

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909

June 17, 2009

CHANGE NOTICE NO. 8
TO
CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE Cari Wegge (314) 989-5947
Express Scripts, Inc. 6625 West 78 th Street Bloomington, MN 55439 cwegge@express-scripts.com		
Contract Compliance Inspector: Susan Kant Prescription Drug Program – DMB/OSE		BUYER/CA (517) 373-1080 Melissa Castro, CPPB
CONTRACT PERIOD: From: June 1, 2003		To: December 31, 2009
TERMS	SHIPMENT	
N/A	N/A	
F.O.B.	SHIPPED FROM	
N/A	N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby EXTENDED through December 31, 2009, and INCREASED by \$70,000,000.00.

Additionally, the Contractor's contact is hereby CHANGED to: Cari Wegge
 Phone: (314) 989-5947
 Email: cwegge@express-scripts.com

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request (PRF dated 4/23/09), Ad Board approval on 6/16/09 and DMB/Purchasing Operations' approval.

REVISED CURRENT AUTHORIZED SPEND LIMIT: \$1,687,855,656.70

FOR THE VENDOR:	FOR THE STATE:
Express Scripts, Inc.	Signature
Firm Name	Elise A. Lancaster
Authorized Agent Signature	Name
Authorized Agent (Print or Type)	Director, Purchasing Operations
Date	Title
	Date

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909

September 17, 2008

CHANGE NOTICE NO. 7
TO
CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE Ron Tyson (800) 279-6602	
Express Scripts, Inc. 6625 West 78 th Street Bloomington, MN 55439			
ron.tyson@express-scripts.com		BUYER/CA (517) 373-1080 Melissa Castro, CPPB	
Contract Compliance Inspector: Susan Kant Prescription Drug Program – DMB/OSE			
CONTRACT PERIOD:		From: June 1, 2003 To: September 30, 2009	
TERMS	SHIPMENT		
N/A	N/A		
F.O.B.	SHIPPED FROM		
N/A	N/A		
MINIMUM DELIVERY REQUIREMENTS N/A			

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby EXTENDED through September 30, 2009, and INCREASED by \$400,000,000.00. Additionally, the attached revised Pricing Supplement is hereby incorporated into this Contract (see attachments – 16 pages). All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency/vendor request and DMB/Purchasing Operations' approval.

REVOSED CURRENT AUTHORIZED SPEND LIMIT: \$1,617,855,656.70

FOR THE VENDOR:	FOR THE STATE:
Express Scripts, Inc.	Signature
Firm Name	Elise A. Lancaster
Authorized Agent Signature	Name
Authorized Agent (Print or Type)	Director, Purchasing Operations
Date	Title
	Date



EXPRESS SCRIPTS®

**PHARMACY BENEFIT MANAGEMENT SERVICES
PRICING SUPPLEMENT
FOR
STATE OF MICHIGAN**

8-13-08

RETAIL PHARMACY NETWORK AND HOME DELIVERY PRICING

12-Month Offer				
2-Tier Plan Design with less than \$15.00 Differential				
3-Tier Plan Design with a minimum \$15.00 Differential				
Option 1: Traditional Minimum 50k Network	Retail	Home Delivery Discounts*	Home Delivery Discounts* Less than 35 days' supply	
Brands	Pricing	The lower of AWP-17.25% or U&C	AWP-25.25%	AWP-17.25%
	Dispensing fee	\$1.35/Rx	\$0.00/Rx	\$1.35/Rx
	Administrative fee	\$0.00/Rx	\$0.00/Rx	\$0.00/Rx
Generics	Pricing	The lower of AWP-17.25%, MRA, or U&C Guarantee Average: AWP – 60.5%	The lower of AWP-25.25% or MRA Guarantee Average: AWP – 67%	The lower of AWP-17.25% or MRA Guarantee Average: AWP – 67%
	Dispensing fee	\$1.45/Rx	\$0.00/Rx	\$1.45/Rx
	Administrative fee	\$0.00/Rx	\$0.00/Rx	\$0.00/Rx
Rebates — Per Claim	Rebate Guarantee BPL 37944 with Step Therapies	Greater of \$3.22 or 100%	Greater of \$13.87 or 100%	Greater of \$13.87 or 100%
	Rebate Guarantee BPL 37943 with Step Therapies	Greater of \$3.49 or 100%	Greater of \$17.25 or 100%	Greater of \$17.25 or 100%
	Rebate Guarantee BPL 37942	Greater of \$1.78 or 100%	Greater of \$13.65 or 100%	Greater of \$13.65 or 100%
	Rebate Guarantee BPL 13572	Greater of \$3.12 or 100%	Greater of \$12.77 or 100%	Greater of \$12.77 or 100%

* If the calculation of the cost of the claim is less than Express Scripts' minimum Home Delivery rate (currently \$8.99) and less than the applicable copayment, then the member will pay the greater of the AWP discount price, or the Minimum Rate.

Assumptions

- Quoted fees and services are valid for 90 days from the date of the proposal.
- Quoted fees are guaranteed for the term of the contract.
- Minimum of 140,000 lives will be implemented on the effective date.
- None of the membership to be enrolled is based on a 100% copayment benefit plan.
- Express Scripts reserves the right to amend the price quotation set forth herein if there is a material change in the number of persons included in the prescription drug program or any material change in the benefit plan from that which was presented to Express Scripts and upon which this price quotation is based.
- State of Michigan agrees to adopt Express Scripts' National Preferred Formulary in order to be eligible for rebates, whether rebates are paid or applied.
- Rebate guarantees assume the current benefit plan design, or new benefit plan design as disclosed by the client, will be implemented at the time these guarantees go into effect. Rebate guarantees are subject to adjustment if any clinical or trend programs intended to drive higher generic or over-the-counter (OTC) utilization are currently in place without Express Scripts' knowledge of both the program and drugs within the program. Rebate guarantees are also subject to adjustment if the client chooses to implement any clinical or trend management programs intended to drive higher generic or OTC utilization during the course of the contract. Rebates are paid only upon receipt of a signed contract.
- Rebates are paid on specialty products dispensed through CuraScript or participating retail pharmacies.
- Rebate allocations will be made quarterly within 150 days from the end of the quarter. Guarantee will be reconciled in aggregate annually with any payment due to State of Michigan made within 240 days from the end of each annual period.
- The rebate guarantee does not apply to claims processed through staff model/hospital pharmacies where such pharmacy is subject to its own manufacturer contracts (rebate or purchase discounts), or through pharmacies that participate in the Federal government pharmaceutical purchasing program.
- The parties understand that pricing indices historically used, (and that are the basis in this Agreement), for determining the financial components of pharmacy billing rates are outside the control of State of Michigan and Express Scripts. The parties also understand that there are currently extra-market industry, legal, government, and regulatory activities, which may lead to changes relating to, or elimination of, these pricing indices that could alter the financial positions of the parties as intended under this Agreement. The parties agree that, upon entering into any resultant Agreement and thereafter, their mutual intent has been and is to maintain pricing stability as intended and not to advantage either party to the detriment of the other. Accordingly, to preserve this mutual intent, if Express Scripts undertakes any or all of the following:

Pricing Supplement

- (i) changes the AWP source across its book of business (e.g., from First DataBank to MediSpan); or
- (ii) maintains AWP as the pricing index with an appropriate adjustment as described below, in the event the AWP methodology and/or its calculation is changed, whether by the existing or alternative sources; or
- (iii) transitions the pricing index from AWP to another index or benchmark (e.g., to Wholesale Acquisition Cost),

the Participating Pharmacy, Curascript, and Mail Service Pharmacy rates, rebates and guarantees, as applicable, will be modified as reasonably and equitably necessary to maintain the pricing intent under this Agreement. Express Scripts shall provide State of Michigan with at least ninety (90) days notice of the change (or if such notice is not practicable, as much notice as is reasonable under the circumstances), and written illustration of the financial impact of the pricing source or index change (e.g., specific drug examples). If State of Michigan disputes the illustration or the financial impact of the pricing source, the parties agree to cooperate in good faith to resolve such disputes.

- For each eligible prescription-drug claim, ingredient cost will be calculated at the lesser of the applicable U&C, MRA, or AWP discount price in determining the discount achieved for purposes of the guarantee, including 100% member copayment (claims where full cost is paid by member).

Administrative Services

PBM Services	Fee
◆ Customer Service for Members	No additional fee
◆ Eligibility submission <ul style="list-style-type: none"> • Electronic/on-line submission • FSA Feeds • Manual/hardcopy submission 	No additional fee No additional fee \$1.00/update (includes initial entry)
◆ Software Training for Access to Our On-Line System(s)	No additional fee
◆ Electronic Claims Processing	No additional fee
◆ Member Submitted Paper Claims Processing	\$1.50/claim
◆ COB (Coordination of Benefits) <ul style="list-style-type: none"> • Standard Process (reject for primary carrier) • Medicare Coordination (+65 population) 	No additional fee \$0.06 per claim
◆ Plan Setup	No additional charge
Participating Pharmacies	
◆ Pharmacy Audit Recoveries	20% of audit recoveries
◆ Pharmacy Help Desk	No additional fee
◆ Pharmacy Network Management	No additional fee
◆ Pharmacy Reimbursement	No additional fee
◆ Network Development Upon Request	No additional fee
Mail Services	
◆ Benefit Education (includes Mail Promotion Program)	No additional fee
◆ Prescription Delivery – standard	No additional fee
Reporting Services	
◆ Web-based Client Reporting – produced by Sponsor	No additional fee
◆ Web-based Client Reporting – produced by ESI	\$100 per report
◆ Ad hoc desk top parametric reports	No additional fee
◆ Additional Reports <ul style="list-style-type: none"> • Billing Reports (including claims paid tape) • Annual Strategic Account Plan Report 	No additional fee No additional fee
◆ Custom Ad-Hoc Reporting	\$150 per hour, with a minimum of \$500
◆ Claims detail extract file electronic (NCPDP format)	No additional fee (avail. upon request)
◆ Load 12 months claims history for clinical programs and reporting	No additional fee
◆ Inquiry access to claims processing system	No additional fee; State of Michigan responsible for telecommunication charges
Formulary Support Services	

Pricing Supplement

<ul style="list-style-type: none"> ◆ Annual Formulary Communications <ul style="list-style-type: none"> • Posted at www.express-scripts.com • Mailed to member's homes • Bulk shipped to Sponsor ◆ Prior Authorization (if Base or Enhanced Trend Package is not selected) 	<p>No additional charge Additional charge TBD No additional charge \$20 per Prior Authorization</p>
Web Site	
<ul style="list-style-type: none"> ◆ Digital Certificates <ul style="list-style-type: none"> • Up to 5 certificates • More than 5 certificates 	<p>No additional fee Up to \$150 for additional users</p>
<ul style="list-style-type: none"> ◆ Express-Scripts.com for Clients—access to reporting tools, eligibility update capability, contact directory, sales and marketing information, and benefit and enrollment support 	<p>No additional fee</p>
<ul style="list-style-type: none"> ◆ Express-Scripts.com for Members—access to benefit, drug, health and wellness information; prescription ordering capability; and customer service 	<p>No additional fee</p>
Implementation Package and Member Communications	
<ul style="list-style-type: none"> ◆ Implementation Support 	<p>No additional charge</p>
<p>Member Packets Standard Member Materials or ID card packets, which contain the following: 2 standard ID cards & carriers, confidentiality and disclosure statement, and mail order form.</p> <ul style="list-style-type: none"> • Mailed to Sponsor • Mailed directly to Members • Replacement Cards • Customized materials • Re-carding of current membership 	<p>No additional charge No additional charge No Additional charge Priced upon request \$1.00 per standard packet</p>

Trend Management Programs

We offer two Trend Management program alternatives: The goal of our programs is to manage Sponsor's drug trend via effective cost management techniques.

<i>State of Michigan Program Savings Guarantees</i>		
<i>BASE TREND PACKAGE</i>	<i>Fee</i>	<i>Guarantee</i>
<p>Base Trend Package</p> <ul style="list-style-type: none"> • Basic Trend Programs: <ul style="list-style-type: none"> ○ Web-Based Member, Physician, and Pharmacist Education ○ Concurrent Drug Utilization Review ○ Mail Service Promotion ○ Prior Authorization – Base List ○ Drug Choice Management • Drug Quantity Management <ul style="list-style-type: none"> ○ Standard per Rx ○ Select per Rx (optional) ○ Select per day supply (optional) • Care Management Level 2 <ul style="list-style-type: none"> ○ Gastrointestinal Disease Management • Safety Management <ul style="list-style-type: none"> ○ Retro DUR ○ Seniors DUR 	<p>20% shared savings provided guarantee is met</p>	<p>\$3.28 PMPM for all programs in the Base Trend Package</p>
<i>ENHANCED TREND PACKAGE</i>	<i>Fee</i>	<i>Guarantee</i>

Pricing Supplement

<p>Enhanced Trend Package</p> <ul style="list-style-type: none"> • Basic Trend Programs: <ul style="list-style-type: none"> ○ Web-Based Member, Physician, and Pharmacist Education ○ Concurrent Drug Utilization Review ○ Mail Service Promotion ○ Prior Authorization – Clinical Base List ○ Drug Choice Management • Prior Authorization – Clinical Supplemental List • Drug Quantity Management <ul style="list-style-type: none"> ○ Standard per Rx ○ Select per Rx (optional) ○ Select per day supply (optional) • Step Therapy – Enhanced Trend Package Modules <ul style="list-style-type: none"> ○ ACE Inhibitors, Angiotensin-2 receptor blockers (ARBs), COX-2 Inhibitors, Non-steroidal anti-inflammatory drugs (NSAIDs), Proton Pump Inhibitors (PPIs), Selective serotonin reuptake inhibitors (SSRIs), Metformin, Leukotriene Pathway Inhibitors, Strattera, Topical Immunodilators, Other Antidepressants • <i>RapidResponse</i> Member Support for Step Therapy • Care Management Level 2 <ul style="list-style-type: none"> ○ Gastrointestinal Disease Management • Safety Management <ul style="list-style-type: none"> ○ Retro DUR ○ Seniors DUR 	<p>20% shared savings provided guarantee is met</p>	<p>\$6.50 PMPM for all programs in the Enhanced Trend Package</p>
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Savings Guarantee Notes for Enhanced Trend Package:

1. Program-specific reports will be provided to validate savings generated and annual review and settlement of guarantee performance. Savings are calculated on Ingredient drug spend only and do not include inferred medical savings. Clients are reimbursed 100% of any savings shortfall, determined on an annual basis. All savings calculations are based on the methodology described below. Savings calculations do not account for rebate or ESI revenue gain or loss that may result from implementation of these programs. If client elects to implement this package, rebate guarantees and administrative fees may be adjusted.
2. This guarantee represents an aggregate of all trend programs listed. No program will be implemented without client approval. In order to obtain the full savings guarantee, client must agree to the implementation of all programs listed above, as well as to ESI recommended standards for selection of target drugs or therapeutic classes, intervention, criteria, override criteria, and procedure protocols. As part of continuous improvement, ESI may add programs or implement modifications to the programs, including changes in ESI recommended standards, upon prior notice to the client.
3. Programs will be re-evaluated for estimated savings impact when changes in clinical practice or market conditions occur. Any changes to the potential impact of the program will be re-evaluated with the client and the guarantee and fees will be adjusted accordingly based on mutually agreeable terms.
4. If member counts vary by more than 15% or client experiences other demographic changes with a material impact on PMPM drug cost, Express Scripts may adjust the guarantee. ESI has the right to modify the guarantee for clients with restrictive formularies and/or with member cost share of greater than 50%.
5. Programs may be implemented at any time without a guarantee, in which case individual program fees will apply.

Clinical Management Programs

Express Scripts offers clinical programs focused on Safety Management and Care Management. Safety Management Programs are designed to provide an additional source of pharmaceutical information (a "safety net") for the most important drug- and member-specific pharmaceutical care issues. Care Management Programs offer disease-based programs focused on improving the health and well being of the patient, optimization of medication therapy, and compliance with prescribed therapy.

Safety Management		
Program Name	Description	Fees <small>(additional per claim administrative fee, except as noted)</small>
Concurrent DUR - Clinical	Point-of-service edits for the most important drug- and member-specific pharmaceutical care issues	No additional charge
Emerging Therapeutic Issues Management	Rapid communication to alert physicians, members, and clients about significant patient-safety related issues (drug withdrawals, black box warnings, and class I recalls). Proactively alerts our clients to new drugs that are anticipated to have a significant impact on pharmacy cost.	No additional charge
Retrospective DUR	Daily and weekly physician communication targeting multiple utilization issues. <ul style="list-style-type: none"> • Drug-Drug Interactions • Drug-Patient Interactions • Drug-Disease Interactions • Drug-Pregnancy Interactions • Drug Overutilization • Drug Underutilization • Duplicate Therapy • Addictive Substances • Long term hypnotics 	20% share in savings
Retrospective DUR for Seniors	Weekly physician intervention to identify inappropriate utilization issues in the senior population <ul style="list-style-type: none"> • Polypharmacy • Drugs of Concern 	20% share in savings

** All programs are optional and will only be implemented upon Client request.

Care Management		
Program Name	Description	Fees
Care Management (Level 1) Member Portal	Disease specific education on more than 40 disease states accessed through member portal. Includes e-bulletins and personal reminders.	No additional charge
Care Management (Level 2)	Disease and/or therapy specific, physician and patient letter based interventions.	20% share in savings

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** All programs are optional and will only be implemented upon Client request.

Program Savings Guarantee

Savings Calculation Methodology for Enhanced Trend Package Programs

A. Prior Authorization

The analysis tracks all PA edits. Calculations are conducted at the drug level (i.e., 8-digit GPI). Savings are based on those members with a prescription subject to prior authorization who do not have a subsequent claim for the drug. The formula for PMPM savings is:

$$\frac{((\# \text{ members with edits with no claim}) * (\text{average ingredient cost /claim}))}{(\text{average expected \# Rx in 12 months})} \\ (\text{total member months})$$

Total savings are equal to the number of members with edits who do not have a claim within 30 days, multiplied by the average ingredient cost per claim and by the average expected number of prescriptions for that drug over the next year. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

Additional Savings

If there is a learning curve and doctors stop prescribing over time, true savings of the program will be underestimated. In order to address this factor, if the number of edits decreases more than 15 percent over 6 months, the decrease in edits can be included in savings.

The formula for additional PMPM savings is:

$$\frac{((\text{change in number of edits between time period 1 and time period 2}))}{(\text{average ingredient cost /claim}) * (\text{average expected \# Rx in 12 months})} \\ (\text{total member months})$$

The additional total savings associated with the learning effect is calculated as the change in the number of edits between time period 1 and time period 2, multiplied by the average ingredient cost per claim and by the average expected number of prescriptions over a year. Additional PMPM savings are equal to total additional savings divided by total member months for the period for which the savings are calculated (i.e., time period 2).

B. Step Therapy

The analysis tracks all Step Therapy edits. Calculations are performed at the therapy class (i.e., 2-digit GPI) level. Savings are based on those members with step therapy who receive the first- line (generic) drug plus those who have no claim for the therapy class.¹

1. For those who receive the generic, the formula for PMPM savings is:

$$\frac{((\# \text{ members with step therapy edits with a generic claim}))}{(\text{average difference in ingredient cost /claim for generic versus brand})} \\ (\text{average \# of generic Rx in 12 months}) \\ (\text{total member months})$$

Total savings are equal to the number of members with step therapy edits who receive the generic alternative within 30 days of the edit, multiplied by the average difference in ingredient cost per claim for the generic alternative versus the original brand drug, and by the average expected number of prescriptions for that generic drug over the next year. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

¹ ESI's research indicates that the majority of patients with no claim have elected to pay out of pocket for the drug, rather than accept an alternative or forego the therapy.

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2. For those who have no claim, the formula for PMPM savings is:

$$\frac{((\# \text{ members with step therapy edits with no claim}) * (\text{average ingredient cost of brand claim}) * (\text{average expected \# Rx over 12 months}))}{(\text{total member months})}$$

Total savings are equal to the number of members with step therapy edits who have no claim for the therapy class within 30 days of the edit, multiplied by the average ingredient cost for the brand drug, and by the average expected number of prescriptions over the next year. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

Additional Savings

If there is a learning curve and doctors stop prescribing over time, true savings of the program will be underestimated. In order to address this factor, if the number of edits decreases more than 15 percent over 6 months, the decrease in edits can be included in savings.

The formula for additional PMPM savings is:

$$\frac{((\text{change in number of edits between time period 1 and time period 2}) * (\text{average difference in ingredient cost /claim for generic versus brand}) * (\text{average expected \# Rx in 12 months}))}{(\text{total member months})}$$

The additional total savings associated with the learning effect is calculated as the change in the number of edits between time period 1 and time period 2, multiplied by the average difference in ingredient cost per claim for the generic alternative versus the original brand drug and by the average expected number of prescriptions for that drug. Additional PMPM savings are equal to total additional savings divided by total member months for the period for which the savings are calculated (i.e., time period 2).

C. Drug Quantity Management

The analysis tracks all DQM edits, and checks for resubmittals of the same drug following rejection of the original prescription.

The formula for PMPM savings is:

$$\frac{((\text{Maximum quantity on edit for member}) - (\text{Total Quantity filled within 30 days of edit}) * \text{Average Ingredient Cost per Unit}) + ((\text{Maximum quantity per member by GPI 14 by month with no claims filled within 30 days for any drug within its therapy class}) * \text{Average Ingredient Cost per Unit})}{(\text{total member months})}$$

Total savings are equal total savings for quantity difference between rejected and filled claims plus total savings for quantity not filled for same drug or any drug within the therapy class within 30 days of edit. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

D. Concurrent DUR

For each Concurrent DUR edit, the analysis checks for reversals within 30 days of the original claim and for subsequent resubmittals for the same therapy class within 30 days of the original claim.

1. Administrative edits

The formula for PMPM savings is:

$$\frac{((\# \text{ edits}) * (\% \text{ not resubmitted}) * (\text{average ingredient cost /claim}))}{(\text{total member months})}$$

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Total savings are equal to the number of edits multiplied by the percentage not resubmitted within 30 days and by the average ingredient cost per claim. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

2. Clinical edits

The formula for PMPM savings is:

$$\frac{((\# \text{ members with edits}) * (\% \text{ reversed}) * (\% \text{ not resubmitted})) * (\text{average ingredient cost / claim}) * (\text{average expected \# Rx in 12 months})}{(\text{total member months})}$$

Total savings are equal to the number of members with edits multiplied by the percentage reversed within 30 days, multiplied by the percentage not resubmitted within 30 days, multiplied by the average ingredient cost per claim and by the average expected number of prescriptions for the drug in a 12-month period. PMPM savings are equal to total savings divided by total member months for the period during which the interventions took place.

Billing and Payment

Billing Information*	
Billing Frequency	Weekly or twice per month
Payment Options	
Wire Transfer	Payments must be transferred within two days of receipt of the Express Scripts invoice/billing statement
Automated Clearing House (ACH)	Payments must be made within two days of receipt of the Express Scripts invoice/billing statement
Pre-Authorized Debit Transaction	Funds must be available in the client's bank account within 48 hours of receipt of the Express Scripts invoice/billing statement

* Please note that each client is subject to a standard credit evaluation.

Financial Disclosure to Express Scripts Clients

Express Scripts is a provider of pharmaceutical benefits management (“PBM”) and other related services to thousands of client groups including managed care organizations, health insurers, employer groups, third-party administrators and government entities. Express Scripts’ subsidiary companies, some of which provide services related to supporting our PBM services, include Express Scripts Mail Pharmacy Service, Inc., CuraScript Pharmacy, Inc., Express Scripts Specialty Distribution Services, Inc., and Phoenix Marketing Group, LLC. This disclosure provides an overview of the revenue sources that allow us to deliver competitive pricing arrangements to our clients.

Express Scripts offers its clients, either directly or through its subsidiary companies, a variety of services related to the management of prescription drug benefits. The specific services provided to each client are documented under the Pharmacy Benefit Management Agreement, or other similar agreement, with our client. Express Scripts’ PBM services typically include claims processing and adjudication, pharmacy network contracting and management, formulary development and management, rebate management and administration, trend management, and clinical program development and fulfillment. Some of our clients also utilize our mail service pharmacy to provide their members with convenient access to safe and affordable prescription drugs through home delivery. In addition to the administrative fees paid to us by our clients for these core PBM services, Express Scripts derives revenue from other sources, including arrangements with pharmaceutical manufacturers and retail pharmacies. Some of this revenue relates to utilization of products by members of the clients for whom we provide PBM services.

Network Pharmacies — Express Scripts contracts for its own account with retail pharmacies to dispense prescription drugs to members of the clients for whom we provide PBM services. The rates paid by Express Scripts to these pharmacies differ from one network of pharmacies to the next, and among pharmacies within a network. Express Scripts generally contracts with clients to be paid an ingredient cost for drugs dispensed in a given retail network selected by the client at a uniform rate that applies to all pharmacies in the selected network. Thus, where the rate paid by a client exceeds the rate negotiated with a particular pharmacy, Express Scripts will realize a positive margin on the applicable prescription. The reverse may also be true, resulting in negative margin for Express Scripts. In addition, when Express Scripts receives payment from a client before payment to a pharmacy is due, Express Scripts retains the benefit of the use of the funds between these payments.

Manufacturer Rebates and Associated Administrative Fees — Express Scripts contracts for its own account with pharmaceutical manufacturers to obtain rebates attributable to the utilization of certain prescription products by individuals who receive benefits from clients for whom we provide PBM services. Rebate amounts vary based on the volume of utilization as well as the benefit design and formulary position applicable to utilization of a product. Express Scripts often pays all or a portion of the rebates it receives to a client based on the client’s PBM services agreement. Express Scripts retains the financial benefit of the use of any funds held until payment is made to a client. In connection with our maintenance and operation of the systems and other infrastructure necessary for managing and administering the rebate process, Express Scripts also receives administrative fees from pharmaceutical manufacturers participating in the rebate program discussed above. The services provided to participating manufacturers include making certain drug utilization data available, as allowed by law, for purposes of verifying and evaluating the rebate payments. Administrative fees retained by Express Scripts in connection with its rebate programs do not exceed 3.5% of the AWP of the products for which rebates are payable to Express Scripts.

