual mandate cut is credit positive for health insurers, August 2019

» Health Insurance - US: Q2 2019 earnings update - Good results, but medical costs higher, August 2019

» Life & Health Insurance - US: Expanded health reimbursement arrangement is credit positive for insurers in the individual market, June 2019

### Outlook

» Health Insurance - US: 2019 outlook stable on moderate medical cost and membership trends, November 2018

### Methodology

» US Health Insurance Companies, May 2018

To access any of these reports, click on the entry above. Note that these references are current as of the date of publication of this report and that more recent reports may be available. All research may not be available to all clients.

## Ratings

Exhibit 4

| Category | Moody's Rating |
|---|---|
| **CIGNA CORPORATION** | |
| Rating Outlook | STA |
| Senior Unsecured | Baa2 |
| Commercial Paper | P-2 |
| **CIGNA HOLDING COMPANY** | |
| Rating Outlook | STA |
| Senior Unsecured | Baa2 |
| Senior Unsecured MTN | (P)Baa2 |
| **CONNECTICUT GENERAL LIFE INSURANCE COMPANY** | |
| Rating Outlook | STA |
| Insurance Financial Strength | A2 |
| **LIFE INSURANCE COMPANY OF NORTH AMERICA** | |
| Rating Outlook | STA |
| Insurance Financial Strength | A2 |
| **CIGNA HEALTH & LIFE INSURANCE COMPANY** | |
| Rating Outlook | STA |
| Insurance Financial Strength | A2 |
| **EXPRESS SCRIPTS HOLDING COMPANY** | |
| Rating Outlook | STA |
| Senior Unsecured | Baa2 |

*Source: Moody's Investors Service*

REPORT NUMBER 1201682

## CLIENT SERVICES

| | |
|---|---|
| Americas | 1-212-553-1653 |
| Asia Pacific | 852-3551-3077 |
| Japan | 81-3-5408-4100 |
| EMEA | 44-20-7772-5454 |

# List of Confidential and/or Proprietary Information – Post RFP Submission

**In accordance with RFP Section I.F.2, Express Scripts considers the following to include confidential and/or proprietary information.**

| Document | Page(s) |
|---|---|
| Commercial_Formulary Disruption_Express Scripts | All |
| EGWP_Formulary Disruption_Express Scripts | All |
| Evernorth's Description of Its Claims Processing System SOC 1_Final | All |
| Evernorth's Description of Its Rebates Share Processing System SOC 1_Final | All |
| Appendix J Section I.4.a.i National Preferred Formulary | All |
| Appendix J Section I.4.b.i Medicare Premier Access Formulary | All |
| Appendix X_Respondent Specialty Drug Pricing_Express Scripts | All |
| PBM RFP – Express Scripts NDA – ERS Redlines | All |
| PBM RFP – Express Scripts NDA – ERS Redlines_ESI acceptance | All |
| PBM RFP – Clarification Request No. 1 Express Scripts | All |
| PBM EGWP RFP - Appendix X - ESI Specialty Drug Pricing by NDC | All |
| PBM RFP – Deviation Request No. 1Express Scripts | 7 |
| Information Security Policy | All |
| Express Scripts NDA | All |
| PBM RFP – SIG Questionnaire_Express Scripts | All |
| Appendix W – Respondent Proposed EDS Network – Express Scripts | All |

| Document | Page(s) |
|---|---|
| National Performance Network Directory_6.17 | All |
| PBM EGWP RFP - Appendix X - ESI Specialty Drug Pricing by NDC (9.26) | All |
| PBM RFP – Clarification Request No. 5 Express Scripts | 1,3 |
| ERS Commercial Formulary w Tier | All |
| ERS EGWP Formulary w Tier | All |
| Express Scripts Proposed Network_Commercial | All |
| Express Scripts Proposed Network_EGWP | All |
| Appendix X - ESI Specialty Drug Pricing by NDC (10.20) | All |
| PBM RFP BAFO Express Scripts | All |
| PBM RFP – Clarification Request No. 7 Express Scripts | 1 |

# APPENDIX A

## SIGNATURE PAGE

**SECOND AMENDED MAY 25, 2022**

## STATEMENT OF OFFICER REGARDING SOLICITATION AND PROPOSAL

1) My name is Amy Bricker.

2) I am the President (title) of Express Scripts, Inc. (legal entity name of contract owner) ("my Company").

3) I do solemnly swear/affirm that I am duly authorized to make the following statements on behalf of my Company in response to the Employees Retirement System of Texas' Request for Proposals No. 21-11565-001 entitled Request for Proposals to Provide Pharmacy Benefit Management Services for the HealthSelect of Texas Prescription Drug Program and the HealthSelect Medicare Rx Prescription Drug Program including all attachments thereto ("ERS' Solicitation").

Antitrust Statement

4) In connection with ERS' Solicitation, I affirm under penalty of perjury of the laws of the State of Texas that neither I nor any representative of my Company have violated any provision of the Texas Free Enterprise and Antitrust Act, Texas Business and Commerce Code Chapter 15.

5) In connection with ERS' Solicitation, neither I nor any representative of the Company have violated any federal antitrust law.

6) Neither I nor any representative of the Company have directly or indirectly communicated any of the contents of ERS' Solicitation to a competitor of the Company or any other company, corporation, firm, partnership or individual engaged in the same line of business as the Company.

Attestation Regarding RFP, Proposal and Financial Stability

7) I have completely read and understand ERS' Solicitation. Each section of ERS' Solicitation includes statements of fact regarding how ERS expects the services to be administered and ERS' requirements. I acknowledge that ERS will presume that my Company agrees with and will comply with each ERS requirement unless my Company specified its deviations therefrom in its Proposal and ERS accepted such deviations in writing in accordance with ERS' Solicitation instructions.