Pharmacy Dispensing and Distribution — Express Scripts has several licensed pharmacy subsidiaries, including our specialty pharmacies. These entities purchase prescription drug inventories, either directly from manufacturers or from drug wholesalers, for dispensing to patients or for distribution to physician offices. Purchase discounts off the acquisition cost of these products are made available by

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manufacturers in the form of both up-front and retrospective discounts. Such discounts are not considered part of the rebates paid to Express Scripts by manufacturers in connection with our rebate program. While rebates are directly attributable to the utilization of pharmaceutical products by individuals who receive benefits from clients for whom we provide PBM services, product acquisition price discounts are based on a pharmacy's inventory needs and, in the case of specialty pharmacies, the performance of related patient care service obligations. The purchase discounts obtained by these facilities are not based on any client's benefit design. When an Express Scripts subsidiary pharmacy dispenses or distributes a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than the pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between this net acquisition cost and the amounts paid for the dispensed products.

Pharmaceutical Program Services — Our specialty pharmacies, including CuraScript Pharmacy, Inc. and Express Scripts Specialty Distribution Services, Inc., receive compensation from manufacturers for their administration of programs related to the distribution of certain pharmaceutical products. This compensation is based on the fair market value of the services provided and is unrelated to the drug formulary development process or drug utilization applicable to the clients for whom we provide PBM services. Examples of these services include (i) administering patient assistance programs for indigent patients; (ii) administering product sample distribution programs; and (iii) dispensing prescription medications to patients enrolled in clinical trials.

Data Reporting — Express Scripts sells certain data resulting from its PBM and pharmacy services to healthcare data aggregators and similar entities from time to time. We do not sell any data unless we are permitted to do so by the terms of our client contract and by applicable patient privacy laws. In addition, as a condition to receiving access to certain products, a specialty pharmaceutical manufacturer often will require a purchasing specialty pharmacy to report selected information to the manufacturer regarding the pharmacy's service levels and other de-identified dispensing-related data with respect to patients who receive such manufacturer's product. A portion of the discounts or other compensation made available to our specialty pharmacies represents compensation for such reporting. All such reporting activities are conducted in compliance with applicable patient privacy laws.

Other Pharmaceutical Manufacturer Services — Phoenix Marketing Group, LLC specializes in the provision of sample fulfillment, sample accountability, alternative sampling, direct mail fulfillment, and literature fulfillment services for pharmaceutical manufacturers. Because its services involve only warehousing and fulfillment-related functions, this subsidiary entity does not review products clinically and it never uses, sells or has access to Express Scripts' client or member information. Compensation paid to Phoenix Marketing Group, LLC by pharmaceutical manufacturers is based on the fair market value of such services, as established most often through an "RFP" process, and any such compensation is unrelated to the drug formulary development process or drug utilization applicable to the clients for whom Express Scripts provides PBM services.

Express Scripts does not conduct business in a fiduciary capacity to plan sponsors or members. Express Scripts exercises no discretion with respect to the management of the plan or control of plan assets.

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909

February 26, 2007

CHANGE NOTICE NO. 6 (REVISED)*
 TO
 CONTRACT NO. 071B3001328
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE Ron Tyson (800) 279-6602
Express Scripts, Inc. 6625 West 78 th Street Bloomington, MN 55439 ron.tyson@express-scripts.com		
Contract Compliance Inspector: Susan Kant Prescription Drug Program – DMB/OSE		BUYER/CA (517) 373-1080 Melissa Castro, CPPB
CONTRACT PERIOD: From: June 1, 2003		To: September 30, 2008
TERMS	SHIPMENT	
N/A	N/A	
F.O.B.	SHIPPED FROM	
N/A	N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby EXTENDED through September 30, 2008. Additionally, the following price changes are hereby incorporated into this Contract:

- Effective 7/1/07 through 9/30/07, Mail Generics will be provided at 58% off AWP and Retail Generic Guarantee will be 54% off AWP
- Effective 10/1/07 through 12/31/07, Mail Generics will be provided at 62% off AWP and Retail Generic Guarantee will be 57% off AWP
- Effective 1/1/08 through 9/30/08, Mail Generics will be provided at 65% off AWP and Retail Generic Guarantee will be 57% off AWP

Additionally, the attached AWP language is hereby incorporated into this Contract and the Contract Compliance Inspector is hereby changed to Susan Kant (517) 335-3068. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency/vendor request and DMB/Purchasing Operations approval.

INCREASE: \$280,000,000.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$1,217,855,656.70

FOR THE VENDOR:	FOR THE STATE:
Express Scripts, Inc.	Signature
Firm Name	Elise A. Lancaster
Authorized Agent Signature	Name
Authorized Agent (Print or Type)	Director, Purchasing Operations
Date	Title
	Date

AWP; Pricing Benchmarks

The parties understand that pricing indices historically used, (and that are the basis in this Agreement), for determining the financial components of pharmacy billing rates are outside the control of Sponsor and ESI. The parties also understand that there are currently extra-market industry, legal, government and regulatory activities, which may lead to changes relating to, or elimination of, these pricing indices that could alter the financial positions of the parties as intended under this Agreement. The parties agree that, upon entering into this Agreement and thereafter, their mutual intent has been and is to maintain pricing stability as intended and not to advantage either party to the detriment of the other. Accordingly, to preserve this mutual intent, if ESI undertakes any or all of the following:

- (i) changes the AWP source across its book of business (e.g., from FDB to MediSpan); or
- (ii) maintains AWP as the pricing index with an appropriate adjustment as described below, in the event the AWP methodology and/or its calculation is changed, whether by the existing or alternative sources; or
- (iii) transitions the pricing index from AWP to another index or benchmark (e.g., to WAC);

the Participating Pharmacy and Mail Service Pharmacy rates and guarantees, as applicable, will be modified as reasonably and equitably necessary to maintain the pricing intent under this Agreement. ESI shall provide Sponsor with at least 90 days notice of the change (or if such notice is not practicable, as much notice as is reasonable under the circumstances), and written illustration of the financial impact of the pricing source or index change (e.g., specific drug examples) and the estimated aggregate annual impact of the pricing source change. If Sponsor disputes the illustration or the financial impact of the pricing source, the parties agree to cooperate in good faith to resolve such disputes.

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

September 12, 2006

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE Barry Rosenthal (952) 893-4676	
Express Scripts, Inc. 6625 West 78th Street Bloomington, MN 55439			
		BUYER/CA (517) 373-1080 Melissa Castro, CPPB	
Contract Compliance Inspector: Peggy Moczul Prescription Drug Program – DMB/OSE			
CONTRACT PERIOD:		From: June 1, 2003 To: October 1, 2007	
TERMS	SHIPMENT		
N/A	N/A		
F.O.B.	SHIPPED FROM		
N/A	N/A		
MINIMUM DELIVERY REQUIREMENTS N/A			

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby EXTENDED through October 1, 2007 and INCREASED by \$160,000,000.00. NOTE: The buyer is changed to Melissa Castro (517) 373-1080. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

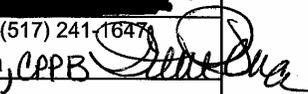
Per agency request, Ad Board approval on September 5, 2006 and DMB/Purchasing Operations approval.

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$937,855,656.70

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

February 17, 2006

CHANGE NOTICE NO. 4
 TO
 CONTRACT NO. 071B3001328
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR Express Scripts, Inc. 6625 West 78th Street Bloomington, MN 55439	TELEPHONE Barry Rosenthal (952) 893-4676
	
	BUYER/CA (517) 241-1647 Irene Pena, <i>APPB</i> 
Contract Compliance Inspector: Peggy Moczul Prescription Drug Program – DMB/OSE	
CONTRACT PERIOD: From: June 1, 2003 To: September 30, 2006	
TERMS N/A	SHIPMENT N/A
F.O.B. N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A	

NATURE OF CHANGE (S):

Effective immediately the attached document replaces Contract Change notice #3.

AUTHORITY/REASON:

Per DMB/Acquisition Services and Agency contact (Mary Miller) on 2/2/06

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$777,855,656.00

REVISED February 1, 2006

NATURE OF CHANGES:

Effective October 1, 2005

- * Retail administrative fee will be reduced from \$.13 to \$.0
- * Mail Service Generic Discount will be increased from AWP -50 to AWP-52

Effective January 1, 2006

- * Generic/Brand Dispensing Fee/Rx will change from \$1.85 to \$1.65.
- * Mail Service Generic Discount will be increased from AWP -52 to AWP-55
- * ESI guarantees a minimum average generic discount of AWP -54% on generic drugs that are covered drugs dispensed through participating pharmacies, to be applied, measured and reconciled in the aggregate on an annual basis within ninety (90) days of the end of the Sponsor's contract year. The guarantee will be calculated as $1 - \frac{\text{total discounted AWP ingredient cost (excluding dispensing fees and claims with ancillary charges, and prior to application of co-payments) of applicable Prescription Drug Claims for the annual period}}{\text{total undiscounted AWP ingredient cost (both amounts will be calculated as of the date of adjudication) for the annual period}}$. Generic drugs subject to patent litigation actions, Single Source products, OTC products, and Specialty Products shall be excluded from the guarantee. The guarantee is further subject to the following:
 - To the extent the assumptions are incorrect as of the implementation date of this Agreement, or Sponsor changes its benefit design or Formulary during the term of the Agreement, the guarantee will be equitably adjusted if there is a material impact on the generic discount achieved.
 - Products with Generic status as of the effective date of the Agreement shall be included in the guarantee
 - Each Generic Drug Prescription Drug Claim ingredient cost will be calculated at the lesser of the applicable MRA, U&C or AWP discount price in determining the discount achieved for purposes of the guarantee, including 100% member co-payments.
 - ESI will pay the difference of Sponsor's net cost for any shortfall between the actual result and the guaranteed result.

- * Express Scripts guarantees that the State of Michigan will receive the greater of 100 percent of rebates payable to the client or a minimum rebate per prescription drug claim submitted electronically by participating pharmacies and the mail service program and approved for payment by Express Scripts.

This guarantee will be \$3.50 per paid retail prescription and \$11.00 per paid mail prescription with a \$15 co-pay differential between the preferred and non-preferred brand and the National Preferred Formulary. The guarantee will be \$2.50 per paid retail prescription and \$8.00 per paid mail prescription with a two tier co-pay design and the National Preferred Formulary.

Specialty and OTC products are excluded with calculating rebate guarantees

Rebate guarantee will be reconciled in aggregate annually with any payment due to State of Michigan within 150 days from the end of each annual period.

The guarantee may be adjusted throughout the course of this agreement in the event of a change in the benefit design mix or other formulary or benefit design changes made by State of Michigan which materially affect rebates earned.

If State of Michigan chooses to make a formulary change, Express Scripts will provide State of Michigan an estimate of the rebate impact of the change and will adjust the guarantee accordingly beginning on the date the change takes affect.

The differential refers to the co-pay differential between the preferred and non-preferred products. The Express Scripts Formulary is designed for sponsors without benefit restrictions for products that compete within the same categories. Within the Express Scripts Formulary are preferred products. These preferred products are selected on the basis of their clinical efficacy and recommended by the Express Scripts National Pharmacy and Therapeutics Committee.

Sponsor acknowledges its requirement to adopt the applicable Express Scripts Formulary identified above and the formulary support programs in order to be eligible for rebates offered above, whether rebates are paid or applied.

Rebate amounts assume 100% of members, for an individual sponsor, are included in the proposed benefit plan design(s).

2. This guarantee represents an aggregate of all trend programs listed. No program will be implemented without client approval. In order to obtain the full savings guarantee, client must agree to the implementation of all programs listed above, as well as to ESI recommended standards for selection of target drugs or therapeutic classes, intervention, criteria, override criteria, and procedure protocols. As part of continuous improvement, ESI may add programs or implement modifications to the programs, including changes in ESI recommended standards, upon prior notice to the client.
3. Programs will be re-evaluated for estimated savings impact when changes in clinical practice or market conditions occur. Any changes to the potential impact of the program will be reevaluated with the client and the guarantee and fees will be adjusted accordingly based on mutually agreeable terms.
4. If member counts vary by more than 15% or client experiences other demographic changes with a material impact on PMPM drug cost, Express Scripts may adjust the guarantee. ESI has the right to modify the guarantee for clients with restrictive formularies and/or with member cost share of greater than 50%.
5. Programs may be implemented at any time without a guarantee, in which case individual program fees will apply.

* Termination

Section I-U (2) Cancellation For Convenience By the State should be removed from the contract.

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

April 16, 2004

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE Barry Rosenthal (952) 893-4676
Express Scripts, Inc. 6625 West 78th Street Bloomington, MN 55439		
		BUYER/CA (517) 241-1647 Irene Pena
Contract Compliance Inspector: Peggy Moczul Prescription Drug Program – DMB/OSE		
CONTRACT PERIOD: From: June 1, 2003 To: September 30, 2006		
TERMS	SHIPMENT	
N/A	N/A	
F.O.B.	SHIPPED FROM	
N/A	N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately the following changes are hereby incorporated into this contract:

- 1) Buyer is changed to Irene Pena.**
- 2) Term on Contract is changed to June 1, 2003 through September 30, 2006 with two (2) one-year renewal options.**
- 3) The following provision is added to this contract: “It is the State’s intention to periodically (no less than once every three years) perform on-site audits of plan administrators. Vendors will make records associated with the administration of the State plan available to, and must cooperate with, such auditors and audits as the State may designate. The state’s current approach has been to audit two (2) plan years at one time, conducted within 12 months of the end of the second year audited. For example, for plan years October 1, 2002 through September 30, 2004, the State would request an audit of claims to be completed by September 30, 2005. This approach may change without prior notice.”**

AUTHORITY/REASON:

Per agency and vendor agreement.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$777,855,656.00

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
 OR
530 W. ALLEGAN, LANSING, MI 48933

May 30, 2003

NOTICE
TO
CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Express Scripts, Inc. 6625 West 78th Street Bloomington, MN 55439		TELEPHONE Barry Rosenthal (952) 893-4676
		BUYER (517) 373-1080 Melissa Castro
Contract Administrator: Peggy Moczul Prescription Drug Program – DMB/OSE		
CONTRACT PERIOD: From: June 1, 2003 To: September 30, 2006		
TERMS N/A	SHIPMENT N/A	
F.O.B. N/A	SHIPPED FROM N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

Estimated Contract Value: \$777,855,656.00

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
 OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B3001328
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR <p style="text-align: center;">Express Scripts, Inc. 6625 West 78th Street Bloomington, MN 55439</p>	TELEPHONE Barry Rosenthal (952) 893-4676 BUYER (517) 373-1080 Melissa Castro
Contract Administrator: Peggy Moczul <p style="text-align: center;">Prescription Drug Program – DMB/OSE</p>	
CONTRACT PERIOD: From: June 1, 2003 To: September 30, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	
MISCELLANEOUS INFORMATION: <p>Estimated Contract Value: \$777,855,656.00</p>	

<p>FOR THE VENDOR:</p> <p style="text-align: center;">Express Scripts, Inc.</p> <hr/> <p style="text-align: center;">Firm Name</p> <hr/> <p style="text-align: center;">Authorized Agent Signature</p> <hr/> <p style="text-align: center;">Authorized Agent (Print or Type)</p> <hr/> <p style="text-align: center;">Date</p>	<p>FOR THE STATE:</p> <hr/> <p style="text-align: center;">Signature</p> <p style="text-align: center;">Sean L. Carlson</p> <hr/> <p style="text-align: center;">Name</p> <p style="text-align: center;">Director, Acquisition Services</p> <hr/> <p style="text-align: center;">Title</p> <hr/> <p style="text-align: center;">Date</p>
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**STATE OF MICHIGAN
ACQUISITION SERVICES**

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DEFINITION OF TERMS

TERMS	DEFINITIONS
Contract	A binding agreement entered into by the State of Michigan resulting from a bidder's proposal; see also "Blanket Purchase Order."
Contractor	Express Scripts, Inc. and its subsidiaries
DMB	Michigan Department of Management and Budget
DCS	Department of Civil Service
RFP	Request For Proposal - A term used by the State to solicit proposals for services such as consulting. Typically used when the requesting agency requires vendor assistance in identifying an acceptable manner of solving a problem.
ITB	Invitation to Bid - A generic form used by the Acquisition Services to solicit quotations for services or commodities. The ITB serves as the document for transmitting the RFP to interested potential bidders.
State	The State of Michigan For Purposes of Indemnification as set forth in section I-J, State means the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents.
Blanket Purchase Order	Alternate term for "Contract" used in the State's Computer system (Michigan Automated Information Network [MAIN])
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
Cancellation	Ending all rights and obligations of the State and Contractor, except for any rights and obligations that are due and owing.

**DEFINITION OF ADDITIONAL TERMS
PRESCRIPTION DRUG PLANS**

Terms	Description
Actual Acquisition Cost – AAC	The pharmacy’s net payment made to purchase a drug product, after taking into account such items as purchasing allowances, discounts and rebates. AAC is typically below AWP.
Average Wholesale Price – AWP	The average wholesale price of a prescription drug as determined by Contractor from the most current information provided to Contractor by First Data Bank or, upon prior notice to and approval of the State, another source nationally recognized in the retail prescription drug industry selected by Contractor for its entire client base. The State will not unreasonably withhold approval. The applicable AWP for prescriptions filled in the Mail Service Pharmacy will be the lesser of the AWP for: (i) the NDC code for the package size from which the prescription drug was dispensed; or (ii) package sizes of 100 units or 16 ounce quantities, or the next larger quantity if such specified quantities are not available.
Brand Drug	A pharmaceutical product that is trademarked by its originator or a licensee. If the product is on patent, it is usually the only source for that particular medication.
Coinsurance	A cost-sharing provision that requires participants to pay a percentage of total eligible expenses.
Copay	A cost-sharing provision that requires participants to pay a set dollar amount per prescription.
Covered Drug(s)	Those prescription drugs, supplies, Specialty Injectables (if applicable), and other items that are covered under the Contract as indicated on the Express Scripts Benefit Design (“EBD”). Specialty Injectables are Covered Drugs.
Disease Management	Programs that manage patients at risk for a particular disease state or medical condition.
Dispense As Written – DAW	Prescribing directives to indicate that the pharmacist should dispense the drug specified on the prescription and not substitute a generic product.
Dispensing Fee	Negotiated professional fee paid to dispensing pharmacy.
Drug Utilization Review - DUR	A quantitative evaluation of prescription drug use, physician prescribing patterns, or patient drug utilization to determine the appropriateness of drug therapy.

Effective Discount (Pricing)	The impact of negotiated discounts, usual and customary pricing, DUR and generic dispensing rates on the overall discount.
Formulary	A list of preferred, cost-effective prescription drugs that are suggested to participants and prescribing physicians by the State. Generally, restricted or closed formularies offer less choice of drugs but greater savings than open or non-restricted formularies.
Formulary Rebates	Payments made by pharmaceutical manufacturers to a payer based on utilization or market share of their products.
Generic Drug	Means a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. For purposes of pricing, the designation of a product as "brand" or "generic" and/or subject to MAC is determined by ESI under its standard policies which take into account various factors, including but not limited to, FDA status, the pricing differential between AWP and WAC, availability and price of therapeutically equivalent drugs and generic exclusivity periods under the Waxman-Hatch Act.
Mail Order	A program that offers maintenance prescriptions mailed directly to participants from a mail order pharmacy.
Mail Service Pharmacy	A duly licensed pharmacy operated by Contractor or its subsidiaries, where prescriptions are filled and delivered to Members via the mail service
Maintenance Drug	A drug that is taken for a chronic condition for a significant period of time (e.g., cholesterol lowering agents, HIV medications, etc.).
Mandatory Generic	Plan designs in which the participants pay the cost difference between the brand and generic drugs if they and/or their physician request a brand when a generic is available.
Maximum Allowable Cost – MAC	A maximum allowable cost list, which is a list of multi-source generic drugs developed and maintained by Contractor. Appendix A sets forth the effective discount rate offered for MAC'd drugs. Notwithstanding the provisions of Appendix A, the effective MAC rate (both retail and mail) is an annual guaranteed average discount off of AWP.

Member	Each person who is eligible as determined solely by the State to receive prescription drug benefits as indicated in the eligibility files.
Multi-Source Drug	A drug for which there are two or more products therapeutically and pharmaceutically equivalent.
National Drug Code - NDC	A national classification system for the identification of drugs.
Network	Retail pharmacies under contract to provide pharmacy benefits programs. Reduced access provides better price discounts.
Over-the-Counter – OTC	Products that are available without a prescription.
Participating Pharmacies	Licensed retail pharmacies with which Contractor has executed an agreement to provide Covered Drugs to Members
Performance Based Pharmacy Incentives	Incentives distributed to network pharmacies for reaching defined levels of generic and formulary drug dispensing.
Pharmacy Benefit Management Company - PBM	An organization that provides administrative services, usually in the processing and analysis of pharmacy claims.
Prior Authorization	A process under which participants must receive approval as to the appropriateness of a medication before it can be dispensed. Usually reserved for high cost drugs with the potential for abuse or misuse. Prior authorization does not guarantee coverage.
Specialty Injectables	Those biotech and other prescription drug products identified on Appendix A that require special ordering, handling and/or Member services
UCR	Usual, customary, and reasonable – this is the price a pharmacy would charge a cash-paying customer.



SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE

The purpose of Contract is to provide Prescription Benefit Management (PBM) services for the Managed Participating Pharmacy Drug Plan services for eligible state employees and dependents in various bargaining units, on behalf of the State. The plan is to be effective June 1, 2003 through September 30, 2006. The Contract must provide all staffing, systems and procedures required to perform the services described herein. Express Scripts, Inc. and its subsidiaries ("Contractor") will be providing these services subject to the terms of the Contract.

Plan services are for Active, COBRA, and retired employees, plus their dependents, participating in the State Health Plan (non-HMO), under the retail and mail order prescription drug programs. Prescription drug services for enrollees in State-sponsored HMO plans are provided by the respective HMOs, and are not included in this plan.

I-B TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by the Contractor prior to signing of this Contract by all parties. The PBM administrative activities in this Contract cover the period June 1, 2003 through September 30, 2006. The State fiscal year is October 1st through September 30th. The Contractor should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

I-C ISSUING OFFICE

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Acquisition Services, hereafter known as Acquisition Services, for the State of Michigan, Department of Civil Service (DCS). Where actions are a combination of those of ACQUISITION SERVICES and DCS, the authority will be known as the State.

Acquisition Services is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract. All communications concerning contractual issues must be addressed to:

Melissa Castro, Buyer
DMB, Acquisition Services
2nd Floor, Mason Building
P.O. Box 30026
Lansing, MI 48909
E-mail: castrom@Michigan.gov
Phone: (517) 373-1080

**I-D CONTRACT ADMINISTRATOR**

The person named below or any other person so designated will be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by Acquisition Services. The Contract Administrator for this project is:

Peggy Moczul, Director

Employee Benefits Division
Department of Civil Service
Department of Management and Budget
P. O. Box 30026
Lansing, MI 48909
E-mail: MoczulP2@michigan.gov

I-E COST LIABILITY

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this Contract. Total liability of the State is limited to the terms and conditions of this Contract.

I-F CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities offered in this Contract whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including but not limited to payment of any and all costs resulting from the Contract. If any part of the work is to be subcontracted, the contractor must notify the state and identify the subcontractor(s), including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State acknowledges that for the purpose of this Contract, retail network pharmacies are deemed to be independent contractors not subcontractors. The State reserves the right to approve subcontractors for this project and to require the Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

I-G NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.



I-H DISCLOSURE

All information in the Contractor's proposal and this Contract is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, *et seq.*, including any exclusions provided for within the Act.

I-I ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available pursuant to this Section I-I, upon request, to the State of Michigan, its designees, or the Michigan Auditor General at any time during the Contract period and any extension thereof, and for three (3) years from the expiration date and final payment on the Contract or extension thereof.

The Contractor may audit the prescription management services provided under this Contract consistent with the Audit Protocol set forth in Appendix C. The State shall bear its own costs associated with any audit. The State may use an independent auditor, so long as such auditor does not have a conflict of interest with Contractor, as reasonably determined by Contractor. Such auditor must execute Contractor's standard Confidentiality Agreement (attached as Attachment 1 to Appendix C) prior to commencement of the audit. Audit materials and documentation provided by Contractor will be limited to the State-specific information. Except as otherwise provided in Appendix C (Audit Protocol), contractual information (e.g., reimbursement rates and fees) concerning participating pharmacies and other providers of products and services, which is proprietary and confidential to Contractor, and will not be disclosed to the State or its auditor. Any requests by the State to permit an Auditor to perform an audit shall constitute the State's direction and authorization to Contractor to disclose Member information to the Auditor.

I-J INDEMNIFICATION

1. General Indemnification

The Contractor shall indemnify, defend and hold harmless the State from and against all lawsuits, liabilities, damages and claims or any other proceeding brought against the State by any third party (which for the purposes of this provision shall include, but not be limited to, employees of the State, the Contractor and any of its subcontractors), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

- a. Any breach of this Contract or negligence or intentional tortious act by the Contractor or any of its subcontractors, or by anyone else for whose acts any of them may be liable, in the performance of this Contract;



b. The death or bodily injury of any person or the damage, loss or destruction of any real or personal property in connection with the performance of this Contract by the Contractor, or any of its subcontractors, or by anyone else for whose acts any of them may be liable provided, and to the extent that the injury or damage was caused by the fault or negligence of the Contractor.

c. Any act or omission of the Contractor or any of its subcontractors in their capacity as an employer in the performance of this Contract;

d. Any claim, demand, action or legal proceeding against the State arising out of or related to occurrences, if any, that the Contractor is required to insure against as provided in this Contract.

2. Indemnification Obligation Not Limited

In any and all claims against the State by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or any other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

3. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred prior to expiration or cancellation.

4. Contractor Disclaimer

Contractor disclaims all liability in connection with, and the State shall not attempt to recover from the Contractor, any costs for claims which may be asserted against, imposed upon or incurred by the State and arising as a result of the State's (i) gross negligent acts or omissions or willful misconduct, (ii) benefit design and coverage decisions, (iii) breach of this Agreement, or (iv) from any use the State may make of PHI, as further defined in Section I-Q hereof, provided to the State by Contractor.

5. DUR Disclaimer

If the State provides the Contractor with Members' named dependents in the eligibility files, the Contractor shall perform a standard concurrent DUR analysis of each prescription filled through the Mail Service Pharmacy or submitted for processing on-line by a participating pharmacy in order to assist the pharmacist in identifying potential drug interactions, incorrect prescriptions or dosages, and certain other circumstances that may be indicative of inappropriate prescription drug usage. In addition, the Contractor may perform certain retrospective reviews upon request of the State and shall communicate the results of such reviews, if warranted, to an Member's physician or the State, in accordance with standard



guidelines. The Contractor's DUR processes are educational programs designed to enhance information available to the pharmacist in filling prescriptions and the physician in prescribing prescriptions, and is based only on the current claim for covered drugs and such Member information as has been previously provided to the Contractor and is available in the Contractor's on-line claims processing system. Furthermore, the DUR processes depend, in part, on clinical drug data and information on dispensing practices provided to the Contractor by third-party vendors, and are limited to certain drugs and certain analytical criteria that are established by the Contractor from time to time. The Contractor's DUR processes are not intended to substitute for the professional judgment of the prescriber, the dispensing pharmacist or any other health care professional providing services to the Member. Accordingly, the Contractor assumes no liability to the State or any other person in connection with the DUR process, including, without limitation, the failure of the DUR process to identify a prescription that results in injury to an Member. Nothing in this Section shall operate to relieve the Contractor of the customary professional obligations of the dispensing pharmacists at its Mail Service Pharmacy.

I-K LIMITATION OF LIABILITY

Except as set forth herein, neither the Contractor nor the State shall be liable to the other party for indirect or consequential damages, even if such party has been advised of the possibility of such damages, and either party's maximum aggregate liability shall be limited to the maximum amount of administrative fees included in the executed Contract. Such limitation as to indirect or consequential damages, and as to a party's maximum liability shall not be applicable for claims arising out of gross negligence, willful misconduct, or the Contractor's indemnification responsibilities to the State as set forth in Section I-J with respect to third party claims, actions and proceeding brought against the State.

I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS

The Contractor warrants that in performing the services called for by this Contract it will not violate any applicable law, rule, or regulation, any contracts with third parties, or any intellectual rights of any third party, including but not limited to, any United States patent, trademark, copyright, or trade secret.

I-M WARRANTIES AND REPRESENTATIONS

This Contract contains customary representations and warranties by the Contractor, including, without limitation, the following:

1. The Contractor will perform all services in accordance with high professional standards in the industry;
2. The Contractor will use adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services;
3. The Contractor will use its best efforts to use efficiently any resources or services necessary to provide the services that are separately chargeable to the State;



4. The Contractor will use its best efforts to perform the services in the most cost effective manner consistent with the required level of quality and performance;
5. The Contractor will perform the services in a manner that does not infringe the proprietary rights of any third party;
6. The Contractor will perform the services in a manner that complies with all applicable laws and regulations;
7. The Contractor has duly authorized the execution, delivery and performance of the Contract;
8. The Contractor has not provided any gifts, payments or other inducements to any officer, employee or agent of the State.

I-N TIME IS OF THE ESSENCE

The Contractor agrees that time is of the essence in the performance of the Contractor's obligations under this Contract.

I-O STAFFING OBLIGATIONS

The State reserves the right to approve the Contractor's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State. Such approval will not be unreasonably withheld.

The Contractor shall not remove or reassign, without the State 's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of the Contractor's obligations under this Contract. Such approval will not be unreasonably withheld. The Contractor agrees that the continuity of Key Personnel is critical and

agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable control of the Contractor including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

For purposes of this contract, Key Personnel include:

Account Manager: Lisa Stout

Account Director: Luke Johnson

Clinical Program Manager: Steve Pepin



I-P WORK PRODUCT AND OWNERSHIP

1. Subject to paragraph I-P(2) below, Work Products shall be considered works made by the Contractor for hire by the State and shall belong exclusively to the State and its designees, if created solely for the State, unless specifically provided otherwise by mutual agreement of the Contractor and the State. If by operation of law any of the Work Product, including all related intellectual property rights, is not owned in its entirety by the State automatically upon creation thereof, the Contractor agrees to assign, and hereby assigns to the State and its designees the ownership of such Work Product, including all related intellectual property rights. The Contractor agrees to provide, at no additional charge, any assistance and to execute any action reasonably required for the State to perfect its intellectual property rights with respect to the aforementioned Work Product.

2. Notwithstanding any provision of this Contract to the contrary, any preexisting work or materials, deliverables, upgrades and updates thereof including, but not limited to, any routines, libraries, tools, methodologies, processes or technologies (collectively, the "Development Tools") created, adapted or used by the Contractor in its business generally, including any and all associated intellectual property rights, shall be and remain the sole property of the Contractor, and the State shall have no interest in or claim to such preexisting work, materials or Development Tools, except as necessary to exercise its rights in the Work Product.

3. The Contractor and its subcontractors shall be free to use and employ their general skills, knowledge and expertise, and to use, disclose, and employ any generalized ideas, concepts, knowledge, methods, techniques or skills gained or learned during the course of performing the services under this Contract, so long as the Contractor or its subcontractors acquire and apply such information without disclosure of any confidential or proprietary information of the State, and without any unauthorized use or disclosure of any Work Product resulting from this Contract.

I-Q CONFIDENTIALITY OF DATA AND INFORMATION

1. All financial, statistical, personnel, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.

2. Proprietary Information. Each party agrees that information of the other party, including, but not limited to the following, shall constitute confidential and proprietary information ("Proprietary Information") unless otherwise public: (a) with respect to Contractor: reporting and system applications, (web-based and other media), and system formats, data banks, clinical and formulary management operations and programs and manuals, information concerning Rebates, prescription drug evaluation criteria, drug choice management, drug



pricing information, and Participating Pharmacy agreements; and (b) with respect to State: State information files, business operations and strategies. Neither party shall use the other's Proprietary Information or disclose it to any third party, at any time during or after termination of this Agreement, except as specifically contemplated by this Agreement or upon prior written consent. Upon termination of this Agreement, each party shall cease using the other's Proprietary Information, and all such information shall be returned or destroyed upon the owner's direction. Notwithstanding the above, this section and this Contract are subject to the provisions of the Freedom of Information Act (see Section I-H).

3. **Trademarks.** Each party acknowledges each other party's sole and exclusive ownership of its respective trade names, commercial symbols, trademarks, and servicemarks, whether presently existing or later established (collectively "Marks"). No party shall use the other party's Marks in advertising or promotional materials or otherwise without the owner's prior written consent.

4. The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State. Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

I-R REMEDIES FOR BREACH OF CONFIDENTIALITY

The Contractor acknowledges that a breach of its confidentiality obligations as set forth in section I-Q of this Contract shall be considered a material breach of the Contract. Furthermore the Contractor acknowledges that in the event of such a breach the State shall be irreparably harmed.

I-S CONTRACTOR'S LIABILITY INSURANCE

The Contractor shall purchase and maintain such insurance as will protect him/her from claims set forth below which may arise out of or result from the Contractor's operations under the Contract (Purchase Order), whether such operations be by himself/herself or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:

(1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other State the Contractor shall have insurance or participate in a mandatory State fund to cover the benefits payable to any such employee.



(2) Claims for damages because of bodily injury, occupational sickness or disease, or death of his/her employees.

(3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than his/her employees, subject to limits of liability of not less than \$300,000.00 each occurrence and, when applicable \$1,000,000.00 annual aggregate, for non-automobile hazards and as required by law for automobile hazards.

(4) Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than \$50,000.00 each occurrence for non-automobile hazards and as required by law for automobile hazards.

(5) Insurance for Subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than \$300,000.00 each occurrence and when applicable, \$1,000,000.00 annual aggregate.

The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract (Purchase Order).

UPON CONTRACT EXECUTION, THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF ACQUISITION SERVICES, ORIGINAL CERTIFICATE (S) OF INSURANCE VERIFYING LIABILITY COVERAGE. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. These Certificates shall contain a provision that coverage's afforded under the policies will not be canceled until at least fifteen days prior written notice bearing the Contract Number or Purchase Order Number has been given to the Director of Purchasing.

I-T NOTICE AND RIGHT TO CURE

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period thirty (30) days to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage or destruction of any real or tangible personal property.

I-U CANCELLATION

The State may cancel this Contract without further liability or penalty to the State, its departments, divisions, agencies, offices, commissions, officers, agents and employees for any of the following reasons:

1. Material Breach by the Contractor. In the event that the Contractor breaches any of its material duties or obligations under the Contract, which are either not capable of or subject to being cured, or are not cured within the time period specified in the written notice of breach provided by the State, or pose a serious and imminent threat to the health and safety of any



person, or the imminent loss, damage or destruction of any real or tangible personal property, the State may, having provided written notice of cancellation to the Contractor, cancel this Contract in whole or in part, for cause, as of the date specified in the notice of cancellation.

In the event the State chooses to partially cancel this Contract for cause charges payable under this Contract will be equitably adjusted to reflect those services that are cancelled.

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a cancellation for convenience, effective as of the same date, and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2. Cancellation For Convenience By the State. The State may cancel this Contract for its convenience, in whole or in part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 30 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.

3. Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.

4. Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity.

5. Approval(s) Rescinded. In the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Article 11, Section 5 of the Michigan Constitution of 1963 and Chapter 7 of the Civil



Services. Notwithstanding any other provision of the Contract to the contrary, the State Personnel Director is authorized to disapprove contractual disbursements for personal services if the Director determines that the Contract or the disbursements under the Contract violate Article 11, Section 5 of the Constitution or violates applicable Civil Service rules or regulations.

Cancellation may be in whole or in part and may be immediate as of the date of the written notice to the Contractor or may be effective as of the date stated in such written notice.

I-V RIGHTS AND OBLIGATIONS UPON CANCELLATION

1. If the Contract is canceled by the State for any reason, the Contractor shall, (a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Administrator or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.

2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date. All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

I-W EXCUSABLE FAILURE

1. Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such



default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the

non-performing party will be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such

party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.

2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor. The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I-X ASSIGNMENT

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the State Purchasing Director.

I-Y DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.



I-Z NON-DISCRIMINATION CLAUSE

In the performance of any Contract or purchase order resulting herefrom, the bidder agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The bidder further agrees that every subcontract entered into for the performance of any Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2101, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.

I-AA MODIFICATION OF SERVICE

The Director of Acquisition Services reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary.

This Contract may not be revised, modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. The Contractor shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, the Contractor shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment. The price adjustment shall be based on a good faith determination and calculation by the Contractor of the additional cost to the Contractor in implementing the change request less any savings realized by the Contractor as a result of implementing the change request. The Contractor's proposal shall describe in reasonable detail the basis for the Contractor's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.

2. If the State accepts the Contractor's proposal, it will issue a change notice and the Contractor will implement the change request described therein. The Contractor will not implement any change request until a change notice has been issued validly.



The Contractor shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.

3. If the State does not accept the Contractor's proposal, the State may:
 - a. withdraw its change request; or
 - b. modify its change request, in which case the procedures set forth above will apply to the modified change request.

If the State requests or directs the Contractor to perform any activities that are outside the scope of the Contractor's responsibilities under the Contract ("New Work"), the Contractor must notify the State promptly, and before commencing performance of the requested activities, that it believes the requested activities are New Work. If the Contractor fails to so notify the State prior to commencing performance of the requested activities, any such activities performed before notice is given by the Contractor shall be conclusively considered to be In-scope Services, not New Work.

If the State requests or directs the Contractor to perform any services or functions that are consistent with and similar to the services being provided by the Contractor under the Contract, but which the Contractor reasonably and in good faith believes are not included within the scope of the Contractor's responsibilities and charges as set forth in the Contract, then prior to performing such services or function, the Contractor shall promptly notify the State in writing that it considers the services or function to be an "Additional Service" for which the Contractor should receive additional compensation. If the Contractor does not so notify the State, the Contractor shall have no right to claim thereafter that it is entitled to additional compensation for performing such services or functions. If the Contractor does so notify the State, then such a service or function shall be governed by the change request procedure set forth in the preceding paragraph.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

I-BB NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

For the Contractor: Express Scripts, Inc.
 13900 Riverport Drive
 Maryland Heights, MO 63043
 Attention: President



For the State: Melissa Castro
 Acquisition Services
 2nd Floor, Mason Building
 530 W. Allegan
 Lansing, MI 48909

Either party may change its address where notices are to be sent giving written notice in accordance with this section.

I-CC ENTIRE AGREEMENT

This Contract shall represent the entire agreement between the parties and supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

I-DD NO WAIVER OF DEFAULT

The failure of a party to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-EE SEVERABILITY

Each provision of the Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-FF HEADINGS

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-GG RELATIONSHIP OF THE PARTIES

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.



I-HH UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to section 2 of the Act. This information is compiled by the United States National Labor Relations Board.

A Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-II SURVIVAL

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor's indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

I-JJ GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

I-KK YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom.

I-LL CONTRACT DISTRIBUTION

Acquisition Services shall retain the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Acquisition Services.

I-MM STATEWIDE CONTRACTS

If the contract is for the use of more than one agency and if the goods or services provided under the contract do not meet the form, function and utility required by an agency, that agency may, subject to state purchasing policies, procure the goods or services from another source.



I-NN TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to up to 90 days after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.

I-OO DISCLOSURE OF LITIGATION

1. The Contractor shall notify the State in its bid proposal, if it, or any of its subcontractors, or their officers, directors, or key personnel under this Contract, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation or deception. Contractor shall promptly notify the State of any criminal litigation or proceedings which are public proceedings or which Contractor has otherwise disclosed to the public involving the Contractor or any of the Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract. Additionally, Contractor shall promptly notify the State of any criminal investigations involving the Contractor or any Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract to the extent such criminal investigation specifically and uniquely involves the State.

2. The Contractor shall notify the State in its bid proposal, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments that may have arisen against it or its subcontractors during the five years preceding its bid proposal, or which may occur during the term of this Contract which involve, (1) products or services similar to those provided to the State under this Contract and which either involve a claim in excess of one million dollars or which otherwise may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor, in any an amount less than one million dollars shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.

3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements which are prevented from disclosure by the terms



of the settlement shall be annotated as such. Semi-annually, during the term of the Contract, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State

4. Assurances - In the event that such investigation, litigation, arbitration or other proceedings disclosed to the State pursuant to this Section, or of which the State otherwise becomes aware, during the term of this Contract, causes the State to be reasonably concerned about:

a) the ability of the Contractor or its subcontractor to continue to perform this Contract in accordance with its terms and conditions, or

b) whether the Contractor or its subcontractor in performing services is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration or other proceedings, which conduct would constitute a breach of this Contract or violation of Michigan or Federal law, regulation or public policy, then The Contractor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that: (a) the Contractor or its subcontractors hereunder will be able to continue to perform this Contract in accordance with its terms and conditions, (b) the Contractor or its subcontractors will not engage in conduct in performing services under this Contract which is similar in nature to the conduct alleged in any such litigation, arbitration or other proceedings.

5. The Contractor's failure to fully and timely comply with the terms of this section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of this Contract.

I-PP DISCLOSURE OF CERTAIN FINANCIAL MATTERS

In addition to the administrative fees paid to Contractor by the State, Contractor derives margin from fees and revenue in one or more of the ways as further described in the Contractor Financial Disclosure to PBM Clients set forth in Appendix D, hereto ("Financial Disclosure"). In negotiating any of the fees and revenues described in the Financial Disclosure or in this Agreement, Contractor acts on its own behalf, and not for the benefit of or as agent for State, Members or the plan. Except for the Rebate amounts, if any, State acknowledges and agrees that Contractor will retain all interest, Rebate administrative fees, revenues, any portion of Rebates thereon not payable to State, and all participating pharmacy discounts, if any, in addition to any administrative and other fees paid by State. State acknowledges for itself, its Members and the plan that, except as may be expressly provided herein, neither it, any Member, nor the plan, has a right to receive, or possesses any beneficial interest in, any such discounts or payments.



SECTION II **WORK STATEMENT**

II-A BACKGROUND/PROBLEM STATEMENT

The State provides health benefit services through the State Health Plan (SHP – the traditional, non-HMO medical plans) to employees, COBRA continues, retirees, and their eligible dependents. The non-HMO medical plans are administered by Blue Cross Blue Shield of Michigan (BCBSM), and by Aetna. These plans cover approximately 36,000 active employees and COBRA participants, plus their 58,000 dependents, as well as 33,000 retirees, plus their 20,000 dependents, for a total covered membership (employees/COBRA/retirees, plus dependents) of 147,000.

Note: This Contract does NOT include participants in any of the following:

- State enrollees in Health Maintenance Organizations (approx. 25,000 employees)
- State enrollees in the Catastrophic Medical plan (approx. 1,000 employees)
- University and public school employees and retirees (these are not part of the SHP)

Prescription drug benefits are “carved out” of these medical plans and provided by separate, stand-alone plans.

II-B OBJECTIVES

The objectives of this retail prescription drug benefit Contract are to:

- provide a retail and mail-order prescription drug benefit program for active employees, COBRA participants, retirees, and their eligible dependents, enrolled in the SHP,
- provide performance-based retail pharmacy network with convenient access for members,
- reduce and control the cost of prescription drugs, where appropriate,
- provide a voluntary formulary and preferred drug list that results in lower cost per Rx, improved health outcomes and lower total healthcare costs,
- offer utilization and health management programs (e.g., DUR, disease state management) that decrease inappropriate Rx and medical utilization while ensuring better compliance with best practice treatment guidelines and improved healthcare outcomes,
- introduce innovative services that improve physician prescribing and treatment, and
- improve service with expanded customer and account service features.

II-C TASK/PLAN REQUIREMENTS

The Contractor must meet the following requirements:



1. Plan Design

The current pharmacy plan design includes both retail and mail-order components, based on an "open" formulary design, with member copayments of \$5 and \$10 for generic and brand drugs, respectively. Copays are the same under both the retail and mail-order plans.

The vendor must be able to duplicate the plan design to be effective January 1, 2003, including the changes scheduled for January 1, 2004. Note that retail plan design copays effective January 1, 2003 will be \$7 per generic script and \$12 for brand-name, and that the copay for brand-name scripts will increase to \$15 effective January 1, 2004.

If an acceptable substitute generic drug is available, then generic substitution is required unless the prescriber specifies "dispense as written" (DAW) on the prescription, or the member has affirmatively requested the brand name with the pharmacy. If the member requests the brand-name drug, the member pays the brand-name copay (\$12 effective 1/1/2003, and \$15 effective 1/1/2004) plus the difference between the brand and generic drug cost. For non-network claims, the member pays the copay plus the difference between the billed charge and the network charge.

Notwithstanding anything else contained herein to the contrary, Contractor shall provide the State with a benefit design form which will permit the State to identify and periodically update coverage and exclusion rules for all Covered Drugs and Non-Covered Drugs.

It should be noted that these plan provisions are subject to change, depending on the outcome of the collective bargaining process. Current collectively bargained contracts run through September 30, 2005, and benefit provisions may change at that time. The Contractor will be expected to administer any plan changes.

2. Covered and Noncovered Drugs

Covered Drugs

- (a) A drug, biological or compounded medication which, by Federal law, may be dispensed only by a prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without a prescription," except those specifically excluded in the exclusions section below.
- (b) State Restricted Drugs, which may only be dispensed by prescription.
- (c) Oral contraceptives.
- (d) Injecable insulin.
- (e) Disposable needles and syringes for injectable insulin, Avonex and Betaseron (Lancets and test strips are covered by BCBSM under the Major Medical benefit, and under the Merck/Medco mail-order plan).
- (f) Chemotherapeutic agents.



- (g) Compound Medications, including any extemporaneously prepared dosage form containing at least one Federal Legend or State Restricted drug in a therapeutic amount, or a combination of ingredients that require a prescription by law. Liquid medications must include weighting of at least one solid or the measuring and mixing of at least three liquid ingredients.
- (h) Up to a 34-day supply of each prescription drug or refill may be dispensed at retail, with the exception of certain maintenance medications, which may be covered in a 100 unit dosage or 34-day supply (whichever is greater) or a 200 unit dosage or 34-day supply (whichever is greater).

The State will cover all prescribed drugs meeting these requirements.

Limitations

- a. Benefits will be payable only for prescription drugs dispensed while the member is covered for this benefit.
- b. Benefits will be payable only for prescription drugs prescribed by a health professional authorized to prescribe medication.
- c. All medications covered by this plan must be reviewed for medical necessity in accordance with FDA approval, subject to guidelines for appropriate age, gender, and/or diagnosis considerations and State Health Plan morbid obesity guidelines.
- d. All eligible injectable medications require prior approval/medical necessity review with the exceptions of Insulin, Epi-pen and Ana-kit.
- e. All forms (oral, topical or injectable) of the following categories require prior approval/medical necessity review:
 - androgenic agents, such as Testosterone
 - anti-obesity agents, such as Ionamin and Fastin
 - dermatology agents, such as Retin-A, Differin
- f. If an acceptable substitute generic drug is available, then generic substitution is required unless the prescriber specifies "dispense as written" (DAW) on the prescription, or the member has affirmatively requested the brand name with the pharmacy. If the member requests the brand-name drug, the member pays the brand-name copay (\$12 effective 1/1/2003, and \$15 effective 1/1/2004) plus the difference between the brand and generic drug cost. For non-network claims, the member pays the copay plus the difference between the billed charge and the network charge.
- g. Certain specified drugs (such as Viagra) may have additional limitations, as determined by the Plan.

Exclusions

Benefits will not be paid for:



- a. Any medication provided on an inpatient basis in a hospital, convalescent facility, psychiatric facility, or any similar institution, health care facility, or on an outpatient basis in any such facility or by a physician to the extent benefits are payable for the prescription under any other plan, or by the health care facility.
- b. Medication covered by Workers' Compensation or similar occupational law, any State or governmental agency, or for which no charge is made to the member.
- c. The administration or injection of any drug.
- d. Any device of any type, such as tubing or crutches, except needles/syringes, lancets and test strips as noted above.
- e. Immunization agents, biological sera, blood or blood plasma, excluding factors 8 and 9.
- f. Drugs labeled "Caution--Limited by Federal law to investigational use," or experimental drugs.
- g. Federal Schedule 1 drugs.
- h. Over-the-counter medications (non-prescription).
- i. Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one (1) year from the physician's order.
- j. Any refill of a drug that is more than the number of refills specified by the prescriber. The Contractor, before filling the prescription, may require a new prescription, or evidence as to need, if the prescriber has not specified the number of refills or the frequency or number of prescriptions or refills appears excessive under acceptable medical practice standards.
- k. More than a thirty-four (34) day supply of a covered drug at retail pharmacies, except those maintenance drugs dispensed in 100-200 unit doses under the retail plan.
- l. Any drug for which the pharmacy charges are less than the copayment.

3. **Administrative Services**

Administrative services must include, but need not be limited to, the following:

Information Systems:

- On-line access with pharmacies for the following:
 - eligibility
 - noncovered items
 - drug to drug interactions
 - drug to sex edit
 - drug to age edit
 - early refill edit
 - duplicate claim edit
 - on-line pricing



- A pharmacy network with an electronic “point-of-sale” (POS) computerized administrative and claims payment system that provides:
 - electronic collection and recording of retail charges
 - records of individual patient prescription drug purchases (based upon the Comprehensive Claim Format Published by the National Council for Prescription Drug Programs, Inc.) to include, but be not limited to:
 - ◇ patient name, sex, Social Security number, relationship to member
 - ◇ medication name, strength, dosage, and days supply
 - ◇ NDC number
 - ◇ Rx number, new fill or refill
 - ◇ date filled
 - ◇ pharmacy NABP/NCPDP number
 - ◇ pharmacy name
 - ◇ dispensing MD number and DEA number
 - ◇ if compound prescription, list ingredients and quantities
 - ◇ usual, customary, and reasonable retail price
- Confidentiality of all data by the Contractor (consistent with HIPAA and other regulations).
- Comprehensible Explanation of Prescriptions (EOPs) that include adequate information about the prescription, including the cost of the prescription to the plan, are desirable.
- Transmittal of prescription drug utilization data to Blue Cross Blue Shield of Michigan, in support of the disease management programs they administer on behalf of the State.

Financial Arrangements:

- A contracted Rx reimbursement formula equal to the lower of the pharmacy's usual and customary or prevailing retail price (i.e., "counter price"), including any discounts offered by the pharmacy to the general customers including senior citizens or a significantly discounted prescription drug average wholesale price (AWP) formula plus a low and competitive dispensing fee.
- A mandatory comprehensive Maximum Allowable Cost (MAC) program for generic drugs that encourages generic substitution by patient, physician, and pharmacy.
- Pharmacy dispensing fees.
- Rebates, as appropriate.
- A contracted fixed administrative fee per prescription.

Participant Services:

- Customized participant communications (with all communications subject to the State's approval).