8) I have reviewed the information contained within my Company's Proposal to ERS' Solicitation. The information presented in my Company's Proposal is complete, true, accurate, and in full compliance with ERS' Solicitation, except as specifically indicated in my Company's Proposal.

9) My Company is in good financial standing, has not been disqualified by the State of Texas to conduct business or perform services of any kind, is not in any form of bankruptcy, and is current in the payment of all taxes and fees.

10) I acknowledge, understand and agree that my responses to the questions and all other provisions of the RFP are material and will be relied on by ERS in connection with ERS' scoring and contract award recommendation.

11) My Company represents and warrants to the truth and accuracy of all statements, warranties and representations contained in the Proposal and other documents submitted by my Company.

Acknowledgement of Receipt of Addenda **FIRST AMENDED MAY 18, 2022, SECOND AMENDED MAY 25, 2022**

12) I acknowledge that the following Addendums were posted: Addendum #1 on May 18, 2022 and Addendum #2 on May 25, 2022.

Attestation Regarding Confidential and/or Proprietary Information

13) I have reviewed the information that I believe, in good faith and with legally sufficient justification, is my Company's Confidential and/or Proprietary information. My Company has submitted its Confidential and Proprietary information with its Proposal to ERS in accordance with ERS' Solicitation instructions.

14) I understand that each time my Company submits information to ERS, my Company must submit any information that we believe, in good faith and with legally sufficient justification, is confidential and/or proprietary, and the information must be submitted in accordance with ERS' Solicitation instructions.

15) I understand that, to the extent my Company finds it necessary, I should have my Company's corporate and/or outside counsel review my Company's Proposal to determine the information that should be considered Confidential and/or Proprietary before I submit it to ERS.

16) I further understand that, upon ERS' receipt of a Texas Public Information Act request, ERS will provide the requestor the information provided by my Company labeled or designated "Public" information (regardless of the format in which it was submitted) without any prior notification to my Company.

17) I also understand that, should my Company fail to submit its Confidential and/or Proprietary information as outlined in ERS' Solicitation, that ERS will presume that all information submitted by my Company is public information and subject to disclosure.

18) My Company agrees to fully cooperate with ERS to provide any or all documentation related to ERS' Solicitation upon request by ERS and within the deadline specified by ERS, whether during the RFP process or any applicable record retention period set forth in the Contractual Agreement attached to the RFP, and regardless if my Company is selected for contract award.

Attestation Regarding Conflicts of Interest Contractual Provisions

19) I hereby attest that I have read and understand the Conflicts of Interest provisions contained within the Contractual Agreement attached to the RFP ("Conflicts of Interest Provisions") and that (check one).

☒ My Company has not engaged nor will it engage in any actions that are or could be perceived to be a conflict of interest, appearance of impropriety or Prohibited Communication (as defined in the Contractual Agreement), as these concepts are further described in the Conflicts of Interest Provisions.

☐ My Company has engaged in the following actions that are or could be perceived to be a conflict of interest, appearance of impropriety or Prohibited Communication (as defined in the Contractual Agreement), as these concepts are further described in the Conflicts of Interest Provisions:

_____

_____

_____

_____

My Company has also taken the following actions or proposes to take the following actions to cure, avoid, or mitigate such issues or potential issues (Please use additional pages, as necessary, to fully respond):

_____

_____

_____

20) I further attest that, if any time after the submittal of my Company's Proposal response to ERS' Solicitation but before award of the work under such Proposal, my Company discovers or is made aware of an actual or perceived conflict of interest, appearance of impropriety or Prohibited Communication that pre-existed the submittal of Company's Proposal or arose thereafter, I will immediately disclose such interest, appearance or communication in writing to ERS.

Electronic Signature Attestation (if applicable)

21) I acknowledge, understand and agree that an electronic signature below constitutes an "electronic signature" as such term is defined in Chapter 322 of the Texas Business and Commerce Code.

By: Amy Bricker
Signature of Officer

Printed Name: Amy Bricker
Title: President, Express Scripts,Inc.
Date: June 20, 2022
Updated July 6, 2022

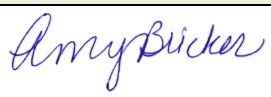
**LIST OF AUTHORIZED REPRESENTATIVES**
**FOR EXPRESS SCRIPTS**

# APPENDIX F

# INCUMBENCY CERTIFICATE

# INCUMBENCY CERTIFICATE

Express Scripts ("PBM") hereby certifies that each person whose name appears below is an authorized officer who is at a vice president or higher level and authorized to act on PBM's behalf (including the authorization to sign any binding legal document) with respect to the attached Contractual Agreement for Pharmacy Benefit Management Services for the HealthSelect℠ Prescription Drug Program and HealthSelect℠ Medicare Rx (Medicare Part D) Prescription Drug Program under the Texas Employees Group Benefits Plan between the Employees Retirement System of Texas ("ERS") and PBM. PBM further certifies that the true signature of each such person is set forth below opposite his/her name, and that ERS may rely upon this certificate until such time as it receives another certificate bearing a later date.

| Printed Name | Title | Signature* |
|---|---|---|
| Amy Bricker | President, Express Scripts, Inc. |  |
| Fred Bendana | Vice-President, Health Plans and Regulated Market Sales, Express Scripts, Inc. |  |
| | | |

Certification Signature:

By: 

Printed Name: Amy Bricker

Title: President, Express Scripts, Inc.

Effective Date: June 20, 2022

Updated: July 6, 2022