- Customer service activities to include but not be limited to:
 - single front-end toll-free 800 telephone number with touch-tone routing (if necessary) for member services to respond to requests for participating pharmacy locations, inquiries on claims, and complaints about pharmacist practices and services
 - a voice response system (if necessary) with a user-friendly menu that customers find easy to understand
 - separate 800 numbers for participants, physicians, and pharmacists
 - access to a pharmacist 24 hrs/day
 - development of same services through the Internet
 - inquiry/service representatives assigned to the SOM account, for both the retail and mail-order programs (these should be integrated).
- Initial credentialing, monitoring, and re-credentialing of network pharmacies.
- Periodic on-site audits of participating pharmacies as necessary (a minimum of 2% of network pharmacies recommended).
- Maintenance of records for auditing and management information reporting and analysis.
- Management of a smooth transition process from the current vendor(s), including capability of accepting refill information from the current vendor so that members will not have to obtain new prescriptions for existing prescriptions when the new vendor contract commences.
- Comprehensive patient and provider education services.
- Utilization and Clinical Management:
 - The prescription drug benefits are to be provided only if medically necessary and only if prescribed by a licensed professional. The proposal must contain statements describing the steps that will be taken by the vendor to ensure accuracy, quality control, timeliness, and drug benefit cost effectiveness.
 - Effective and innovative programs for Drug Utilization Review (DUR), physician and pharmacist profiling, case and disease management.

Account Management:

- An assigned account representative, and assigned service representatives, responsive to inquiries, requests and issues raised by the State.
- An assigned pharmacist to provide a reasonable amount of analytical assistance and clinical advice to the State.

4. **Formulary**

The plan must provide a formulary on a strictly voluntary basis for the member that would require a fixed, stated percentage of pharmaceutical rebates or a guaranteed minimum refund, to the State.



5. **Subcontracting**

Provisions regarding use of subcontractors are given in Section I-F. The State expects that all essential services associated with delivery of this program will be provided directly by the Contractor, and that use of subcontractors will be minimal, with the possible exception of certain peripheral services such as printing, communications design, etc.

6. **Clinical Management**

The State is interested in new, innovative and effective programs for clinical and disease management, and recognizes that this is an area under active development.

7. **Funding**

The State will fund the pharmacy program on an administrative services only (ASO) basis, for the duration of the contract.

8. **Eligibility**

Eligibility information will be maintained by the Contractor. Premium deduction and eligibility information for active employees and their participating dependents will be transferred by the State via tape, diskette, CD-ROM, EDI, Email or the Internet on a weekly basis. Eligibility information for pension recipients will be transferred by the Office of Retirement Services via tape, diskette, CD-ROM, EDI, Email or the Internet on a monthly basis. The Contractor must have the capabilities to accept electronic data transfer, and to administer membership information in compliance with HIPAA requirements.

9. **Performance Guarantees**

The Contractor shall agree to Performance Standards. The objective of these standards is to encourage an acceptable level of performance in key contract administration areas. These include:

- Eligibility,
- Claim turnaround time,
- Claim payment accuracy on both a dollar and per occurrence basis,
- Inquiry handling.

See Appendix B for specific Performance Guarantees for this Contract.

10. **Systems and Reporting Requirements**

a. Claim Information

Maintenance of detailed claims information is necessary to facilitate claims review and cost containment functions. It is also essential to produce reports to be submitted to the State for use in effectively administering the program.



Data collected on behalf of the State program is not to be distributed to any party without the written consent of the State and is not to be used by the Contractor for any purposes unless specifically approved by the State. All data identifying specific enrollees or their dependents are highly confidential and are to be treated accordingly.

Capture of additional claim items may be required by the State in the future. It will be the responsibility of the Contractor to maintain records in such a manner that will allow reporting of claims submitted by providers.

b. Claims Records File

To provide the State with an in-house capacity to conduct detailed analysis of activities related to prescription drug utilization, the Contractor will be required to provide, on a regularly scheduled basis, no less frequently than quarterly, a suitable tape or CD-ROM disk file containing detailed claim records in a format required by a contractual claims analysis company (currently, Medstat).

The file is to be produced quarterly, and submitted to the data consolidation vendor specified by DCS.

c. Contractor/State Interface

The following are additional Contractor requirements related to the necessary systems interface between the selected Contractor and the State.

1. Capability and capacity to accept the State's computerized enrollment files and process change transactions to maintain up-to-date information for claims certification.
2. A dedicated staff of systems professionals to provide timely service covering systems analysis and programming required to implement system changes and produce reports.
3. Designation of a high-level management staff member to serve as liaison for systems related matters.

d. Reports

The State expects to receive the Contractor's standard report package and those reports described below. Reports must be furnished within 45 days of the end of the month and end of the quarter and within 90 days of year-end.

- Monthly activity summaries, including:
 - A brief narrative of significant accomplishments, administrative issues, outstanding problems, etc. which occurred in the month, as well as developments in major new drugs, drugs going generic or OTC, etc.,
 - Number of prescriptions, average wholesale ingredient costs, discounted ingredient costs charged, employee copays, dispensing fees and amount paid, split between Retail and Mail Order, and between single-source brand, multi-source brand, and generics,



- Claims “lag” reports, showing total payments by “incurred” and “paid” months, separated by Retail and Mail Order,
- Covered membership reports, showing total counts of covered employees/retirees and covered members (including dependents), with
- All reports split between Actives, COBRA, retirees, and combined.
- Quarterly reports, including,
 - Year-to-date summaries of the Monthly summary reports, and
 - Quarterly Performance Standards Results.
- Annual Report, containing:
 - Management summary,
 - Full financial and enrollment experience, and
 - Top 100 sole source drugs and top 25 generic drugs.
- Formulary Reimbursement Reports.
- Physician Profiling/Other Clinical Effectiveness Reports.
- Additional Ad-Hoc reports, as requested.
- On-line reporting tool – the State is interested in on-line reporting capabilities.

11. **Network Match**

The Contractor must maintain a network of preferred community pharmacies in areas where State employees reside.

General objectives are at least one pharmacy within 1 mile in urban areas, 3 miles in suburban areas and 10 miles in rural areas.

12. **Identification Cards**

Identification cards must be provided to eligible employees and their dependents.

13. **Communication Materials**

The Contractor will prepare and cover the cost of all announcements, letters, notices, brochures, forms, postage and other supplies and services for U.S. mail distribution to employee residences.

The State will have approval of drafts of communication materials. All information/ material must be approved by the State prior to use.

14. **Audits**

The terms of any audits shall be controlled by the terms of the Contract section I-I.



II-D PROJECT CONTROL AND REPORTS

I. Project Control

a. The Contractor will carry out this project under the direction and control of the Office of State Employer (DCS).

b. Although there will be continuous liaison with the Contractor team, the client agency's project director will meet no less often than quarterly during the first contract year, with the Contractor's project manager for the purpose of reviewing progress and providing necessary guidance to the Contractor in solving problems which arise.

c. The Contractor will submit, as part of the monthly report (see II-C 8.c) brief written summaries of significant activities during the month, issues or problems, real or anticipated, which should be brought to the attention of the client agency's project director, and significant activities anticipated for subsequent months. A copy of this report will be forwarded to the named buyer in Acquisition Services.

d. Within five (5) working days of the award of the Contract, the Contractor will submit to the Contract Administrator project director for final approval a work plan. This final implementation plan must be in agreement with section IV-C subsection 2 as proposed by the bidder and accepted by the State for Contract, and must include the following:

(1) The Contractor's project organizational structure.

(2) The Contractor's staffing table with names and title of personnel assigned to the project. This must be in agreement with staffing of accepted proposal. Necessary substitutions due to change of employment status and other unforeseen circumstances may only be made with prior approval of the State.

(3) The project breakdown showing sub-projects, activities and tasks, and resources required and allocated to each.

(4) The time-phased plan in the form of a graphic display, showing each event, task, and decision point in your work plan.

II-E PRICE PROPOSAL

See Appendix A, Pricing Proposal.



SECTION III

CONTRACTOR'S PROPOSAL

III-A BUSINESS ORGANIZATION

Express Scripts' full name and address is:

Express Scripts, Inc.
13900 Riverport Drive
Maryland Heights, MO 63043

List all subcontractors; include firm name and address, contact person, complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization and abilities.

Name/Address: Jerome Card, 2465 Centerline Industrial Drive, Maryland Heights, MO 63043
Contact: Jim Hughes, Phone: (314) 991-1000
Work Performed Processes and prints member education and enrollment material; Patient Identification cards.

III-B MANAGEMENT SUMMARY

Key Personnel / Account Management

Account Manager—Lisa Stout is your daily contact for activity and operational needs. Lisa handles all standard operations needs, reporting, ad-hoc inquiries, and issue tracking, as well as implementation of new groups and benefits and maintenance of on-going ones. She also acts as your liaison to all Express Scripts operational areas.

Account Director—Luke Johnson is a seasoned account executive with a strong track record providing strategic account management and sterling customer service. He will be responsible to the State to develop, build and execute a pharmacy management business plan, including key goals, objectives, metrics, and provide direction to your account team based on your goals and objectives.

Clinical Program Manager—Steve Pepin will serve as the State's liaison for Express Scripts' clinical functions. He is responsible for implementing, measuring, and monitoring all clinical programs and services the State receives through Express Scripts. Steve will create a personalized plan that will take into account the State's unique utilization patterns, corporate culture, financial and service goals, and ensure that drugs are utilized safely, appropriately, and rationally. He will assist the State with drug review and utilization management, formulary discussion, network services, and therapy-specific research and intervention programs.



Benefits Analyst and Consultant—This team member provides continual client-specific analysis and subsequent consultation on opportunities to leverage your benefit plan design. In addition to studying and monitoring the State's drug trends, your BACS analyst will provide benchmarks that compare the State's drug trend and utilization patterns with similar clients of similar demographics. Benefits and program solutions as well as decision support are provided directly by this analyst, in both scheduled meetings like the Annual Strategic planning session and in time-critical situations like contract negotiations and budgeting.

Implementation Project Manager (IPM)—This team member is dedicated to the task of implementing your managed pharmacy program. Operating from an established set of implementation best practices and tracking mechanisms, the IPM will facilitate and manage all activities associated with transition from Medco Health Systems to Express Scripts.

Regional Director—Craig Oberg provides management oversight and institutes best and consistent practices for all members of your account management team.

Executive Sponsor—As your executive sponsor for the past five years, John Abell has been highly involved in bringing his knowledge and understanding from a strategic level within our organization to the State. John has established and will continue to maintain a high-level strategic relationship with the State of Michigan.

Sales Director—Sales Director Barry Rosenthal has been working with your account team for the past year to bring new ideas to the State. Barry will continue to work with the account team to make sure that all commitments made during your selection process are fully implemented.

Your account management team is backed by an internal extended service team—experts within Express Scripts' business and operational areas that are key to program success. This direct accountability into operational areas and across functional boundaries distinguishes our service model from others in the industry. Our extended service team is very familiar with the State of Michigan and will continue to provide the excellent service the State of Michigan has come to expect.



Extended Service Team

While transparent to the State of Michigan, this team is actively involved with your dedicated account service team in the continuous, quality management of your pharmacy benefits program and includes representatives from:

- MIS Product Administration
- Underwriting
- Eligibility Support
- Mail Service Operations
- Call Center Services
- Retail Network Support
- Member Services
- Formulary Management
- Marketing Communications
- Legal
- Banking
- Provider Relations

Subcontractors

Name/Address: Jerome Card, 2465 Centerline Industrial Drive, Maryland Heights, MO 63043
Contact: Jim Hughes, Phone: (314) 991-1000
Work Performed: Processes and prints member education and enrollment material; Patient Identification cards.

III-C QUESTIONNAIRE

1. Plan Design

A. Confirm that the Contractor will adhere strictly to all components of the current plan design.

Express Scripts agrees to meet all plan design requirements.



B. Some State employees and retirees reside outside the United States (chiefly in Canada). Discuss the availability of pharmacy services in Canada, including issues relating to coordination of services with Canadian governmental health plans (such as OHIP). Discuss the process for submitting and paying these claims.

State employees and retirees living outside of the United States may utilize paper claim forms to gain reimbursement for prescriptions filled by retail non-participating pharmacies. The member initially pays full price for the prescription and then submits a claim along with the pharmacy receipt for reimbursement to Express Scripts. Lisa Stout, the State's account manager, can e-mail claim forms to members who request them. These forms can be filled out and sent back electronically, along with an imaged receipt, for reimbursement. Turnaround time is 24 to 48 hours. State employees may also utilize the mail service. Express Scripts mail service will dispense prescriptions written by Canadian physicians as well as ship to Canadian addresses.

2. Account Servicing

A. What office do you propose to use to service the State's pharmacy plan? From which of your office(s) will claims be paid?

Express Scripts is committed to offering the State a continuation of the high level of account and member services they currently enjoy. This account team has the advantage of our experience serving your members, as well as the knowledge of your goals toward containing costs and managing utilization. Your Account Director, Luke Johnson (Minneapolis, MN), will continue to lead your current Account Team, which consists of Account Manager Lisa Stout (Farmington Hills, MI), and Clinical Program Manager Steve Pepin (Minneapolis, MN).

Claims Processing

Nearly 100% of pharmacy claims are submitted and adjudicated electronically.

Member-submitted paper claims will be processed at the address below. Hours of operation for this office are 6:00 a.m. to 4:30 p.m., Monday through Friday:

Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166-6773
ATTN: Claims Dept

Members may also contact our Call Center 24 hours per day, seven days per week, to assist members with any questions they may have regarding claims.



B. Describe, in two paragraphs or less each, your services for the following:

- **Routine administrative support, including attendance at meetings with the State as needed,**
- **Clinician resources – a pharmacist available for a reasonable amount of consultation; provide the credentials of the pharmacist.**

Routine Administrative Support

The Account Team has worked closely with the benefit department in administering the active retail population. Lisa Stout, the State's Senior Account Manager, is responsible for day-to-day administrative support and works closely with Luke Johnson and Steve Pepin in administering the benefits. The Account Team's time commitment will vary upon the State's changing needs. For example, a significant amount of time will be spent with the State during implementation to ensure your program is transitioned successfully.

The Account Team will hold a face-to-face meeting with the State of Michigan at least quarterly. During implementation and the initial period of operation, we may suggest more frequent meetings. In addition, we will be in continuous communication by phone and email.

Lisa's day-to-day responsibilities are detailed in our response to Item C. below.

Clinician Resources

As the Clinical Program Manager it is Steve Pepin's job to provide expert advice and clinical assistance to the State. Steve will have resources available to help communicate and implement clinical programs that will assist you in managing the plan to promote member health.



C. Service Approach – Describe the account servicing approach and address the following:

- Responsibilities of the day to day contact
- Problem resolution process
- Title/level with problem resolution authority
- Year-end plan performance analysis
- Monitoring account service satisfaction

Responsibilities of the day-to-day contact

Lisa Stout, the State's Senior Account Manager, is responsible for day-to-day communication with the State.

Lisa knows the State well and works with members of the State's Employee Benefit Division and Personnel Offices to manage day-to-day issues. Lisa, as always, has available to her all of Express Scripts' internal resources to meet the State's needs.

Lisa will continue to work with the State to provide exceptional account service. Lisa is a seasoned individual who understands how to make the necessary level of expertise (e.g., clinical, customer service, strategic planning, and reporting) available and accessible to the State.

Lisa's primary responsibilities include:

- Acting as central contact and primary day-to-day State of Michigan contact for account activity and operational needs:
 - Primary responsibilities (e.g., standard operations needs, ad-hoc inquiries, issue tracking)
 - Implementation of new groups and maintenance of ongoing groups
 - Implementation of benefit changes and overall maintenance and monitoring of benefit plan.
 - Empowered to resolve service challenges
 - Monitor Client Support Center (CSC) performance on manual eligibility and inquiry resolution.
- Updating the online reference system with State-specific information enabling our Customer Center Associates to respond to the needs of your members
- Establishing and maintaining reporting requirements
- Acting as liaison to all operational areas



Problem resolution process

Our model empowers everyone involved in your service to effectively resolve problems. As your day-to-day contact, Lisa Stout is the focal point in the problem resolution process.

We are very conscientious about effective customer service and monitor our performance on a consistent basis. We survey each of our clients annually to assess the value our account managers place on the assigned account team, including measures of responsiveness and knowledge of the client.

Title/level with problem resolution authority

Problem resolution authority depends on the type of issue.

As your Executive Sponsor for the past five years, John Abell has been highly involved in bringing his knowledge and understanding from a strategic level within our organization to the State. John has established and will continue to maintain a high-level strategic relationship with the State of Michigan.

As your Regional Director, Craig Oberg has the authority to resolve contractual issues, staffing, and financial decisions.

Your Account Director, Luke Johnson, has the authority to handle large, complex operational issues and initiate changes that involve many operational areas within Express Scripts. Examples include customizing business processes (such as system processing or network management changes), strategic client issues (such as benefit design modeling and working with State stakeholders), and processes related to managing the account team.

As Account Manager, Lisa Stout has the authority to resolve most issues that arise on a day-to-day basis and is your primary point of contact. Lisa has well-established relationships with multiple business and operations areas within Express Scripts to enable her to quickly get to issue resolution on behalf of a client. Our multi-disciplinary team approach ensures that your account manager, or one of the other team members, is always available to respond to immediate concerns of our clients.



Year-end plan performance analysis

Express Scripts will continue to provide year-end performance analysis. The Benefits Analysis and Consultative Services (BACS) team develops analysis for reviews, as well as ad-hoc reporting and analysis as needed. Your BACS team works closely with the members of your management team, helping design State-specific programs and recommendations. Together with your Clinical Program Manager, Steve Pepin, they monitor your pharmacy claim trends, benchmark these against our book of business and other related pharmacy claims experience, and pinpoint opportunities for strategic interventions. As a dedicated benefits analysis unit, the BACS team works with you, your consultant, and your account team to design programs tailored to your needs. This relationship helps distinguish Express Scripts as a consultative, service leader within the pharmacy benefit management industry.

One of the most asked questions when we meet with our clients to discuss plan changes is “What are others doing?” In order to answer this question, we have developed an application called Informatics. Informatics tracks all National Employer Division accounts at the plan design level. More than 90 benefit plan elements are tracked and categorized by size, region, and SIC. These plan design characteristics are updated twice a year coinciding with the most common plan change times. In addition, these plan characteristics can be “bounced” against actual claims experience to see what the real effect of the plan design is on costs and utilization. This powerful tool enables Express Scripts to provide its clients the best information in the industry on plan design options.

Monitoring account service satisfaction

Express Scripts wants to be sure we are providing our clients with the level of service they expect. For this reason we formally monitor our clients’ satisfaction through our client and member satisfaction surveys.

We measure client satisfaction on a four-point scale, ranging from very satisfied to very dissatisfied. Clients rate their overall satisfaction of key pharmacy benefit management services. Products and services are also rated according to their importance to the organization. Account management team member compensation is dependent on the satisfaction of their respective clients.

Additionally, we monitor satisfaction with account services on a client-specific basis by asking clients to complete an annual report card.



The report card asks clients how well their account team:

- Understands the employer's corporate culture and goals
- Demonstrates thorough knowledge of plan design
- Returns phone calls/e-mails promptly
- Follows through on commitments
- Is accessible and responsive
- Understands employer's challenges/marketplace
- Demonstrates knowledge of Express Scripts' products and services
- Provides Benefit Plan Design insight/strategy through consultative services
- Provides clinical insight/strategy through consultative services

D. Account Transition – Describe how you will manage the transition process from the current vendor(s). Describe the specific tasks, data requirements, and decisions which will be needed. Describe how you expect your transition team to be organized, including both vendor and State resources, and how it will interact with the State.

We are in an excellent position to implement new members quickly and with minimal disruption due to our already well-established relationship with the State. Because many of your members are already being served by the programs Express Scripts has to offer, we have a clear understanding of your unique pharmacy benefits structure, reporting requirements, organizational structure, and stakeholders. This familiarity with the State makes us confident of our ability to implement your new contract elements quickly and efficiently.

Implementation is the first, and possibly the most critical step to ensure the long-term success of a partnership with our clients. Because of the significance of this process, we have built formal policies and procedures, complete with trained experts to manage the smooth transition of your pharmacy prescription services and metrics to measure the results. To support your benefits staff and ensure administrative efficiency, we dedicate a specialist—an Implementation Program Manager (IPM)—who works in tandem with your Express Scripts account management team and your internal staff to manage the transition.

Your IPM will manage the implementation process and will provide regular status updates by phone, written report, e-mail, or other preferred means to the State. Your IPM will work closely with your account management team and other functional areas within Express Scripts to ensure that your implementation is a positive experience for the State and your members. Items that are managed by the IPM include:

- | | |
|------------------------|---------------------------------|
| *Benefit design | *Financial and billing |
| *Eligibility | *Paper claims processing |
| *Clinical services | *Call Center |
| *Account management | *Prior authorization |
| *Rebate administration | *Member communication materials |
| *Pharmacy network | *Rebate administration |
| *Report package | *Mail service |



Jon Schlosser, Senior Manager, Implementation, will have ultimate responsibility for the success of their transition. He will provide strategic support and direction to your Implementation Project Manager who will be assigned during the finalist stage. With extensive experience establishing managed pharmacy benefit accounts, your IPM specializes in guiding this crucial phase of the program and represents your needs to all operational and clinical areas with Express Scripts. Your IPM is typically involved until four weeks post-implementation to ensure a smooth transition for you and your members.

Express Scripts conducts internal and external surveys after the implementation is completed to help ensure continued successful management of the implementation process. Our 2001 survey included 41 survey responses from 60 implementations from 1/1/01 - 12/1/01. We received the following ratings:

- 95% rated satisfaction with the implementation process
- 3.5 average rating on a 4-point scale
- Clients reported strong satisfaction ratings with their technical support, benefits, mail service, member materials, call center, pharmacy network and provider communications.

Express Scripts has significant experience transitioning pharmacy activity from Medco Health Solutions, and we anticipate a smooth transition for the State. Since January 1, 2002, we have transitioned mail service from Medco Health Solutions, the State's current mail order vendor, for approximately 1.5 million lives.

4. Customer Service

A. Describe your hours of operation, including times available, separately for retail and mail order:

With the expansion in the size of this account, we plan to base customer service for the State's members in our Minneapolis, Minnesota, Call Center. An experienced core team of Customer Service Associates will continue to handle calls from the State's members. All of our Customer Service Associates are trained to respond to both mail and retail service inquiries.

i) Member inquiries – “live” customer service representatives

Express Scripts' Call Center is staffed 24 hours a day, 365 days a year to address member inquiries. Your core team of experienced Customer Service Associates will continue to address approximately 85 percent of your members' calls during normal business hours. Any remaining calls will overflow to a secondary core team, also trained on your pharmacy benefit program.



Each call received by the Call Center is logged with the date, caller ID number, two-digit call reason code, and severity level. Inquiries that require additional research are directed to the Associate Support Center, which is staffed by senior Customer Service Associates. The inquiry is investigated, researched and resolved. The member receives a response within 48 hours.

ii) Member inquiries - voice messages

Express Scripts' Call Center is available to the State's members 24 hours per day, seven days per week, which eliminates the need for members to leave messages.

iii) Member inquiries – emergencies

If we can verify the member's eligibility with the client, we will ask the pharmacist to fill the prescription and submit the claim later in the day or on the next day, after we have had an opportunity to do an urgent update to our system.

If we cannot verify eligibility with the client, we will ask the member to pay cash for the supply. Once eligibility is updated, the member should submit a paper claim for reimbursement. In the event the member cannot pay cash for the prescription, we will ask the pharmacist to provide the member with an emergency supply (typically 2-5 days). The Call Center will make the account manager aware of the situation. The account manager will work with the client to ensure that all eligibility and pharmacy reimbursement issues are resolved.

iv) Pharmacy call center inquiries (hours a pharmacist can talk to a person)

Pharmacists can contact our Pharmacy Help Desk, which is a function of our Call Center, 24 hours per day, seven days per week using a toll-free number and talk to a knowledgeable person trained to assist with pharmacy inquiries and grievances.

Pharmacy Help Desk personnel view the same online system as retail pharmacies. This allows for real-time access to eligibility information and claims adjudication data. We maintain a call tracking system that identifies the reasons for each pharmacist call and the percentage of pharmacist calls closed at the first point of contact. A follow-up call is made to the pharmacy within 24 hours to ensure that the situation has been successfully resolved.

v) Prior authorization requests

All of our Customer Service Associates have access to your pharmacy benefit program, including up-to-the-minute information about your prior authorization policies, and can work with members so that they understand this portion of the benefit.



Prior Authorization Specialists are on-site and take calls 24 hours a day, 365 days a year. They review written and verbal override requests from physicians and pharmacists and facilitate resolution of drug coverage issues.

Our Client Support Center, which is available to the State's representatives via a toll-free number, handles non-clinical prior authorizations with written documentation from the State. The Client Support Center is staffed from 6:00 a.m. to 6:00 p.m. CST, Monday through Friday. AT&T Language Line service is available for calls from non-English-speaking client representatives.

vi) Account administration – assigned client/service managers.

Lisa Stout, your Senior Account Manager, will continue to work closely with the State to resolve day-to-day issues as they arise. Lisa will handle all standard operational needs, ad-hoc inquiries, and issue tracking, and act as your liaison to all operational areas within Express Scripts.

Luke Johnson, your Account Director, will continue to oversee the State's account and be responsible for executing your pharmacy management business plan. He will continue to provide direction to your account team by addressing key goals, objectives, and metrics.

Your account team members are available during normal business hours.

B. Confirm that the State will have a dedicated toll free number.

The State will continue to have access to our Call Center through the current, dedicated toll-free number.

C. Do you currently provide automated interactive telephone communication service? Describe the menu available to callers and indicate if a touch-tone phone is required or if a voice-response feature is available. If available for our review, please provide the phone number, and sample id/login.

Yes. Our Interactive Voice Response (IVR) application, available 24 hours per day, seven days per week, allows members to access certain information and services quickly and efficiently without the assistance of a Customer Service Associate. At any time, however, a caller can choose to speak to a Customer Service Associate directly.

The brief voice mail message provides the caller with several options including the following:

Retail/Integrated

Option 1: Order Member Materials



Option 2: Pharmacy Locator

Option 3: Mail Service Option

Press "0" to speak with a Customer Service Associate

Mail

Option 1: "If you are calling to refill a prescription and you know the prescription number, press 1 now."

Option 2: "If you are calling on the status of a recently placed refill and you know the prescription number, press 2 now."

Option 3: "If you are not calling from a touch tone phone, remain on the line for the next available Customer Service Associate."

"To repeat your options, press 7."

To review our IVR, call 1-800-505-2324 and when prompted refer to User ID 666666661.

- D. What are your telephone standards for response time, abandonment rate and time on hold? What were your actual results compared to these standards, for the most recent year available? What was the average response time for a caller to talk to a person, not an automated answering system, between the hours of 8:00 a.m. and 6:00 p.m. EST Monday through Friday, for the most recent year available? Also supply current performance against these standards.**

Our performance standards include an average speed of answer of 30 seconds for all calls, and an abandonment rate of no greater than 4 percent. We do not separately track the "daytime" average speed of answer.

- E. Do you employ computer-assisted telephone answering capability? If so, is there default to an individual operator? If so, how long does it typically take to reach a live operator?**

Yes. Our IVR application allows members to bypass the Customer Service Associate and obtain specific information and services 24 hours per day, seven days per week. If the member does not choose any of the menu items offered through the IVR, the call will default to one of our Customer Service Associates. The average speed of answer for calls handled by the IVR is two seconds or less. We do not track the time it takes a member to move from the IVR to a Customer Service Associate.



F. Highlight any distinctive features of service provided to plan participants, such as internet or phone refill services.

We offer the following convenient Internet services to our members:

Internet

Express-Scripts.com for Members, our member portal, offers instant access to pharmacy benefit information for members. This interactive service educates members regarding cost saving opportunities, such as mail service and generic use, while enabling self service 24 hours a day, 7 days a week. The member portal offers personalized drug and health information, such as side effects and drug interactions, through our relationship with Drug Digest.

The member portal improves the use of the pharmacy benefit by offering members an easy way to gain a greater understanding of the pharmacy benefit, promotes savings opportunities by demonstrating the benefits of mail service and generic use in an interactive and personalized format, and increases member satisfaction by allowing members to transact with Express Scripts when and how they choose.

Summary of Features

Feature	Description
Personalized Home Page	Highlights easy to access online features and may include customized welcome texts and alerts.
Benefit Summary	Summary of pharmacy benefit information including copays, deductible information, maximum-out-of-pocket expenses, and dependent coverage.
Formulary Lookup	Allows the member to view and print formulary drug information, including the formulary drug list and generic alternatives.
Pharmacy Locator	By entering their location, members are provided with the closest pharmacy in their network and a map with driving directions.
Drug Information	Provides instant access to personalized information from Drug Digest, providing clinically sound and objective drug information.
Health Information	Provides reliable and relevant health and wellness information regarding specific conditions and general health topics.
Online Mail Service	Allows access to Express Scripts mail service online including forms for new prescription orders, online prescription refill requests, patient profile form access, and prescription order status/tracking.
Claim History and claim forms	Displays claim history of prescriptions over the past 12 months, or print prescription claim forms.



Customer Service	Access Express Scripts' customer service team via secure email 24 hours a day, 7 days a week.
Price Check	Reviews out-of-pocket expenses associated with a specified drug, including cost comparisons with mail service and generic alternatives, if applicable.
Members Under Your Coverage	Allows members to view a list of covered family members and information regarding annual deductibles and accumulated amounts, if applicable.
Personal Reminders	Allows members to create and schedule personal reminders to receive via email or to appear on an electronic calendar.
Express Health Line and Health At Home Contract necessary	Dedicated Ask a Nurse service available for email questions and responses. Health at Home – Online home medical reference which provides up to date info on over 200 health topics.

Customizable Features

The Express-Scripts.com for Members site can be customized by:

- Adding the client's name and logo
- Specifying the phone number that appears on the "Call Us" page
- Adding links of interest to the client's members in the Other Resources section
- Providing the client's own "welcome" text to appear on the home page
- Displaying customized messages in the Alerts area, providing important information directly to the client's members

The State may log on to this site through https://client.express-scripts.com/esi_client/user_login. Your user name is DEMOID07 and your password is P83PXC.



Call Center Services

We offer the following special services through our Call Center:

Phone Refill and other IVR Services

Through our IVR application, members can quickly and efficiently order mail service refills without the assistance of a Customer Service Associate. Members can also easily locate a pharmacy near their home or office, check the status of an order, and order member materials.

G. Provide information about your customer service representatives and address the following points:

i) Education requirement

All Customer Service Associates must have a high school diploma or GED equivalent.

ii) Experience requirement

Preferred qualifications include:

- A minimum of six months of customer service experience (preferably in a call center environment)
- PC proficiency in a Windows environment
- Strong written and verbal communication skills
- Aptitude for problem solving

When hiring Call Center supervisors, we look for individuals with leadership skills, including the ability to effectively develop and assist team members to become self- leaders.



iii) Initial training program

The chart below describes our initial training program:

Customer Service Training Program	
<p>Initial Training Classroom training session over a period of three-weeks</p>	<p>Customer Service Associates must successfully complete the training program before being allowed to take calls without direct support from an experienced Customer Service Associate.</p> <p>Program objectives ensure proficiency in the following areas:</p> <ul style="list-style-type: none"> • Mail and retail pharmacy benefit program fundamentals including eligibility, claims, benefit structure, drug terminology, and adjudication processes • Use of our database and phone systems • Knowledge and awareness of the diverse demographics of our client base including cultural, income, and educational levels • Proper telephone etiquette techniques, ensuring respect for all callers • Online claims <p>Customer Service Associates are assigned a mentor (an experienced peer) who works with them to polish skills learned during the initial training when needed.</p> <p>Performance goals are built into the program, which each trainee must pass before proceeding to the next phase. After the training period, associates begin a 90-day qualification period. During this period, Customer Service Associates are again required to demonstrate continued development.</p> <p>Program also includes special services training (e.g., serving elderly members and people with disabilities). The program features includes the following:</p> <ul style="list-style-type: none"> • We use the “Service Older Customers Training Program” created by the American Association of Retired Persons (AARP). • Through role-playing, we train Customer Service Associates to understand both sides of a call. For instance, this training includes a turn as a caller with a mechanically produced hearing deficit. This experience — the frustration and embarrassment of not being sure what the Customer Service Associate is saying — helps promote empathy in the Customer Service Associate trainee playing the caller. The trainee acting as the Customer Service Associate gains valuable experience and feedback about how to be more helpful.



iv) Ongoing education

Customer Service Training Program	
Ongoing Training	<p>Training is based on analysis of calls and input from team supervisors.</p> <p>Classroom training sessions cover customer service, leadership, benefit designs, and systems.</p> <p>Customer Service Associates receive ongoing coaching from team supervisors. At least two one-on-one coaching and feedback sessions per month address customer service skills, accuracy, call management, and use of the computer system. Supervisors and Customer Service Associates work together to define goals and identify opportunities for improvement and areas of success.</p> <p>One of the key ongoing training and reference tools is the Online Reference System/Direct Reference System (ORS). This intranet tool provides Customer Service Associates with up-to-date, company-wide, and client-specific information. ORS includes <i>The Daily Bulletin</i>, which provides Customer Service Associates with daily updates on Call Center issues as well as the most current client-specific information available.</p> <p>We routinely conduct motivational programs that target skill expansion, service levels, and new client reward and recognition. We also target specific, individual learning opportunities. We recognize that a Call Center environment requires ongoing reward, reinforcement, and recognition, as well as “just in time” training in order to maintain a high level of expertise, interest, and morale.</p>

v) Turnover rates

Overall Customer Service Associate turnover for all facilities was 40% in 2001, which is well within the average range of 30-50% for call centers across the nation, according to Call Center News Service, an independent, web-based publication that reports on call centers nationwide. Part of our turnover rate is the result of upward movement within the company; Express Scripts takes great pride in the number of key Call Center employees who we are able to promote to other areas of the company.



H. Do customer service representatives have real-time on-line access to (a) eligibility? (b) claims history/status? (c) benefit descriptions? (d) status of question/complaint?

Yes. Our Customer Service Associates have access to online, real-time information through our fully integrated system. Our Call Center sites are integrated with our retail pharmacies and mail service facilities through a shared data platform so that information regarding eligibility, claims history and status, benefit descriptions, status of questions and complaints, and status of orders can be tracked from any point in the system.

I. Based on the potential number of eligible lives, what is your anticipated customer service unit staffing plan for both the initial enrollment, and for ongoing customer support?

Express Scripts currently employs 1,300 Customer Service Associates which take member and pharmacy calls. The Customer Service Associates take an average of nine calls per hour. The breakout of pharmacy to member calls is outlined below:

- 65% of calls are made by a member
- 25% of calls are made by a pharmacy
- 10% of calls are made by clients

Express Scripts is contracted to handle calls for approximately 31 million lives directly, with a CSA ratio of 1:23,839. However, Express Scripts has the capability of providing call service for over 48 million lives.

J. Describe the process established to handle written inquiries from participants and plan sponsors including tracking procedures and follow-up steps.

Upon receipt of a written request from a member, the inquiry letter is date stamped and the issue is immediately researched. Upon research completion, a call is placed to the member in order to resolve the issue. If the member has requested a written response, the Customer Relations team will draft a letter to send to the member.

Luke Johnson, your account director, and Lisa Stout, your Account Manager, will personally address written inquiries from State staff.

K. Describe special customer services developed for the following participants:

i) Seniors

We offer customized service to seniors in our Call Center and specialized print materials to ensure efficient communication.



Senior-friendly Service in the Call Center

Because many seniors call us for help, we focus considerable attention on their needs. In fact, we begin this focus during the hiring process. New Customer Service Associates are specifically trained in the techniques and sensitivity that produce effective phone communications with elderly members. As part of our training, we use the “Serving Older Customers Training Program” created by the American Association of Retired Persons (AARP), which features a video and workbook that Customer Service Associates view and complete. Training also includes role playing that gives Customer Service Associates the opportunity to understand an elderly person’s calling experience.

Specialized Materials

Express Scripts offers customized communication pieces in large print for our senior members. Customization is available for both member ID cards and supplemental materials. Member Materials professionals work with our clients to tailor materials as needed. These materials ensure that members completely understand their pharmacy benefit plan and the special directions that come with their medications through our mail service.

ii) Non-English speaking

Our Call Center is staffed with Spanish-speaking Customer Service Associates to assist those members who are most comfortable discussing benefit questions in this language. Any Customer Service Associate can transfer a Spanish-speaking caller to this extension.

We also subscribe to the AT&T Language Line, which offers interpretive services for more than 140 languages. The Customer Service Associate assisting the non-English-speaking member can set up a three-way conference call with the Language Line to address the caller’s inquiry.

iii) Hearing impaired

We utilize the Telecommunication Device for the Deaf (TDD), which is available via a toll-free number, to ensure that hearing-impaired callers can communicate with our Customer Service Associates and counseling pharmacists.

iv) Visually impaired

Our Customer Service Associates are specially trained to use effective explanations to help members who are unable to read member materials and other communications understand their pharmacy benefit program.



- L. Describe your quality assurance or audit program for customer service and the grievance system that will be in place for participants. Who is responsible for the quality of the customer service unit? What monitoring results would be made available to the State?**

We are currently providing the State with a quarterly performance guarantee report, which reflects our performance in key service areas.

We also utilize an annual satisfaction survey, which can be tailored to a client's unique population, to measure member satisfaction with our Call Center, network pharmacies, and mail service pharmacies. We have described these surveys in detail as our response to **question N**, below. The results of these surveys allow us to make improvements to better serve our members.

Process for Addressing and Tracking Member Complaints

Express Scripts is committed to listening to our customers. Formal complaints will be resolved by Express Scripts on behalf of clients in accordance with a defined and consistent process. When a complaint is received via phone that cannot be resolved by the Customer Service Associate, it is transferred to an associate support center (ASC) team member. The ASC team member assesses which departments need to be involved for call resolution and coordinates a way to develop a resolution. Complaints are resolved within seven business days and responses are provided by phone or in writing. Complaint resolution details are tracked, including member, complaint reason, resolution, and turnaround time. The customer relations team continually monitors complaint trends and patterns and then works cross-functionally to develop and implement process enhancements.

We track all inquiries and complaints received in a single, consolidated data warehouse. The data warehouse allows us to efficiently access, sort, and report complaint data, regardless of the method by which the complaint was received. This tracking process meets the requirements of our clients for internal and NCQA reporting and quality improvement initiatives.

We are able to track and report on the following data:

- Number of complaints received in a given period
- Number of complaints resolved in a given period
- Turnaround time for resolution
- Number and percentage of complaints resolved within a specified timeframe
- Number and dates of complaints forwarded to clients
- Members that have made repeated complaints
- Number and percentage of issues by party at fault
- Number and percentage of issues by primary complaint reason
- Group-specific report functionality
- Inventory Management reports: includes number of open issues by specific date
- Number of escalated calls
- Open issues reports



We can also break out any of the above-listed measurements by state, geographic region, and lines of business.

Ensuring Quality Service

To oversee quality in our service areas, we employ a dedicated quality management staff, which is located within our call center/mail service operation facilities. This group of staff members is comprised of individuals experienced in Six Sigma process management, as well as operations and quality management experience in related healthcare companies.

- M. Describe services available through a website, including on-line resource directories, coverage information, refill capabilities, etc. If currently active and available for our review, provide the web address. Describe any expected enhancements.**

Our member portal, Express-Scripts.com for Members, offers instant access to pharmacy benefit and drug information. The site offers many features including pharmacy directories, access to mail service forms for new prescription orders/online prescription refill requests/patient profiles, order status/tracking, claims history, formularies, drug cost comparisons, and many other options.

The member portal educates members about their pharmacy benefit, promotes savings opportunities, and increases member satisfaction by empowering the member to make independent, educated choices.

The State may log on to this site through https://client.express-scripts.com/esi_client/user_login. Your user name is DEMO1D07 and your password is P83PXC.

- N. Describe all methods used to determine participant satisfaction. Indicate the frequency of surveys. Indicate if account-specific satisfaction surveys are available. Provide results of the most recent book-of-business survey.**

Express Scripts conducts client-specific member surveys according to the client's contract, or at the request of the client and the client's account management team. The survey results are used as an internal tool to target areas of opportunity and to enhance service. The client and the account management team review the survey results in detail; Express Scripts does not, however, release the results publicly.

The survey population included randomly selected members who had recently used Express Scripts' mail service pharmacy, network retail pharmacies and/or Call Center services. The Research Edge, an independent research firm in St. Paul, Minnesota, conducted 2,569 telephone surveys during November and December 2001. Specific results of the survey are shown in the following chart:



National Employer Division Participant Satisfaction Results	
Mail	96.9%
Retail	95.9%
Call Center	91.8%
Overall	96.6%

Client-Specific Measurements

Member Surveys

Express Scripts conducted a State of Michigan-specific member survey this year. This survey summarized below, was conducted to measure the level of satisfaction experienced by State of Michigan members who use Express Scripts' retail pharmacy network and call center services. We are pleased to report that the vast majority of members are giving Express Scripts high marks for service.

The Research Edge, an independent research firm in St. Paul, Minnesota, contacted 385 members for the survey between June 19, 2002 and July 11, 2002.

In this summary, we present members' evaluation of overall service from the retail pharmacy network and the call center, shown by the number of responses and by percentages for each satisfaction level rating. Responses are similarly shown reflecting members' cumulative impressions of service as a whole. The margin of error is +/- 5% for all questions except those relating to the call center. Call center response levels have a +/- 15% margin of error, due to fewer respondents.

Retail Pharmacy Network: Overall Satisfaction Ratings

Of the 385 members interviewed, 366 had filled a prescription at a local network pharmacy within the past six months.

Satisfaction Level	Number of Responses	Percentage of Responses
Very Satisfied	193	52.7%
Satisfied	148	40.5%
Dissatisfied	18	4.9%
Very Dissatisfied	7	1.9%
Total	366	100%



The combined percentage of members who said they were either *satisfied* or *very satisfied* with their most recent experience using the retail pharmacy network was 93.2 percent. In addition, 96.7% of members were either *satisfied* or *very satisfied* with the availability of participating local pharmacies in their area.

Call Center: Overall Satisfaction Ratings

It should be noted that the total number of responses in this category does not reflect the entire survey population of 385.

Satisfaction Level	Number of Responses	Percentage of Responses
Very Satisfied	11	52.4%
Satisfied	7	33.3%
Dissatisfied	3	14.3%
Very Dissatisfied	0	0.0%
Total	21	100%

Overall, 85.7% of members who used the call center were either *satisfied* or *very satisfied* with the service they received. The primary reason that members contacted the call center was for questions and information.

All Services Combined: Satisfaction Ratings

Members were asked: "Taking into consideration your entire experience with Express Scripts, how satisfied are you with Express Scripts service?" The responses below reflect members' cumulative service experience.

Satisfaction Level	Number of Responses	Percentage of Responses
Very Satisfied	154	40.0%
Satisfied	212	55.1%
Dissatisfied	15	3.9%
Very Dissatisfied	4	1.0%
Total	385	100%

Out of 385 respondents, 366 or 95.1 percent, were *satisfied* or *very satisfied* with their experience as a whole.



Conclusion

In summary, the majority of members were satisfied with the retail pharmacy and call center services. Customer satisfaction surveys provide Express Scripts with valuable information that helps to identify opportunities for continually improving service and, as a result, the service experience of members. Throughout 2001, Express Scripts successfully implemented a number of service-improvement initiatives, and further initiatives are ongoing in 2002. These include both technological enhancements and training. This survey, as others conducted for both specific clients and our entire book of business, will be used for guidance in developing future initiatives.

A. Recommended Facility – Indicate the dispensing facility recommended for this account and briefly explain the reasons for this recommendation (if multiple facilities available) or the advantages of this location (if a single facility).

Express Scripts owns and operates eight mail service facilities located in St. Louis, Missouri (2); Tempe, Arizona; Albuquerque, New Mexico; Philadelphia, Pennsylvania; Troy, New York; East Hanover, New Jersey; and Harrisburg, Pennsylvania.

Express Scripts is recommending our Philadelphia facility for the State. This facility offers the following advantages:

- Proven history of providing excellent service and health care
- A 99.99% accuracy rate on specific drug selection
- In-house prescription turnaround time averaging 1.3 days
- Available capacity to match the State's current and future mail volume
- Technology quality and efficiency
- Healthcare focus – we are a pharmacy first
- Capacity to grow/expand
- Geographic proximity to the State

Our mail facilities offer state-of-the art service and are fully integrated with our Retail Pharmacy Network through our online, real-time, claims adjudication system.

B. Problem Capacity Level - Indicate the level of capacity which could cause delays/problems at the recommended facility and briefly explain the actions which would be taken to avoid such delays/problems.

Express Scripts carefully forecasts current capacity against future demand, which ensures that potential capacity issues are avoided. The Philadelphia mail service facility is currently operating at 41% of capacity with the average monthly number of prescriptions at approximately 690,000.



C. Errors by Facility - Disclose the number and percentage of incorrectly filled, dispensed, labeled, shipped, etc. drugs (for whatever reason) generated out of the recommended facility over the following periods: Please list all errors, not just Type I errors.

Recommended Facility	1999		2000		2001	
	#	%	#	%	#	%
Philadelphia Mail Service Facility		Less than .01%		Less than .01%		Less than .01%

The Express Scripts mail service dispensing accuracy rate is calculated in the following manner:

As dispensing errors are reported to our pharmacists in charge at each dispensing site, they are logged into a database that is maintained by our Quality Assurance department. These errors are categorized and tracked on a daily basis. Dispensing errors include incorrect patient, incorrect drug and incorrect directions for use. Our dispensing accuracy is measured by dividing all dispensing errors by the total number of prescriptions dispensed during that period of time and then multiplied by 100.

D. Incorrectly Dispensing Drug Circumstances – Briefly explain the general reasons or circumstances which resulted in the incorrectly dispensed drugs disclosed above and what was done to correct the errors.

Due to the intensive involvement of pharmacists throughout our dispensing process, errors are almost always corrected or prevented before our final quality control check. Most errors occur in the following categories: incorrect address, incorrect copayment credited, warning label not attached to vial, additional instructions omitted, and missing address labels or invoices.

Initial inspection relates to a pharmacist verifying the initial data entry information in the mail service system. Subsequent review relates to a pharmacist inspection of the dispensed prescriptions and a packaging technician verifying the number of items and address information. These are two different inspection points in the process.



Upon inspection of the data entry information entered in our mail service system, pharmacists reject orders due to:

- Data entry error
- Incorrect medication
- Incorrect address
- Incorrect quantity

These orders are reprocessed. At a later stage in the dispensing process, pharmacists inspect the dispensed prescription. At this stage, packaging technicians also verify the quantity of products to be shipped and the shipping address. Prescription percentages are reprocessed at this stage for the following reasons:

- Incomplete address
- Incorrect number of items or incorrect item
- Inadequate labeling

Equipment used to count medications is cleaned, calibrated, and tested several times daily to ensure accurate counts. If a miscount is detected, a recount is automatically performed.

On a rare occasion, a member will notify us that an incorrect medication has been received.

Errors in prescriptions dispensed to members accounted for less than 0.01% of total volume in 2001. These errors included incorrect information regarding:

- Directions
- Prescribed Amount
- Drug Information
- Physician's Name

Express Scripts believes that many reported fill errors result from a combination of misperception and miscommunication between the member and the physician. For example, the member's physician has authorized a generic or therapeutic switch and the member has yet to read the accompanying letter. Occasionally the medication may appear different due to a manufacturer change.

If the prescription was filled incorrectly, Express Scripts will replace it at no charge. In the event that a dispensing error does occur, we will contact the member to assess the situation. Following this consultation, the appropriate medication will be sent via overnight mail to the member. Express Scripts will mail a prepaid envelope to the member to return the medication.

Additionally, our Process Improvement Team will meet to discuss the circumstances. Our primary goal in such meetings is to develop a method to prevent recurrence of the error. Following implementation of any process or procedural changes, errors are tracked and trended to determine the effect of the quality improvement change on our accuracy.



E. Mail Order Transition - Explain the transition process you recommend for SOM, including:

Express Scripts is well experienced in mail order transition and has worked on numerous occasions with Medco Health Systems to effect successful transfer of mail order service. We are familiar with Medco's mail operations and can anticipate the challenges we will need to address in making the transition. Many of these items will be addressed during the implementation process.

(a) Pre-installation testing of customer service, hotline, etc.

The State of Michigan currently receives customer service support from Express Scripts for its retail pharmacy program. Adding mail service customer service is simply a matter of loading the new benefit structure into our system.

Members would call the same toll-free number they now call for retail inquiries. If we have eligibility and benefit structure loaded into the system before the mail service plan is activated, we can answer the following types of calls:

- Verify a member's eligibility as of the program effective date
- Verify a member's coverage and copay for specific drug(s) as of the program effective date
- Find participating pharmacies nearest to the member
- Determine whether a particular drug(s) is on the member's formulary
- The call center can continue to answer questions regarding retail service

(b) Hotline, pre- and post-effective date

State of Michigan members would call the same 800 number for mail service as they now call for retail customer service.

(c) Mail order Rx transition assistance for member

Members will receive a communication packet to explain the process of transitioning their prescriptions to Express Scripts. Members also may contact our Call Center for a price quote on any prescription drug. We will work with your current mail vendor to provide members with pre-implementation notification.

Express-Scripts.com for Members, our member portal, offers instant access to pharmacy benefit information including member copay information.

(d) Different generic manufacturer used than prior mail order vendor, and transition from that manufacturer

Medco Health Systems dispenses selected brand name products for generic through the mail pharmacy. The result of their "house-generic" policy is the receipt of a brand name medication for a generic copayment. This issue must be addressed during implementation to be sure that the product to be dispensed is identified and agreed to and that the proper copayment (i.e., brand rather than generic) is effectively communicated to the beneficiaries. We have successfully dealt with this issue on a number of transitions in the past.



Generic pharmaceuticals are purchased directly from manufacturers under contract. These contracts are negotiated for a minimum of two years and include a price protection clause for all items. Express Scripts does not change manufacturers of generic drugs unless absolutely necessary. However, if we dispense a certain generic manufacturer's product and then, for some reason, dispense a different manufacturer's product on the next refill, we notify the member in writing that the medication's appearance may have changed but it is still the same medication. A change in manufacturer occurs very infrequently.

Express Scripts purchases generic medications from the following suppliers:

Top Six Generic Suppliers

Generic Supplier	Current Share of Total Generic Volume Based on Number of Prescriptions
Geneva	17%
Roche	10%
Jones	10%
Teva	9%
Watson	8%
Mylan	6%

Express Scripts has no way of knowing whether the transition from the previous PBM will result in a switch to a different generic manufacturer. However, if a member is concerned about his or her generic medication, the member is always encouraged to call the call center to receive an explanation.



(e) Transfer of refill information from the previous vendor, so that members will not have to re-submit or re-obtain current scripts.

Express Scripts accepts electronically transferred prescriptions. We accept faxed prescriptions from physicians to expedite mail service processing before and after the effective date. Members can contact their physician and ask him or her to call or fax current prescription to Express Scripts' toll-free mail service number. If requested by the member, an Express Scripts mail service registered pharmacist will contact the physician to transfer a prescription to our facility.

(f) Other unique servicing ideas.

Express Scripts has extensive experience working with Medco Health Systems in mail service transitions, and we understand that the most important aspect of transition is a smooth implementation for members.

Express Scripts accepts electronically transferred prescriptions. We are experts at mail service transitions and take a strategic, proactive approach. The following helps ensure a smooth mail service transition from your current vendor to Express Scripts:

- We provide members with educational materials, a web site, and 24-hour customer service via a toll-free number, seven days a week.
- Express Scripts will establish a process with State of Michigan's existing vendor to express ship new and refill prescription orders to our mail facilities (typically occurs after the effective date). Express Scripts will provide your current mail service vendor with a Fax cover sheet to be faxed daily to Express Scripts to indicate the number of pieces of mail being forwarded and the tracking number of the package.

Express Scripts will provide reminder notices to the prior vendor for inclusion in refill orders.



6. Clinical Management

- A. **Programs:** List all physician and patient education programs that you would recommend be implemented, and list those programs that are provided as a part of the administrative fee together and those programs that you would recommend but have an added charge after the previous programs. These may include ongoing physician educational on proper drug and dosage prescribing protocols, choice of medications for certain diagnoses, proper dosages, selection of generics when available and utilization of preferred single source product as needed. Do not list any utilization review programs.

In response to your question, we are providing a table indicating the programs that provide physician and patient education, a brief description, and whether or not there is a fee. Following the table we have provided State-specific recommendations.

Physician and Patient Education Programs			
Program	Description	Audience	Fee
Drug Choice Management	Interventions provide information on generic or preferred brand alternatives. Communications promote use of chemically or therapeutically equivalent drugs from the preferred list.	Physician and Patient	Included
Dose Consolidation	Intervention messages guide members into using doses of medications once daily when medically appropriate. The program is designed to improve member compliance and convenience, as members would take a medication once daily instead of multiple times.	Physician	Included
Preferred Drug Transition	Interventions promote movement to cost-effective preferred brand or generic alternatives.	Physician and Patient	Included
Physician Direct Mailing	Intervention materials provide information on preferred brand alternatives. Letters include a formulary and/or brief clinical message related to the targeted product. The program includes quarterly newsletters with information on specific disease states and drug classes.	Physician	Included



Program	Description	Audience	Fee
Academic Detailing	Express Scripts pharmacists provide scheduled physician consultations to educate physicians on preferred brand and generic alternatives. To identify physicians for intervention, we use aggregate book-of-business data. Interventions are based on individual prescribing patterns and savings opportunities.	Physician	Included
Physician Consultation	Interventions are designed to meet client-specific formulary compliance and cost management initiatives. Top high-cost physicians who write prescriptions for your members will receive medication analysis documents that compare generic and formulary prescribing patterns to patterns of peers. In addition, physicians receive scheduled phone consultations with Express Scripts clinicians.	Physician	See Cost Proposal
Patient Consultation	Selected members have the opportunity to discuss medication use during one-on-one discussions with clinical pharmacists. Members who use a high number of prescriptions and are at greater risk to experience negative drug interactions receive intervention. Patient Consultation promotes use of preferred brand and generic alternatives, and helps reduce clinical risk.	Patient	See Cost Proposal
Step Therapy	Requires use of first-line alternatives before more expensive second-line drugs are covered by the pharmacy benefit.	Physician	See Cost Proposal



Program	Description	Audience	Fee
Care Management Level 1	Members can access easy-to-understand information on 40 health conditions and disease states through the Member portal at <i>Express-Scripts.com</i> . A link can be provided at your Web site to the Care Management site. For some disease states, members can register for e-bulletins that provide updates and personal reminders. Information provided to members is designed to increase compliance with recognized treatment guidelines. Online risk assessments are included.	Patient	Included
Care Management Level 2	Care Management programs encourage use of appropriate drug therapies for high-risk patients. Patients receive educational materials that discuss treatment options and self-monitoring of their particular disease or health condition. Materials also promote adherence to prescribed drug therapy. Modeled upon national treatment standards, mailed interventions serve to educate physicians on current consensus guidelines and patient-specific therapy issues. Disease states addressed include: <i>Allergy, Asthma, Cardiovascular Disease, Congestive Heart Failure (CHF), Depression, Diabetes, GI Disorders, Hypertension, and Migraine.</i>	Physician and Patient	See Cost Proposal



Program	Description	Audience	Fee
Care Management Level 3	Care Management Plus is a series of disease-specific sessions that offer health assessment, education, and counseling via telephone and mailed interventions designed to improve or maintain appropriate patient care. By empowering patients to better manage their chronic condition, we anticipate improved quality of life, decreased adverse clinical symptoms, and cost savings related to appropriate medical resource utilization. Care Management Plus programs are staffed by registered nurses and supported by pharmacists who assess the targeted member's health risk and provide information related to health, wellness, and medical care to the patient to discuss with their physician. <i>Modules include Asthma, Cardiovascular Disease, and Diabetes.</i>	Physician and Patient	See Cost Proposal
Express Health Line	Express Health Line is an informed-decision counseling service staffed by experienced nurses and pharmacists. Care counselors provide 24-hour health care counseling support to member callers. The program provides non-directional health care options via inbound phone calls from patients through utilization of state-of-the art, online medical protocols.	Physician and Patient	See Cost Proposal

Steve Pepin has worked consultatively with you to help manage your pharmacy benefit over the years. For example:

- Realizing that you have a benefit design that does not allow implementation of aggressive clinical strategies and that you are bound by bargaining unit agreements, we made recommendations for your consideration within these guidelines.
- We have used our Emerging Therapeutic Management strategies to keep you abreast of key developments on the pharmaceutical landscape that might negatively impact your pharmacy benefit.
- We have fully reviewed the Prior Authorized drugs with you and will continue to update these as necessary upon the State's review of inappropriate utilization.



Your Clinical Program Manager has done various modeling and analysis to identify strategies for the State to manage rising pharmacy benefit costs over the past year. Based on your specific data and our experience working with you over the years, our comprehensive clinical management plan for the State over the next three years includes:

Year One

We would recommend implementation of the programs in the chart above which are included in the administration fee, including Drug Choice Management at mail, Drug Choice Management at retail after further review, Dose Consolidation, Preferred Drug Transition, Physician Direct Mailings, Academic Detailing, and Care Management Level 1. These programs have minimal member impact in terms of disruption and will result in an increase of proper drug and dosage prescribing, selection of generics, when available, and the right medication provided to the right person at the right time.

Year Two

We would recommend implementing Drug Quantity Management (described in response to C in this section) as well as our Care Management Level 2 GI, Depression, and Asthma Programs. (These programs are described in detail in response to Question 8 – Disease Management Programs.) These three disease states represent top therapeutic categories for your population. Better management of these disease states will equate to cost savings for the State and better care for your members. We would also recommend the State consider our client-specific Physician Consultation Program.

Year Three

We recommend implementing our Care Management Level 2 programs for Cardiovascular and Allergy. In addition, we recommend that the State consider implementation of our Level 3 Asthma program which will provide more advanced interventions for members with Asthma to help them learn how to better manage their health.

As always, your Clinical Program Manager will continue to work consultatively with you, analyzing your data and plan performance, and helping you make decisions that are right for the State and for your members.

B. Effectiveness – Describe the effect on the net cost per Rx and formulary rebates from prior year with respect to the “open formulary” designs.

Within our employer book of business, 2-tier open formulary net cost per claim trend from 2001 over 2000 was 13.6%. In contrast, our 3-tier incented formulary book incurred a net cost per claim trend average of 9.7%.



- C. **Preferred Drugs – Provide the complete list of preferred drugs for which active intervention have been established. Report the therapeutic category, the targeted drug, the preferred drug, and meaningful information that demonstrates the cost effectiveness and clinical appropriateness of each preferred drug product.**

Active intervention to switch to a preferred product is provided by our Drug Choice Management Program.

Clinical evaluation to support the decision to make a therapeutic substitution follows our formulary drug review process, with exceptions specific to therapeutic substitution noted, which is described below:

Formulary Development

Clinicians apply a three-stage process when considering products for Express Scripts formularies.

- Primary research
- Comparative evaluation
- Financial evaluation

Primary Research—Express Scripts clinicians in our Drug Evaluation Unit evaluate a drug when it has been approved by the FDA. Pharmacists conduct a search of medical literature through specialized medical databases to identify published clinical trials in peer-reviewed journals. Express Scripts contacts the manufacturer for an approved package insert and data from pivotal trials submitted to the FDA. Primary investigators, physician specialists, and physicians may be contacted to obtain additional information. In addition, pharmacology, pharmacokinetics, clinical efficacy, comparative efficacy, adverse drug reactions, drug interactions, dosing, and pharmacoeconomic considerations are evaluated. Indirect costs such as customer acceptance (e.g., how many times a day the drug must be taken), nonpharmacologic alternatives, and required concomitant therapies are also considered.

Comparative Evaluation—The information acquired in the Primary Research stage is assimilated into a formulary evaluation document. The clinical reviewer presents the formulary evaluation document to the Express Scripts Therapeutic Assessment Committee. This committee includes clinical pharmacists with advanced training in general or specialized clinical practice, research, and study design. The committee critically evaluates the new drug to identify issues relating to its use; the committee also identifies the drug's niche among therapeutic alternatives available to prescribers. In addition, the Therapeutic Assessment Committee recommends management techniques to promote appropriate drug utilization, and develops criteria and guidelines for the drug's use, if necessary. Only clinical information is considered during the first two stages—the Therapeutic Assessment Committee does not consider drug price in its deliberations.



Financial Evaluation—The Therapeutic Assessment Committee forwards its recommendations to the Value Assessment Committee. The Value Assessment Committee adds cost and contracting considerations to the recommendations of the Therapeutic Assessment Committee. The Value Assessment Committee combines clinical recommendations with cost considerations and creates a formulary strategy for new drugs. The committee evaluates combined clinical and financial considerations to make an official formulary recommendation.

Finally, recommendations from the Value Assessment Committee are presented to the Express Scripts National P&T Committee. This independent committee makes the final decision whether or not to include new drugs on our formularies.

In the case of our **Drug Choice Management Program**, once TAC recommendations are made, an internal clinical committee, The Product Initiation Committee (PIC) reviews the therapeutic switch recommendations from a business perspective considering AWP and switching to a lower cost product.

If the therapeutic switch is approved by both the TAC and the PIC, the pair is included on the Drug Choice Management List, which is updated quarterly.

Drug Choice Management Program

Our Drug Choice Management program, which works to promote the use of chemically or therapeutically equivalent drugs from a preferred list, is voluntary and includes all products on our list. Selected pairs can be optional and our clinical program management team will work with you to determine what is appropriate for your population.

In the mail service environment, when a prescription for a non-preferred drug is received, a mail service pharmacist or pharmacy technician contacts the physician for approval to dispense the preferred drug. If the physician approves the change, he or she provides a new prescription to the pharmacist. The member receives the preferred drug along with a letter explaining that his or her physician approved the change.

To support the physician's decision, a one-time edit is placed in the system to prevent the non-preferred drug from being dispensed the next time. The edit provides a trial period for the member and increases the likelihood that the member will comply with the physician-approved change. The preferred drug is dispensed when the member requests a refill. If the physician can't be reached, the member receives the non-preferred drug rather than being required to wait for the prescription. Express Scripts contacts the physician the next time the prescription is filled. If the physician does not approve the change, a notation is entered into the member's profile, and the member receives the non-preferred drug as prescribed.

The following table shows the average success rate for our Drug Choice Management program:



Sample Drug Choice Management Results

Measurement	Results
Mail Service Module	
Letter interventions distributed to physicians and members (Level 2 intervention)	Average success rate: 26%
Retail Pharmacy Module	
Letter interventions distributed to physicians and members (Level 2 intervention)	Average success rate: 15%

Results for the Drug Choice Management program will be included in the Clinical Outcomes Summary and Results report that the State can receive quarterly. The report includes the following components:

- An activity report that breaks out physician and member mailing activity.
- A summary report that highlights program intervention success rates and identifies cost or savings impact based on total dollars and per member per month.

D. Intervention Process – Describe the process for formulary interventions. Differentiate between retail and mail order.

Our physician and member intervention programs are described below.

Physician Formulary Compliance Programs

Express Scripts offers the following physician intervention programs designed to increase formulary compliance.

Drug Choice Management

Interventions provide information on generic or preferred brand alternatives. Communications promote the use of chemically or therapeutically equivalent drugs from the preferred list. This program is offered in both the retail setting (retrospective) and in our mail service pharmacies (concurrent).



We have described this program as applied to the mail service in the previous question. In the retail environment, when a prescription for a non-preferred drug is presented at a pharmacy, the dispensing pharmacist is notified via an online message that the drug is non-preferred. At that time, the member receives the non-preferred drug. Express Scripts analyzes retail claims data to identify prescriptions for non-preferred drugs. We contact members via letters that describe the potential savings incurred when preferred alternatives are used. Letters suggest that members talk to their physicians about preferred alternatives. Members receive letters every 6 months if they continue to receive the non-preferred products.

Pharmaceutical manufacturers in some instances provide financial support for the Drug Choice Management program, but do not influence clinical formulary decisions. A portion of the manufacturers involved in this program are billed fees for each call or letter initiated representing their products. No patient-specific information is provided to any manufacturer.

Expected average pharmacy cost savings for our Drug Choice Management program (including mail and retail) is \$0.03 per member per month. Average success rate in the mail service is 26% and average success rate at retail is 15%.

Express Scripts Academic Detailing Program

Through the Express Scripts Academic Detailing program, Express Scripts clinicians provide direct physician consultation to the top 5000 prescribers for our book of business. This consultation helps guide the top high-cost prescribers into increased prescribing of generic and preferred brand products when appropriate.

Consultations are designed to:

- Promote medically appropriate, cost-effective prescribing
- Increase physician satisfaction
- Increase client savings through increased use of generic and preferred brand alternatives

Physicians identified for intervention receive a program introduction letter signed by the Express Scripts medical director. Express Scripts then contacts prescribers to schedule a phone consultation appointment with an Express Scripts clinical pharmacist. Consultation materials include:

- Prescriber Medication Analysis documents that compare generic and preferred brand prescribing patterns to patterns of their peers. Cost-effective prescribing opportunities are presented. The medication analysis documents are faxed to physicians' offices 48 hours prior to the consultation session.
- Additional materials are provided as appropriate. Materials can include summaries of recognized treatment guidelines for a particular disease state or client-specific formulary documents.
- A satisfaction survey that allows physicians to provide feedback on the program and consultation.



Physician Consultation Program

This program uses pharmacy claims analysis to identify the highest-cost prescribers of a client's members. Physicians are selected for intervention based on potential savings that would result from prescribing pattern changes. Therapeutic classes to be addressed through intervention are selected because they offer the greatest savings potential. High-cost prescribers of drugs for chemotherapy, HIV, and anti-hemophiliac therapies are excluded.

Physicians identified for intervention receive a program introduction letter, which is signed by the Express Scripts medical director or the client's medical director or representative. The letter encourages participation in the program. A scheduler then contacts the prescriber's office to establish an appointment for the phone consultation session with an Express Scripts clinical pharmacist. Print materials and the phone consultation review share the following information:

- A prescriber medication analysis illustrates the physician's prescribing patterns in the targeted therapeutic classes, provides a prescribing comparison to peers in the same specialty, provides cost information, and identifies recommendations based on current prescribing patterns and the client's benefit design.
- Physician-specific educational materials to reinforce verbal messages.
- A satisfaction survey for the physician to provide feedback on the value of the consultation.
- Patient medical chart reminders and patient educational materials are offered to the physician during the visit or included in the follow-up letter, if requested. A follow-up letter is sent to the physician after each visit to thank them and provide any additional information requested.

Physician Consultation offers the following benefits:

- An increase in clinically appropriate and cost-effective prescribing.
- Physician Satisfaction—During 2001, 89% of physicians who provided feedback found the consultations with pharmacists to be useful and 86% indicated they were interested in participating in future consultations.
- Savings—Prescribing pattern changes result in significantly decreased use of high-cost, targeted agents. Results based on pharmacy claims analysis showed an average net saving of \$1,000 over a 12-month period per physician receiving intervention.



Preferred Drug Transition Program

The Preferred Drug Transition program effectively supports formulary changes made at any point during the year. Quarterly mailings to members and prescribers promote movement to cost-effective preferred brand or generic alternatives. Members are encouraged to discuss preferred alternatives with their physicians. Interventions are designed to lessen disruption to members affected by upcoming changes and to maintain satisfaction with the pharmacy benefit. This program is applicable to both mail and retail. Expected average pharmacy cost savings for HMGs is \$0.02 per member per month.

Member Formulary Compliance Programs

Express Scripts offers the following member intervention programs to increase formulary compliance.

Patient Consultation

Through this program, selected members have the opportunity to discuss medication use during one-on-one discussions with clinical pharmacists. Members who use a high number of prescriptions and are at greater risk to experience negative drug interactions receive intervention. Patient Consultation promotes use of preferred brand and generic alternatives, and helps reduce clinical risk. This program is applicable to both mail and retail.

Prior to program implementation, Patient Consultation program staff meet with the plan sponsor's representatives to review the sponsor's pharmacy benefit design and membership demographics. Using this information, the Patient Consultation program is tailored to meet the plan sponsor's objectives and help members use their benefits more effectively. A clinical pharmacist uses member-specific benefit design information during each consultation. For example, a member with a \$500 annual plan stop loss will learn how that benefit component works and receive recommendations on using generic alternatives to help maximize the benefit. The clinical pharmacist will identify which medications being taken are available in generic form.

Members whose pharmacy claims histories show five or more unique NDC numbers for chronic or maintenance medications receive a letter inviting them to participate in the Patient Consultation program. Members complete a questionnaire on their health and medications, and return it to Express Scripts in a pre-addressed, pre-stamped envelope.

An Express Scripts clinical pharmacist screens all returned questionnaires to identify problems related to prescription and non-prescription drug utilization. Each participating member is grouped into one of three categories:

No potential problem identified—Members receive letters informing them that the clinical pharmacist does not have recommendations based on the information submitted.

Prospective cost reduction identified without potential clinical problems—Members receive letters informing them that the clinical pharmacist does not have any clinical recommendations. However, opportunities exist for them to reduce their medication costs.



Potential clinical problem identified—Members are contacted and scheduled for a telephone consultation with an Express Scripts clinical pharmacist. Members are encouraged to discuss recommendations and any additional questions with their physicians.

Phone Consultations

An Express Scripts clinical pharmacist counsels each participating member, noting interventions and documents resolution. The consultation includes collecting additional prescription and utilization information, evaluating the member's understanding of their medications (what each is used to treat, when to take each medication, etc.), and addressing clinical concerns identified by the pharmacist. During the consultation, the member receives information on medications, including how and when to take them and contraindications.

Results

The Patient Consultation program has successfully changed medication utilization behaviors while garnering acceptance and high satisfaction ratings from program members. Initial quantitative results will be available during 1st quarter of 2003. Clients will receive quarterly program activity reporting and results evaluations. Measured and reported outcomes will include:

- Cost savings
- Clinical recommendations
- Health conditions
- Member satisfaction survey results

Preferred Drug Transition Program

This program utilizes mailings to instruct members regarding upcoming changes to their formulary. Members are encouraged to discuss preferred alternatives with their physicians. This program is applicable to both mail and retail.

The program is effective in supporting formulary changes made at any point during the year. Interventions guide members into using preferred brand drugs consistent with their formularies. Prescribers receive print materials identifying brand or generic alternatives for brand products that will no longer be preferred. Members who will be affected by an upcoming change receive informational materials that they are encouraged to discuss with their physician. Interventions are designed to lessen disruption to members affected by upcoming changes and to maintain satisfaction with the pharmacy benefit.



- E. Drug Recall – Describe any mechanisms currently in place to obtain refunds for SOM on FDA Class 1, recalled medications for SOM employees. Emphasis should be placed on those drugs that are removed from the market and not those that only have a specific lot(s) removed. Specifically address how your organization addresses this ongoing issue when contracting with the pharmaceutical manufacturers for rebates or other programs.**

Our Emerging Therapeutic Issues Process addresses medication recalls. The recall process is determined by the manufacturer and unique to each situation. While Express Scripts cannot act on behalf of the State to obtain refunds, we will act as a conduit between the State and the manufacturer providing necessary claims information. To meet this need, Express Scripts has developed a process whereby account management, sales, and clinical staff may request data specific to their clients through a front-end portal. A team of analysts then works to extract the data from our data warehouse. The Express Scripts data warehouse maintains a rolling 27 months of history. All history prior to the earliest date in our warehouse is maintained at an off-site location with services provided by EDS. Once extracted, the data is scrubbed and provided electronically to our clients. Because of our data warehousing and mining techniques we can be very flexible in providing data.

- F. PA Medications – List all medications that are available for prior authorization. Report the pricing for the performance of the PAs and list those medications that would be recommended for Prior Authorization. List the percentage of prior authorization requests that are approved for each PA medication.**

Express Scripts recommends that the following drugs be included on our clients' prior authorization lists. These low-volume, high-cost drugs are selected by Express Scripts and listed in the client contract. We administer prior authorization for these drugs for no additional charge.

- Adderall
- Amphetamine, dextro-amphetamine
- Cerezyme
- Desmopressin (DDAVP and Stiminate)
- Epoetin, Procrit, Aranesp
- Growth Hormone
- Prolastin
- Botox



In addition, we recommend prior authorization review to determine coverage for the following:

- Antifungals (Diflucan, Lamisil, Sporanox)
- Wellbutrin SR

We do not currently track the overall book-of-business approval/denial ratio of prior-approval medications or the percentage of decisions modified through our appeal process. Lists of medications requiring prior authorization vary by client. Also, some clients apply stricter approval criteria than others, causing denial rates to vary greatly from medication to medication and client to client. However, information from our clinical reviews indicates an overall approval ratio for initial requests to be in the 75-80 percent range.

Each of our clients can require PA for any drug. Our flexible claims system even allows PA to be applied to any particular dosage level, quantity, dosage form for any drug, and you can apply PA to any particular groups of members or your whole population. In addition, we have a number of Step Therapy programs that significantly reduce the need for PA. Your account team will work with you to determine which PA programs are appropriate and cost-effective for your needs and goals.

G. PA Hours of Operations – List the hours of operations for the PA Area and the average turnaround time for prior authorization decisions.

Express Scripts supports prior authorization review services 24 hours a day. Requests are made through the Call Center to help ensure that physicians and pharmacists have quick, easy access to prior authorization information.

We do not measure average turnaround time for prior authorization decisions. However, resolution to a request is usually completed within a few moments. The short turnaround time is possible because drug-specific criteria are available online to Prior Authorization Services Specialists and pharmacists. Some inquiries require a return call if the specialist needs to perform additional research and/or consult a clinical pharmacist. Regardless, we always respond within two business days of having received the request (sooner if required by law or client contract).



7. Utilization Management

- Provide the requested information about your utilization management programs in the following areas:
 - Concurrent and retrospective DUR
 - Prospective DUR/academic detailing
 - Formulary Management/Physician Interventions
 - Physician and Pharmacist Profiling
 - Case Management
 - Demand Management/Nurse advice lines
- Requested information: (provide for each program)
 - Name of Program(s)
 - Number of years in use with clients
 - Number of current enrollees
 - Description of program elements
 - Cost of program
 - Expected and/or guaranteed savings from program, differentiating between pharmacy costs and overall medical costs.
 - Sample materials and reports

The following charts provide brief descriptions of our clinical offering with cost savings (where available) based on actual Express Scripts performance.

Express Scripts offers three types of clinical programs, *Care, Safety, and Trend Management*. Each program type has three levels of intervention.

- Level 1: Patient initiated Internet based information available on Express-Scripts.com and Drug Digest, point of service messaging, and preferred product education
- Level 2: Disease and/or utilization specific, letter-based interventions targeted to patients, pharmacists, and physicians
- Level 3: Advanced disease management, physician consultation, and patient-centered interventions via letter and telephone


Name of Program: Concurrent Drug Utilization Review (Basic and Enhanced)
Number of years in use with clients: 10 years

Number of current enrollees: More than 30 million lives

Our Concurrent DUR program provides real-time, online messaging at the point of service. Edits are either administrative or clinical in focus. Selective messaging optimizes outcomes by reducing the number of false-positive alerts. This allows dispensing pharmacists to review and address the highest priority edits.

Concurrent DUR is addressed through several Express Scripts clinical programs including: On-line Concurrent DUR, Drug Quantity Management, Prior Authorization, and Step Therapy.

Safety Management - Level 1: Online Concurrent DUR

Concurrent DUR edits support patient safety at the point of service. Each pharmacy claim is reviewed by the claims processing system to identify pertinent clinical or utilization concerns. In establishing the Concurrent DUR program, Express Scripts identified the most important drug- and patient-specific pharmaceutical care concerns supported by First DataBank and proprietary edits. As a result, outcomes are optimized because of the decreased number of false-positive alerts—pharmacists are more likely to research and resolve identified concerns.

Concurrent DUR edits include:

- Benefit design
- Drug-age interaction
- Drug-disease interaction
- Drug-gender interaction
- Drug-drug interaction
- Drug-pregnancy interaction
- Formulary messaging
- High-dose warnings
- Therapy duplication
- Drug-allergy interaction (at mail)

Additional safety management at mail: An Express Scripts mail service pharmacist will review DUR edits on a daily basis to determine inappropriate dispensing based on drug-age, drug-drug, drug-gender, etc. and perform any patient and physician interventions as appropriate.

Expected savings: Online Concurrent DUR edits are intended to encourage appropriate use. Appropriate use leads to increased safety and decreased adverse events, which can ultimately equate to financial savings.



Trend Management – Level 2: Drug Quantity Management

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copay are consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving members access to quality care. Express Scripts clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help ensure optimal quantities of medication are dispensed per copay and per days' supply.

Expected savings: Expected average pharmacy cost savings for our standard list = \$0.09/PMPM

Trend management – Level 2: Clinical Prior Authorization

Prior authorization protocols are enforced through concurrent analysis of pharmacy claims. For select interventions, our adjudication system automates the process by screening claims history. Online messaging instructs the pharmacist to contact our Prior Authorization Services department and/or the physician if criteria are not met. The Prior Authorization program employs a hard edit at the point of service where pre-established criteria must be met before a patient can receive a prescription for a particular drug under the regular pharmacy benefit.

Expected savings:
 Expected average pharmacy cost savings:
 Base = \$0.03/PMPM
 PA for Lamisil/Sporanox = \$0.14/PMPM
 PA for Wellbutrin = \$0.03/PMPM

Trend Management – Level 2: Step Therapy

The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member's claims history. Our capability enables online, concurrent review of the member's claims profile for first-line drug use. Only claims for members whose histories do not show use of first-line products are rejected for payment at the point of service. As a result, our step therapy program minimizes impact on members at the point of service, reduces prior authorization call volume, and decreases administration cost. Members are guided into using more cost-effective alternatives when medically appropriate.

Modules include: NSAIDS, ACE Inhibitors, Proton Pump Inhibitors, Hypnotics, H2RAs, SSRIs, generic metformin, and Enbrel and Kineret.

Expected average pharmacy savings:
 Step-Therapy (H2) = \$0.07/PMPM
 Step-Therapy (PPI) = \$0.16/PMPM
 Step-Therapy (NSAIDS) = \$0.11/PMPM



Name of program: Retrospective DUR
Number of years in use with clients: 10 years
Number of current enrollees: More than 20 million lives
<p>Description of program elements: Retrospective DUR involves accumulating, analyzing, and interpreting information about prescriptions after the drugs have been dispensed. Our retrospective DUR programs utilize our pharmacy claims data to identify dispensing, prescribing, and usage patterns that can be improved through intervention.</p> <p><i>Retrospective DUR is addressed through several of Express Scripts programs including: Level 2 Retrospective DUR Standard Edits, Level 2 Seniors DUR, Level 3 Patient Consultation, Dose Consolidation, and Retail-to-Mail program.</i></p>
Safety Management – Level 2: Retrospective DUR Standard Edits
<p>The Retrospective DUR program identifies members whose drug profiles reflect possible therapeutic or clinical concerns. Inappropriate prescribing, dispensing, and prescription use are identified. The program includes modules which address a specific therapeutic or utilization concern. Interventions are performed weekly. Edits include:</p> <ul style="list-style-type: none"> • Therapeutic • Drug-disease interaction • Drug-drug interaction • Utilization • Addictive substances • Drug-age interaction • Drug-pregnancy interaction • Duplicate therapy • Hypnotics • Drug over utilization • Drug under utilization
<p>Expected savings: Expected average pharmacy cost savings = \$0.04/PMPM</p>
Safety Management – Level 2: Seniors DUR
<p>Seniors DUR encourages physician review of identified senior members’ drug therapies and changes in therapy when appropriate. Specifically, interventions address the following pharmacy care issues:</p> <p><i>Drugs of Concern</i>—Interventions identify patients whose medication use history suggests the potential for inappropriate therapy related to drug-age interactions. This program encourages appropriate review and possible change of medications with the goal of decreasing the risk of adverse drug events.</p> <p><i>Polypharmacy</i>—Interventions encourage review and simplification of complex drug therapy in patients receiving multiple maintenance medications. The goal of this program is to help seniors manage complex medication regimens by encouraging physicians to coordinate care and simplify drug therapy regimens where appropriate.</p>
<p>Expected savings: Expected average pharmacy cost savings = \$0.26/PMPM</p>

**Safety Management – Level 3: Patient Consultation**

The Express Scripts Patient Consultation program gives selected members a chance to discuss medication use during a one-on-one discussion with a clinical pharmacist. Members who use a large number of prescriptions receive intervention. Such members are at greater risk to experience negative drug interactions and high prescription drug costs. Patient Consultation promotes use of formulary and generic alternatives and helps reduce clinical risk.

Expected savings:

Patient Consultation promotes use of formulary and generic alternatives and helps reduce clinical risk.

Dose Consolidation Program

The Express Scripts Dose Consolidation program guides members into using doses of medications once daily when medically appropriate. The Dose Consolidation program offers the following benefits:

- Improved member compliance and convenience, as members take a medication once daily instead of multiple times.
- Ingredient cost savings as high as 50% to clients, and savings to members, depending on the benefit design.

Retail-to-Mail Program

The Retail-to-Mail program guides members who receive maintenance medications at retail pharmacies into receiving them from the mail service pharmacy. Based on the client's benefit design, drug costs are decreased by members receiving 90-day supplies at mail service for lesser copays. Clients benefit from deeper discounts and paying fewer dispensing fees.

Identified members receiving maintenance medications through retail pharmacies receive letters that:

- Provide notification mail service pharmacy option is available
- Identify the select maintenance medication (now received at a retail pharmacy) that can be received at mail
- Identify the copay amount (as a percentage) the member could save by using mail service
- Inform that standard shipping on mail service prescriptions is free
- Instruct the member how to begin using the mail service pharmacy

Interventions are performed daily.



Name of program: Prospective DUR/Academic Detailing
Number of years in use with clients: 10 years
Number of current enrollees: More than 10 million lives
Description of program elements: Prospective DUR is addressed through the following product lines ETI, Preferred Drug Transition, Academic Detailing, Therapy Adherence Patient Consultation, and Physician Consultation.
Safety Management – Level 1: Emerging Therapeutic Issues (ETI) Management
<p>The Emerging Therapeutic Issues (ETI) Program focuses on significant patient safety issues, such as drug recalls or drug interaction issues.</p> <p>In addition to managing the communications process for urgent clinical concerns, pharmacists on the Emerging Therapeutic Issues team also track new drugs that are anticipated to have a significant impact on pharmacy costs and make recommendations on the use and coverage of these products. Recommended coverage options might include providing full coverage, no coverage, or limited coverage through controls such as age/gender limits, quantity limits, or prior authorization.</p>
Trend Management – Level 1: Preferred Drug Transition
<p>The Preferred Drug Transition program is designed to:</p> <ul style="list-style-type: none"> • Prepare members and their physicians for upcoming changes to the formulary • Improve formulary compliance • Educate members and physicians on newly available generic alternatives <p>The program is effective in supporting formulary changes made at any point during the year. Quarterly mailings to members and prescribers promote movement to cost-effective preferred brand or generic alternatives. Members are encouraged to discuss preferred alternatives with their physicians. Interventions are designed to lessen disruption to members affected by upcoming changes and to maintain satisfaction with the pharmacy benefit.</p>
Expected savings:
Expected average pharmacy cost savings for HMGs = \$0.02/PMPM
Trend Management – Level 2: Academic Detailing
Express Scripts pharmacists provide direct physician consultation to educate physicians on preferred formulary products and generic prescribing. We analyze aggregate data across our book of business to identify physicians based on their individual prescribing patterns and savings opportunities. The top 5000 prescribers for Express Scripts’ book of business are identified for intervention. Consultation discussions focus on the use of preferred brand products, generic prescribing, and physician connectivity.



Trend Management – Level 2: Therapy Adherence—Mail

The Therapy Adherence program addresses member non-compliance with recognized treatment guidelines for specific disease states. Program interventions include education and medication refill reminders to members and physicians. The program increases awareness of the importance of taking medications according to recognized treatment guidelines. Member interventions include:

- Education and drug information
- Refill reminders via letter and phone call
- Notification when prescriptions have no refills remaining

In some cases, physicians receive letter notification of possible therapy non-compliance by their patients. The program is supported for mail service claims.

Expected savings:

Program facilitates compliance with chronic medication therapy. Adherence programs achieve a success rate of 48% in improving compliance on intervened members.

Safety Management – Level 3: Patient Consultation

The Express Scripts Patient Consultation program gives selected members a chance to discuss medication use during a one-on-one discussion with a clinical pharmacist. Members who use a large number of prescriptions receive intervention. Such members are at greater risk to experience negative drug interactions and high prescription drug costs. Patient Consultation promotes use of formulary and generic alternatives and helps reduce clinical risk.

Expected savings:

Patient Consultation promotes use of formulary and generic alternatives and helps reduce clinical risk.

Trend Management – Level 3: Physician Consultation Program (Client-Specific)

Express Scripts pharmacists provide 1:1 consultations with physicians. Phone-based discussions focus on the appropriate use of medications, current guidelines for treatment, and cost-effective medication options. Physicians are targeted based on their individual prescribing patterns and their savings opportunities. We use the top 32 therapeutic categories to assess each physician's savings opportunity.

Physician satisfaction with the consultation sessions is very high with the overwhelming majority of responding prescribers indicating that they find the information useful in their practice and also revealed:

- 89% of the physicians providing feedback find the discussions with the clinical pharmacists useful
- 86% of the respondents indicated that they are interested in meeting with the Consultants again

Expected savings:

Prescribing pattern changes were demonstrated through significantly lower utilization of the targeted therapies. Results based on pharmacy claims analysis showed an average net saving of \$1,000 over a 12-month period per physician receiving intervention.



Name of program: Formulary Management/Physician Interventions
Number of years in use with clients: 10 years
Number of current enrollees: More than 30 million lives
Description of program elements: <i>Formulary Management/Physician Interventions can be addressed through the following programs: Drug Choice Management, Preferred Drug Transition, Physician Consultation, Academic Detailing, and Physician Direct Mailings.</i>
<i>Trend Management – Level 1: Drug Choice Management</i>
This formulary management program increases utilization of preferred drugs through therapeutic and generic substitutions. This program targets non-preferred drugs that are dispensed through retail and mail pharmacies. Communications to the pharmacist, patient, and/or physician promote use of chemically or therapeutically equivalent drugs from a preferred list.
Expected savings: Expected average pharmacy cost savings for Drug Choice Management Mail and Retail = \$0.03/PMPM
<i>Trend Management – Level 1: Preferred Drug Transition</i>
The Preferred Drug Transition program is designed to: <ul style="list-style-type: none"> • Prepare members and their physicians for upcoming changes to the formulary • Improve formulary compliance • Educate members and physicians on newly available generic alternatives The program is effective in supporting formulary changes made at any point during the year. Quarterly mailings to members and prescribers promote movement to cost-effective preferred brand or generic alternatives. Members are encouraged to discuss preferred alternatives with their physicians. Interventions are designed to lessen disruption to members affected by upcoming changes and to maintain satisfaction with the pharmacy benefit.
Expected savings: Expected average pharmacy cost savings for HMGs = \$0.02/PMPM
<i>Trend Management – Level 1: Physician Direct Mailings</i>
This program is designed to provide formulary and/or clinical information to physicians. Physicians receive a letter with a formulary or brief clinical message relating to a drug product. Physicians also receive a newsletter with a focus on disease states or drug classes.

***Trend Management – Level 2: Academic Detailing***

Express Scripts pharmacists provide direct physician consultation to educate physicians on preferred formulary products and generic prescribing. We analyze aggregate data across our book of business to identify physicians based on their individual prescribing patterns and savings opportunities. The top 5000 prescribers for Express Scripts' book of business are identified for intervention. Consultation discussions focus on the use of preferred brand products, generic prescribing, and physician connectivity.

Trend Management – Level 3: Physician Consultation Program

Express Scripts pharmacists provide 1:1 consultations with physicians. Phone-based discussions focus on the appropriate use of medications, current guidelines for treatment, and cost-effective medication options. Physicians are targeted based on their individual prescribing patterns and their savings opportunities. We use the top 32 therapeutic categories to assess each physician's savings opportunity.

Physician satisfaction with the consultation sessions is very high with the overwhelming majority of responding prescribers indicating that they find the information useful in their practice and also revealed:

- 89% of the physicians providing feedback find the discussions with the clinical pharmacists useful
- 86% of the respondents indicated that they are interested in meeting with the Consultants again

Expected savings:

Prescribing pattern changes were demonstrated through significantly lower utilization of the targeted therapies. Results based on pharmacy claims analysis showed an average net saving of \$1,000 over a 12-month period per physician receiving intervention.



Name of program: Physician Profiling
Number of years in use with clients: 4 years
Number of current enrollees: More than 3 million lives
Description of program elements: <i>Physician Profiling is addressed through the following programs: Physician Direct Mailings, Academic Detailing, and Physician Consultation.</i>
A. <u>Trend Management – Level 1: Physician Direct Mailings</u>
This program is designed to provide formulary and/or clinical information to physicians. Physicians receive a letter with a formulary or brief clinical message relating to a drug product. Physicians also receive a newsletter with a focus on disease states or drug classes.
B. <u>Trend Management – Level 2: Academic Detailing</u>
Express Scripts pharmacists provide direct physician consultation to educate physicians on preferred formulary products and generic prescribing. We analyze aggregate data across our book of business to identify physicians based on their individual prescribing patterns and savings opportunities. The top 5000 prescribers for Express Scripts' book of business are identified for intervention. Consultation discussions focus on the use of preferred brand products, generic prescribing, and physician connectivity.
C. <u>Trend Management: Physician Consultation Program</u>
Express Scripts pharmacists provide 1:1 consultations with physicians. Phone-based discussions focus on the appropriate use of medications, current guidelines for treatment, and cost-effective medication options. Physicians are targeted based on their individual prescribing patterns and their savings opportunities. We use the top 32 therapeutic categories to assess each physician's savings opportunity. Physician satisfaction with the consultation sessions is very high with the overwhelming majority of responding prescribers indicating that they find the information useful in their practice and also revealed: <ul style="list-style-type: none"> • 89% of the physicians providing feedback find the discussions with the clinical pharmacists useful • 86% of the respondents indicated that they are interested in meeting with the consultants again



Name of program: Pharmacist Profiling
Number of years in use with clients: More than 10 years
Number of current enrollees: 47 million lives
Description of program elements: We have two complementary programs that offer profiling and incentives to pharmacists at a local level: our <i>Report Card Program</i> and our <i>Generic Dispensing Program</i> .
D. <u>Report Card Program</u>
<p>We monitor several statistical indicators that are used to produce Pharmacy Report Cards for all pharmacies. Specific pharmacy dispensing practices are monitored and reported including:</p> <ul style="list-style-type: none"> • Brand/generic/multi-source dispensing rates as a percent of the total • DAW code rates • UCR percent of claims paid • Reversal percentages • Percent of formulary drugs dispensed <p>In addition, special formulary messaging identifies opportunities and specific drugs. The results may be used to determine if a pharmacy audit is necessary.</p> <p>Report cards are generated on a quarterly and ad hoc basis, as appropriate, to evaluate performance and expected results. The data contained within the report cards is presented to the provider and used to investigate potential areas of performance enhancement. Additionally, changes in the contractual relationship may be evaluated or initiated based on the results of the profiling.</p>
E. <u>Generic Dispensing Program</u>
<p>Our PERxCare pharmacy network includes a Generic Incentive Program for pharmacies. We evaluate each pharmacy or chain’s generic fill rate quarterly, and we increase or decrease their generic dispensing fee based on how well they performed against our generic incentive fee scale.</p>
<p>Expected savings: The expected savings of our Pharmacist Profiling/Incentive Program is not currently measured. Express Scripts has not specifically evaluated the effectiveness of the report card system at lowering prescription costs. Rather, we view it as one of many tools used to continuously evaluate, support, and enhance provider performance.</p>



<p>▪ <u>Name of program: Case Management/Coordinating with Medical Vendor</u></p>										
<p>Number of years in use with clients: 3 years</p>										
<p>Number of current enrollees: 1,538</p>										
<p>Description of program elements: We offer Case Management through our High Utilizer Case Management Report and our Care Management Plus Programs</p>										
<p><i>Trend Management – Level 2: High Utilizer Case Management Report</i></p>										
<p>The High Utilizer Case Management Report is useful in identifying case management candidates, new users of high cost therapies, and newly identified patients with inferred disease states. This report is a valuable tool in a total carve out environment and can identify the top 5% of members who are driving 50% of a client’s utilization.</p>										
<p><i>Care Management – Level 3 Care Management Plus</i></p>										
<p>Care Management Plus is a series of disease-specific sessions that offer health assessment, education, and counseling via telephone and mailed interventions designed to improve or maintain appropriate patient care. By empowering patients to better manage their chronic condition, we anticipate improved quality of life, decreased adverse clinical symptoms, and cost savings related to appropriate medical resource utilization. Care Management Plus programs are staffed by registered nurses and supported by pharmacists who assess the targeted member’s health risk and provide information related to health, wellness, and medical care to the patient to discuss with their physician. <i>Modules include Asthma, Cardiovascular Disease, and Diabetes.</i></p>										
<p>Expected Savings:</p> <p>Aggregate Survey Responses for Care Management Plus Programs¹</p> <table> <tr> <td>Improvement for SF-12 measures²</td> <td>80%</td> </tr> <tr> <td>Decline in emergency room utilization</td> <td>100%</td> </tr> <tr> <td>Decline in office-based services, sick visits</td> <td>80%</td> </tr> <tr> <td>Stabilization or decline in urgent care visits</td> <td>86%</td> </tr> <tr> <td>Decrease in absenteeism from work or school</td> <td>83%</td> </tr> </table> <p>1 Results are determined using member-reported predisposition and call outcomes.</p> <p>2 SF-12 measures refer to a single-page health survey used to monitor health outcomes in general and specific populations. SF-12 measures are used by medical professionals, health care study investigators, and health care delivery organizations to evaluate patient well-being.</p>	Improvement for SF-12 measures ²	80%	Decline in emergency room utilization	100%	Decline in office-based services, sick visits	80%	Stabilization or decline in urgent care visits	86%	Decrease in absenteeism from work or school	83%
Improvement for SF-12 measures ²	80%									
Decline in emergency room utilization	100%									
Decline in office-based services, sick visits	80%									
Stabilization or decline in urgent care visits	86%									
Decrease in absenteeism from work or school	83%									



Name of program: Demand Management/Nurse Advice Lines
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Care Management – Level 3: Express Health Line

<p>Express Health Line is an informed-decision counseling service staffed by experienced nurses and pharmacists. Care counselors provide 24-hour health care counseling support to member callers. The program provides non-directional health care options via in-bound phone calls from patients through utilization of state-of-the art, online medical protocols.</p>

<p>The desired outcomes from Express Health Line interventions are:</p>

- | |
|--|
| <ul style="list-style-type: none"> • Decreased dependence on office-based medical care • Increased ability to appropriately handle health care concerns earlier • Identification of lower risk treatment options • Increased understanding of cost-effective health care options • Informed health care decisions |
|--|

8. Disease Management Programs

While recognizing that any plan changes are subject to collective bargaining, the State is interested in reviewing the disease management programs that you may have to offer. Please indicate your types of programs, the number of lives enrolled in each program, and expected savings and fees for these services.

- **Describe the philosophy and strategy behind your clinical management services and initiatives, including:**
 - **How the program emphasizes patient-centered care**
 - **Summary of top five features that distinguish your clinical management capabilities from your competitors**
 - **Frequency and reasons for communication with the State regarding possible clinical interventions**
 - **Describe Philosophy and strategy of your clinical management services and initiatives**

Express Scripts' clinical programs are designed to help you reach defined clinical, utilization, and cost management objectives. Express Scripts clinical management capabilities emphasize patient-centered care. The following five features distinguish our clinical management capabilities:

Clinically Sound—Objective research, including findings published in respected peer-reviewed literature, forms the foundation of all our programs. In addition, programs undergo independent review by leading health professionals.

Promote Quality of Care—Programs are designed to optimize patient health by educating patients about their disease states and/or promoting compliance with recognized treatment guidelines. Ensuring that patients are on the right drug at the right time for the appropriate duration is key to optimizing health care outcomes. Physicians receive information on cost effective alternatives, recognized treatment guidelines, and other clinical information as appropriate.



Yield Results—Interventions for each clinical program are easy to understand and provide reproducible results. Timely, accurate reporting will give you the information you need to monitor clinical program performance and evaluate cost impact.

Anticipate the Impact of Change—We identify emerging pharmaceutical trends and analyze potential implications for clients, members, physicians, and pharmacists. Through our modeling capabilities and ongoing consultation, we can help you anticipate how emerging trends might affect your program. As a result, you will be better prepared to address pharmaceutical trends proactively.

Member- and Prescriber-Friendly—Each program is designed with a simple, important message for the member, physician, and/or dispensing pharmacist. Clinical information is written in language appropriate for the intervention audience.

Each clinical program is designed to meet one of the following objectives:

- Safety Management
- Trend Management
- Care Management

All clinical programs are evaluated to determine member, physician, and financial impact. That means we can help you predict and balance cost savings and satisfaction.

Steve Pepin will continue to be the State’s main point of contact regarding clinical interventions. As always, we will continue to work consultatively with you to determine which programs best meet your needs, communicate their impact and their effectiveness.

- **Requested information: (provide for each program)**
 - **Name of Program(s)**
 - **Number of years in use with clients**
 - **Number of current enrollees**
 - **Description of program elements**
 - **Cost of program**
 - **Expected and/or guaranteed savings from program, differentiating between pharmacy costs and overall medical costs. Indicate any cap on penalties.**
 - **Sample materials and reports**

Name of program: Disease Management
Number of years in use with clients: 6 years
Number of current enrollees: 5 million lives



Description of program elements: *Disease Management is addressed through the following programs: Care Management Levels 1,2 and 3 and Express Health Line*
Level 1 interventions include messaging at the point of service, and patient-initiated information available through the member portal of Express-Scripts.com and **Drug Digest**.

- *Level 2 interventions* include disease- and utilization-specific print materials distributed to members and their physicians.
- *Level 3 interventions* include advanced, patient-specific disease management services, patient-centered interventions, and physician consultation.

Disease Management is addressed through the following programs: Care Management Levels 1,2 and 3 and Express Health Line

Care Management - Level 1: Web-based Care Management

Members can access easy-to-understand information on 40 health conditions and disease states through the member portal at Express-Scripts.com. A link can be provided at your Web site to the Care Management site. For some disease states, members can register for e-bulletins that provide updates and personal reminders. Online risk assessments are included. Information provided to members is designed to increase compliance with recognized treatment guidelines.

Care Management - Level 2: Care Management Programs

Care Management programs encourage use of appropriate drug therapies for high-risk patients. Patients receive educational materials that discuss treatment options and self-monitoring of their particular disease or health condition. Materials also promote adherence to prescribed drug therapy. Modeled upon national treatment standards, mailed interventions serve to educate physicians on current consensus guidelines and patient-specific therapy issues. Disease states addressed include: Allergy, Asthma, Cardiovascular Disease, Congestive Heart Failure (CHF), Depression, Diabetes, GI Disorders, Hypertension, and Migraine.

Expected savings:

Expected average pharmacy cost savings for Gastrointestinal Disorders = \$0.21/PMPM

Care Management - Level 3: Care Management Plus

Care Management Plus is a series of disease-specific sessions that offer health assessment, education, and counseling via telephone and mailed interventions designed to improve or maintain appropriate patient care. By empowering patients to better manage their chronic condition, we anticipate improved quality of life, decreased adverse clinical symptoms, and cost savings related to appropriate medical resource utilization. Care Management Plus programs are staffed by registered nurses and supported by pharmacists who assess the targeted member's health risk and provide information related to health, wellness, and medical care to the patient to discuss with their physician. *Modules include Asthma, Cardiovascular Disease, and Diabetes.*

Expected Savings:

Aggregate Survey Responses for Care Management Plus Programs

Improvement for SF-12 measures ²	80%
Decline in emergency room utilization	100%
Decline in office-based services, sick visits	80%



Stabilization or decline in urgent care visits 86%
Decrease in absenteeism from work or school 83%

¹ Results are determined using member-reported predisposition and call outcomes.

² SF-12 measures refer to a single-page health survey used to monitor health outcomes in general and specific populations. SF-12 measures are used by medical professionals, health care study investigators, and health care delivery organizations to evaluate patient well-being.

Care Management – Level 3: Express Health Line

Express Health Line is an informed-decision counseling service staffed by experienced nurses and pharmacists. Care counselors provide 24-hour health care counseling support to member callers. The program provides non-directional health care options via in-bound phone calls from patients through utilization of state-of-the-art, online medical protocols.

The desired outcomes from Express Health Line interventions are:

- Decreased dependence on office-based medical care
- Increased ability to appropriately handle health care concerns earlier
- Identification of lower risk treatment options
- Increased understanding of cost-effective health care options
- Informed health care decisions



9. Networks

Provide the network access data requested below on your national network options (e.g., broad, restricted, and/or performance-based) of preferred community pharmacies. However, only one network will be selected and offered to all participants with reimbursement of prescription drugs at the lower of negotiated prices or usual, customary or prevailing retail charges, including any discounts offered by the pharmacy to general customers, including senior citizen discounts (commonly referred to as the counter price).

The preferred network will provide at least one or more network pharmacies located within a convenient distance of participant residences, provided there is an available pharmacy within that distance. Otherwise, the standard shall be the nearest available pharmacy. Convenient distances, for purposes of this RFP, are defined to be:

- 1-mile distance in urban areas,
- 3-mile distance in suburban areas, and
- 10-mile distance in rural areas.

Provide network access data separately for each proposed network, separately for Actives and Retirees.

A. Network Access Data – Complete a network geo-analysis for the standards defined above.

We have provided a complete network geo-analysis using the standards defined above and provided member residence ZIP Codes.

B. Access Not Guaranteed – Identify the 5-digit zip codes where the mileage access standards (defined above) cannot currently be guaranteed. Report data using the following format in a Microsoft Excel file on a diskette:

State	City	5-Digit Zip Code	Number of Participants	Distance to Nearest Pharmacy
TOTAL	NA	NA		

We have identified the 5-digit ZIP Codes where the access standards cannot be guaranteed.



C. Achieving Access Target – For 5-digit zip codes with available pharmacies that do not meet the required access standard, describe the procedures and timing required to increase network participation in order to achieve the requested standard. Describe the process that allows SOM and its participants to recommend pharmacies for addition to the network.

Network geo-analysis indicates excellent coverage for the State’s members.

To ensure the best possible access for the State’s employees and retirees, we would seek to include any additional pharmacies meeting our credentialing requirements in our network for the State. New pharmacies can be added the next business day after we have received certification and a completed, signed contract from the pharmacy.

Our account team will work with the State to identify any pharmacies that would improve member access and our Provider Relations department actively solicits those pharmacies. Plan members can also send requests for network additions to the account manager, who will contact our Provider Relations department. Pharmacies that wish to become members of our network must complete a pharmacy agreement and satisfactory credentialing documents.

D. Chain Listing – Provide a listing by state of the major chain pharmacies participating in each proposed network.

We have included a listing of the major chain pharmacies by state.

E. Network Distribution – For each proposed network, provide the following information based on your geo-analysis results:

State of Michigan Network	Urban (one w/in 1 mile)	Suburban (one w/in 3 miles)	Rural (one w/in 10 miles)
No. of Plan Participants	N/A	N/A	N/A
No. of Available Pharmacies	18,227	11,418	26,354
No. of Pharmacies as of RFP Date	18,227	11,418	26,354
% of Plan Participants w/no pharmacy within standard	16.3%	5.6%	6.7%
% of Plan Participants with no network pharmacy within standard	2.8%	0.1%	0.6%
% of Plan Participants with a network pharmacy within standard	97.2%	99.9%	99.4%



10. Systems and Data Reporting

A. Detail the system integration between retail and mail order, including but not limited to claim adjudication, billing and support of clinical programs.

Express Scripts provides fully integrated pharmacy benefit management services, including retail pharmacy network claims processing, mail-order pharmacy services, benefit design consultation, drug utilization review, formulary management, and clinical and utilization management programs, and billing. Express Scripts also provides complementary services, including specialty medication distribution services.

Our proprietary Anchor system platform, combined with our proprietary Integrated Medication Management System (IMMS) software, delivers the benefit design flexibility, point-of-service, and retrospective utilization management our clients require.

Underlying our efficient claims processing system is a network of automated functions that incorporate clinical criteria and information management objectives into every aspect of your program.

All management programs include tracking of program activity and impact, as well as quantification of value to clients, patients, and providers. Results are communicated to clients through standard reporting and personal consultation with ESI professional staff.

Retail and mail services are fully integrated, providing single-system adjudication and billing services. When a member submits a prescription at a network or mail service pharmacy, the claim is entered via the online system to validate copay and clinical requirements before the claim is adjudicated. We bill the client at the end of each billing period for program fees less any applicable credits. Each line includes the administrative and claims processing fees. The detail report is synchronized with the invoice and lists every member (names are optional) and prescription number.

B. List all available reports, including frequency (monthly, annually, and as requested), and give samples of each. Indicate the time needed to produce each report. Indicate availability of reports on tape, diskette, CD-ROM, Internet, or on-line transmittal.

Express Scripts offers a comprehensive suite of reporting options to keep you informed about your pharmacy benefit program performance. Our web-enabled consultative reporting tools provide accurate utilization data as well as supporting aggressive strategic planning. The goal of our reporting products is to provide valuable data that you can use to identify drug trends, monitor the results of management activity, and make well-informed clinical and financial decisions.

The Express Scripts suite of reporting products provides the State the following benefits.

Flexibility—Express Scripts recommends a set of core reports or you can tailor your report package by adding or substituting other reports from our extensive report library.



- You can tailor your report package to meet your informational needs. Express Scripts recommends a set of reports, or you can tailor the report package by adding or substituting other reports from our extensive report library.

Timely Access—The State has timely access to the vital information regarding the management of your pharmacy benefit program.

- Reports go beyond offering data—you will receive report interpretation through analytical tools and through your Express Scripts account team.
- Report information and analysis will help you identify management opportunities and help you target your resources effectively.

Reliability—You can count on your reports to be up-to-date, accurate, and comprehensive.

Choice—The State can access information for printed or online distribution.

- Online reports can be downloaded so that you can further manipulate data on your own desktop applications.

Express Scripts has offered online reporting tools since 1997.

Web-enabled Client Reporting

Express Scripts' suite of web-enabled reports offer our client's a convenient way to access prescription utilization information. The State will have online access to production reports, which provide group, member, and physician-level utilization summaries, rankings, and profiles. Data can also be downloaded from the application to the State's other desktop applications to sort and use as you require.

Our online reporting system retains up to 27 months of the claims data we process. You will find online reporting applications to be most useful after accumulating approximately three to four months of data in order to have a baseline for comparison. Data in the system is updated with every pharmacy reimbursement cycle, typically every two weeks.

The State will have access to the following types of reports.

- Executive-level summary reports
- Member-level reports
- Drug-level reports
- Pharmacy-level reports
- Physician-level reports
- Physician utilization review (PUR) option

Express Scripts' web-enabled client reports are available as an online and interactive application. The State users or your account team can sort, drill, chart, and view results instantaneously at their desktops



Web-Enabled Client Reports

Executive Level Summary Reports	Member Level Summary Reports
Claim Activity Summary Claim Activity by Age and Gender Utilization Summary Utilization Summary by Group Benefit Code Claims Processed with Prior Authorization Trend Comparison	Controlled Substance Utilization High Utilization Member Ranking Member Ranking by NABP Member Ranking by Drug Members Using Two Specified Drugs Members Using X or More Pharmacies Members Using X or More Different Drugs
Drug Level Summary Reports	Pharmacy Level Summary Reports
Drug Ranking Drug Ranking by NABP Drug Ranking by Therapy Class Drug Utilization Summary-All Members Therapy Class Ranking Non-Formulary Rank by Therapy Injectable Medication Utilization	Pharmacy Ranking Member Ranking by NABP Drug Ranking by NABP

C. Provide a sample or description of additional reporting capabilities

Express Scripts has also developed reports to evaluate components of the pharmacy program, identify cost drivers, and evaluate cost-driver variables. These tools provide a variety of cost-analysis pathways that allow the State to examine the net-cost effects of variables in your benefit design, clinical management, and network arrangements.

Customized data extracts help diagnose specific contributors to a rising drug trend. These tools address all components of the pharmacy program to identify cost drivers and evaluate cost-driver variables. Time periods can be compared (e.g., first quarter 2001 and first quarter 2002), which allows you to measure the impact of formulary decisions, benefit design changes, or utilization management programs you implement.

Express Scripts' report library provides scheduled and specially requested reports from the Express Scripts internal report production system. The report library contains information that supports in-depth analysis of program performance and addresses specific management needs. As part of your reporting package, the State can select scheduled reports. Your account team will consult with you during implementation to determine which reports will meet your objectives. The reports will be delivered to you according to your defined schedule (i.e., quarterly, monthly).

The following table lists additional reports available to the State:



Scheduled Report Library

Executive Level Reports	Physician Level Reports
<ul style="list-style-type: none"> • QuikLook Report • Pharmacy Performance Summary by Benefit • Usual and Customary versus Contracted Rate Performance • Utilization by Subscriber versus Dependent • Integrated Claims Summary 	<ul style="list-style-type: none"> • Noncompliance by Physician • Primary Care Physician Performance • Physician Utilization Review • Physician/Total Cost by Therapy Class
Drug Level Reports	Pharmacy Level Reports
<ul style="list-style-type: none"> • Summary of Top Drugs by Cost and Count • Summary of Top Therapy Classes by Cost and Count • Market Shares within Therapy Class • Drugs by Therapy Class or Generic Code • Claims Activity by Specified Drug • Injectable Drug Utilization • Noncompliant Drugs by Specified Therapy Class 	<ul style="list-style-type: none"> • Claims with Unknown Days Supply • Claims for Compound Drugs • Claim Analysis by Pharmacy Zip Code • Claims by Specific NABP • Pharmacy Compliance and (Dispense as Written (DAW) Patterns • Noncompliance by Pharmacy
Member Level Reports	Operational Reports
<ul style="list-style-type: none"> • Members Using Duplicative Therapy • Members Using Specific Therapy Class/GCN/NDC • Members with DAW Claims Activity • Members Using X or More Different Drugs • Members Using X or More Physicians • Members Using X or More Pharmacies • Members with utilization of \$X or More • Patient Prescription Profile • Mailing Labels for Members Using Specific Drug/GCN • Mailing Labels for Members Using a Specified Pharmacy 	<ul style="list-style-type: none"> • Claims Reimbursement Report Package • Billed Claims Detail Tape • Prescriptions by Eligibility Groupings • Claims Paid with Prior Authorization • Claims Filled after Termination Date • Claims Detail Files

Support from our Benefit Analysis and Consultative Services Team

Express Scripts offers the State custom reporting and consultation services from our Benefits Analysis and Consultative Services (BACS) team. If the State has a reporting requirement not already met with our flexible report package, our benefit team can offer you the additional flexibility you require. Customized reporting requests may require an additional fee, although we are proud to say that the division through which the State is currently being serviced has yet to require a service fee. Typically, reports are programmed in 5-10 business days and generated in 1-2 days. Specific requests related to union negotiations can be turned around back to the State within a few hours.



In addition to complex reporting requirements, the BACS team will continue to provide the State with key updates and ongoing consultation regarding your performance in the areas of cost per prescription, cost per member per month, and number of prescriptions per member per month as compared and benchmarked against similar client programs. With more than 500 million claims in our data warehouse to measure against, you can be assured that the information we provide to you is accurate and reliable. The focus of our analyses is to identify the areas of your benefit design that require improvement.

As a dedicated benefits analysis unit, the BACS team works directly with your account team to design client-specific programs and recommendations. This relationship helps distinguish Express Scripts as a consultative, service leader within the pharmacy benefit management industry.

D. Describe on-line reporting/management capabilities. Provide sample printouts from your on-line system.

Please see the response to **Question C** above for a description on our online reporting offering.

E. Describe your Internet web site and plans for future enhancements. If a generic or sample web site is available for viewing, supply the web address and access.

You may view our sample websites by doing the following:

- For the member site, go to website <http://member.express-scripts.com>. Use the following ID: DEMOID07 and the following password: P83PXC.
- For the client site, go to https://client.express-scripts.com/esi_client/user_login. Use the following ID: DEMOID07 and the following password: P83PXC.

We have described many of our standard Internet offerings in the answer to the question above. Below, we describe additional tools the State may find beneficial to their members. These features can be accessed the sample website described above.

Express Choice

Express Choice is a pharmacy benefit strategy designed to balance prescription cost trend management with employee/member satisfaction. Because individual prescription needs vary, Express Choice offers members multiple pharmacy benefit plans and lets them select the plan that best fits their specific needs.



Historically, clients have generally attempted to manage cost trend by requiring members to pay more for existing plans or by restricting plans. Unfortunately, members have no input in this type of decision-making process. With Express Choice, however, members can choose to either pay more to participate in a particular plan or modify their behavior to save money. They select the plan that best fits their lifestyle and personal needs. Because members have a choice, they are more satisfied with the outcome and have a greater sense of responsibility.

To help members make sound decisions during their open enrollment period, Express Choice is supported by interactive and online tools that:

- Educate members about the plan choices
- Display savings opportunities members can take advantage of by using mail service and generics
- Compare the estimated costs of each plan

The result is an educated member who is empowered to make an informed decision.

Empower Members to Ensure Satisfaction—Express Choice involves members in plan decisions, leaving them with a sense of empowerment and accountability. By offering members options and allowing them to make their own healthcare decisions, Express Choice *encourages* cost management rather than *imposing* it. Members can make trade-offs and set their own limitations, while the client continues to manage trend.

Increase Members' Understanding—Our user-friendly, personalized Web tool helps members understand plan options and appreciate how the choices they make directly affect them. After using Express Choice to compare different plans and their associated costs side by side, members are prepared to make a confident choice. Returning members can even use their own drug history to compare different plans and estimate costs.

Encourage Member Education—Not only does Express Choice help members make better decisions during open enrollment, it also educates them about the upcoming pharmacy benefit. So, members know exactly what to expect from the very beginning. Our interactive tool also introduces members to cost-savings opportunities through mail service and generic use.

Express Preview

Express Preview is an online tool available during open enrollment. The State can preview this site by logging on to: <http://member.express-scripts.com/choice/ese>. It offers a personalized and interactive way for members to learn about their upcoming pharmacy benefit so they can make more informed decisions. Using their own utilization history, members can review estimated prescription costs and learn how to save money by using mail service and generics.

Deliver Personalized Open Enrollment Information—Traditional open enrollment materials are written for mass audiences. Express Preview delivers the upcoming benefit information in a personalized and interactive way, letting the member see how plan changes directly affect them. Using their own utilization history, members can review estimated prescription costs and learn how to save money by using mail service and generics.



Educate Members During Open Enrollment—Express Preview educates members about their benefit plan at the most important time — before the plan begins. Using Express Preview, members can review forecasted out-of-pocket expenses, copays, and premiums and take a look at their specific pharmacy network and formulary (drug list). By the time the plan begins, members have a complete understanding of plan details, leading to greater satisfaction and improved trend management.

Introduce Personalized Savings Opportunities—Clients can take advantage of the open enrollment period to introduce lower-cost alternatives and provide plan benefit details. Express Preview takes each member's utilization into account and suggests savings opportunities available through use of mail service and generics. In addition, this tool improves members' ability to accurately plan for and manage upcoming prescription expenses.

Increase Use of Flexible Medical Spending Accounts—Organizations reap great tax benefits when employees participate in flexible spending accounts (FSAs). With its easy-to-use tools, Express Preview improves members' comfort level with FSAs and increases the likelihood of participation. Using a personalized drug list, our tool can “predict” out-of-pocket expenses for the upcoming year, helping members plan and budget.

To Support the Management Function

Express Scripts has invested time and resources in the development of tools that facilitate access to information and enhanced service on a number of different levels. Our account management philosophy emphasizes customize service coordination of objectives in order to manage plans more effectively. The tools described below are resources for our clients which assist our account teams towards this end as well insofar as they greatly enhance the interaction between client, plan, and account team.

Express Scripts.com for Clients is a web site for our clients that offers access to secure plan management tools and real-time, client-specific details and information. The site enhances decision-making by providing clients with education and modeling tools that offer insight to benefit plan savings. The tools offered through the client portal improve operational efficiencies by supplying information sharing and transactional tools that simplify key administrative functions and reduce transaction times. Client Portal tools include:

Online Eligibility—Clients will be able to log in to the Express Scripts Eligibility System through our web site and view, update, or edit eligibility as necessary. Real-time editing capabilities allow for rapid response to member coverage issues. Electronic file transfer is also available through our web site. Clients may view eligibility reports online for quick verification of successful eligibility data loads to Express Scripts.

Reporting—Express Scripts' standard reporting package includes Executive Reports, which can be accessed through the client portal of our web site. This feature of the client portal presents unlimited access to plan performance reports providing key summaries of critical measures, including trends and utilization. Clinical evaluations and benefit summaries by cost impact are also available.



Sales, Marketing Information and Articles—Clients have the capability to review and print marketing and promotional materials for their pharmacy benefit program. In addition, articles include industry trends and topics important to clients such as drug trend strategies. Documents can be opened, viewed and printed using Adobe® Reader® to allow for easy access.

Plan Management—Clients have the convenience of one-stop access to simple, secure plan management tools. By online management of eligibility and access of our Benefit and Claims System, clients are able to determine claim status and specific benefits information about individual members with improved efficiency. Clients are also have the ability to print proof of benefit coverage letters for members and groups with immediate needs.

Plan Analysis—Clients can use Express Scripts' analysis and modeling tools to maximize their members prescription drug benefit. This feature provides educational information about plan designs available and options for cost containment. Case studies demonstrating how Express Scripts' services have provided documented benefit for clients are available for review. We also provide the client with access to normative data, age/sex demographic information, and informatics, comparative information used to assess current benefit offerings and determine future alternatives.

APPENDIX A, PRICING PROPOSAL

Retail Pharmacy Network	Associated Fees
State of Michigan Custom Network 55,999 pharmacies	
<ul style="list-style-type: none"> Usual and Customary Brand Drugs Generic Drugs 	Lower of AWP less 16% or UCR ¹ Lower of MAC, Brand Discount or UCR
Dispensing Fee per Brand Prescription	\$1.85
Dispensing Fee per Generic Prescription	\$1.85
Administrative Fee per Prescription	\$0.10
Administrative Fee per Prescription (Paper/Member)	\$1.50
Retail Pharmacy Network	Associated Fees

¹ ESI estimates the value of UCR to range from 0.5% to 1.5% depending on the AWP discount.

Mail Service Pharmacy*	Associated Fees
<ul style="list-style-type: none"> Brand Drugs Generic Drugs 	AWP less 24% AWP less 50%
Dispensing Fee per Prescription	\$0.00
Administrative Fee per Prescription	\$0.00

* Notwithstanding the preceding rates, if the calculation of the cost of the claim is less than the standard copayment, then Express Scripts will charge the greater of the AWP discount or Express Scripts' current minimum rate of \$8.99.

Rebates

Market Share

Express Scripts guarantees to share 100% with a minimum \$1.50 per retail rx and \$5.50 per mail rx of the manufacturer's rebates with State of Michigan. This assumes the ESI 500 Formulary. This guarantee will be measured on an annual basis. Any payment made under this guarantee will be allocated on a quarterly basis. Rebates quoted are dependent upon the proposed plan design and a signed contract. Express Scripts will hold all rebates until a contract is signed.

0 Pharmacy Management Account

-
- (a) ESI will establish and fund a Pharmacy Management Account (“PMA”) in the amount of \$4 per member to be jointly managed by ESI and Sponsor. Funds in the PMA are specifically designated for (i) Sponsor’s programs that would likely have a material effect on controlling outpatient pharmacy trends, and (ii) the actual costs associated with implementation of this Agreement by Sponsor (i.e., transition of Members to ESI).
- (b) The PMA is further subject to the following requirements:
- (i) *Mutual agreement on the scope of programs to be funded, such agreement not to be unreasonably withheld by either party;*
 - (ii) *Amounts applied against the PMA must be based on, and clearly linked to, the fair market value of the direct expenses of the transition of Members, and the service or program funded;*
 - (iii) Qualifying expenses must be incurred during the term of this Agreement or the four (4) months preceding its effective date
 - (iv) *Either Sponsor or ESI may withdraw funds from the PMA to cover the fair market value of related expenses for projects requiring joint resources;*
 - (iv) *Sponsor shall have no right to interest on, or the time value of, any amounts in the PMA; and*
 - (v) *Sponsor shall comply with any applicable federal and/or state disclosure requirements concerning receipt of funds from the PMA. Funds may not be used or withdrawn by either party for any purpose that is not in compliance with applicable law.*

Pricing Assumptions

- 0 Effective date of 6/1/2003.
- 1 Minimum three-year agreement.
- 2 Express Scripts will be the exclusive provider of PBM services.
- 3 None of the business to be enrolled is based on a 100% copayment benefit plan.
- 4 Rebates quoted are dependent upon a signed contract. Express Scripts will hold all rebates until a contract is signed.
- 5 If rebate revenue is materially decreased because of brand products moving off-patent to generic status, ESI reserves the right to make an equitable adjustment to the rebate as of the effective date of such change or action.
- 6 Upon early termination of client, the pro-rated portion of the unamortized expenses will be reimbursed to Express Scripts upon client termination.
- 7 Offer valid for 90 days from date of issue.
- 8 All participating pharmacies serving members will be on line with Express Scripts and prescription drug services dispensed by such pharmacies will be eligible for rebates under the Express Scripts rebate program.
- 9 Funded clinical programs are effective through the life of the funding.

0 <u>Services</u>	1 <u>Associated Fees</u>
<u>Administrative Services</u>	
◆ Customer Service for Members	No additional charge
◆ Electronic Claims Adjudication	No additional charge
◆ Implementation Support	No additional charge

0 <u>Services</u>	1 <u>Associated Fees</u>
◆ Member Submitted Paper Claims	\$1.50/claim
◆ On-Line Eligibility Management (one line)	No additional charge
◆ Pharmacy Audit Recoveries	Express Scripts retains 20% of audit recoveries
◆ Pharmacy Help Desk	No additional charge
◆ Pharmacy Network Management	No additional charge
◆ Pharmacy Reimbursement	No additional charge
◆ Software Training for Access to our On-Line System	No additional charge
◆ On-Line Eligibility	State of Michigan is responsible for ongoing line charges/ connections. There are a few methods that can be utilized depending upon State of Michigan's needs. This can be discussed in detail with State of Michigan and Express Scripts' on-line experts.
◆ COB (coordination of benefits) Standard Process (reject for primary carrier) Medicare Coordination	No charge \$0.06 per all Scripts for the +65 population (additional to quoted rates)
Reporting Services	
◆ Electronic Report: On-Line only Paper Reporting	\$0.00/rx without Physician Utilization Review \$0.02/rx with Physician Utilization Review \$0.00/rx for Paper Reporting
◆ Printed Reporting Package (on standard schedule)	No additional charge
◆ Custom Ad-Hoc Reporting (programming required)	\$150 per hour
Implementation Package	
◆ Member Materials Standard Package, mailed to member via First Class Mail:	Bulk shipped to plan sponsor at a cost of \$1.00 per member
◆ Two (2) Resin ID cards, two-sided (standard)	Mailed to members' homes at no additional charge
◆ Current Plastic ID Card – re-carding new members only	\$0.01/rx
◆ Current Plastic ID Card – re-carding all members	\$0.02/rx
◆ Replacement ID cards	\$0.25 per card
◆ Two (2) Page Benefit Info Packet	Mailed to members' homes at no additional charge
◆ Buck Slip with Confidentiality Statement and Preferred Drug List	Mailed to members' homes at no additional charge
◆ Education Buck Slip on Mail Generics and Internet	Mailed to members' homes at no additional charge
◆ Customized/Enhanced/Non-Standard Communications Materials	Billed to the client at cost

0 <u>Services</u>	1 <u>Associated Fees</u>
<ul style="list-style-type: none"> ◆ Annual Formulary Communication <ul style="list-style-type: none"> ◆ Posted at www.express-scripts.com ◆ Bulk shipped to plan sponsor ◆ Mailed to the member's home 	No additional charge No additional charge Additional charge TBD on a case-by-case basis
<ul style="list-style-type: none"> ◆ Network Development upon Request 	No additional charge
<ul style="list-style-type: none"> ◆ Plan Setup 	No additional charge
Rebate Program	
<ul style="list-style-type: none"> ◆ Includes quarterly allocations 	No additional charge

Clinical Products

CARE MANAGEMENT	
1 Level 1	
<p>◆ Care Management – Web Based Disease specific education on 39 disease states accessed through member portal. Includes e-bulletins and personal reminders.</p>	No additional charge
2 Level 2	
<p>◆ Care Management Disease and/or therapy specific, physician and patient letter based interventions.</p>	<p>\$0.02/Claim – Allergy \$0.01/Claim – Asthma \$0.01/Claim – Cardiovascular Disease \$0.02/Claim – CHF \$0.02/Claim – Depression \$0.01/Claim – Diabetes \$0.02/Claim – GI Disease \$0.02/Claim – Hypertension \$0.02/Claim – Migraine</p>
<i>Level 3</i>	
<p>◆ Care Management Plus <i>Comprehensive disease management service that helps patients improve their health through ongoing, 1:1 consultation sessions with a registered nurse.</i></p>	<p>\$225.00/case/year – Asthma \$225.00/case/year – Diabetes \$225.00/case/year – Cardiovascular Disease</p>
<p>◆ Express Health Line <i>Comprehensive demand management providing triage services based on guidelines developed by the American Institute of Preventative Medicine (AIPM).</i></p>	\$0.24 - \$0.40 PMPM

2 <u>Clinical Services</u>	3 <u>Associated Fees</u>
<u>SAFETY MANAGEMENT</u>	
3 Level 1	
<ul style="list-style-type: none"> ◆ On line Concurrent DUR <ul style="list-style-type: none"> ◆ Drug-Drug Interactions ◆ Drug-Disease Interactions ◆ Therapeutic Duplication ◆ Duplicate Ingredient ◆ Drug-Allergy Interactions (Mail) ◆ High Dose ◆ Drug-Age Interactions ◆ Formulary Messaging ◆ Benefit Design 	No additional charge
<ul style="list-style-type: none"> ◆ Emerging Therapeutics Issues Management Monitors patient safety concerns and proactively alerts our clients to new drugs that are anticipated to have a significant impact on pharmacy costs. 	No additional charge
4 Level 2	
<ul style="list-style-type: none"> ◆ High Utilizer Case Management Report 	\$150 per report
<ul style="list-style-type: none"> ◆ Retrospective DUR Weekly disease and/or therapy specific physician intervention targeting multiple utilization issues. <ul style="list-style-type: none"> ◆ Drug-Drug Interactions ◆ Drug-Disease Interactions ◆ Drug-Pregnancy Interactions ◆ Overutilization ◆ Underutilization ◆ Duplicate Therapy ◆ Addictive Substances ◆ Long Term Hypnotics 	\$0.03/per claim
<ul style="list-style-type: none"> ◆ Seniors DUR Weekly interventions focused on senior-specific medication utilization issues to decrease the risk of adverse drug and medical events. <ul style="list-style-type: none"> ◆ Polypharmacy ◆ Drugs of Concern 	\$0.03/per claim
5 Level 3	
<ul style="list-style-type: none"> ◆ <i>Patient Consultation</i> <i>The Express Scripts Patient Consultation program gives selected participants an opportunity to discuss medication use during a one-on-one discussion with a clinical pharmacist.</i> 	\$35 per response Estimated target population and response rates: <u>Retiree</u> 10% target, 33% response <u>General Population</u> 3% target, 20% response

TREND MANAGEMENT		
Level 1		
◆ Preferred Drug Transition * Supports appropriate selection of cost-effective formulary and generic medications.	No additional charge	
◆ Drug Choice Management* Supports appropriate selection of cost-effective medications through active interventions.	No additional charge	
◆ Physician Direct Mailings* Provides formulary and/or clinical information to physicians via newsletters or formulary updates.	No additional charge	
◆ Retail to Mail Conversions Encourages maintenance medications to be filled at mail.	No additional charge	
Level 2		
◆ Academic Detailing Express pharmacists and nurses consult with selected physicians on prescribing patterns including use of generics and formulary products.	No additional charge	
◆ Therapy Adherence* Encourages patient compliance with chronic medication regimens.	No additional charge	
◆ Step Therapy Programs intervene and support appropriate use at the point of service through pre-established clinical criteria.	No additional charge	
◆ Drug Quantity Management – standard list Ensures that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and a clients benefit design	No additional charge	
◆ Client Specific Formulary, Generic and Benefit Design Communications	Per mailing charge	
Level 3		
◆ <i>Physician Consultation</i> <i>Express Scripts' pharmacists conduct client specific one-on-one phone consultations with selected physicians.</i>	Number of Physicians Targeted	Cost per Target
	<200	\$100
	200-299	\$80
	300-399	\$75
	400-499	\$70
500+	\$65	
PRIOR AUTHORIZATION		
◆ <i>Base List: Botulinum toxin type A (Botox), Epoetin alfa (Epogen and Procrit), Darbopoetin alfa (Aranesp), Somatropin and Somatrem (growth hormone - Humatrope, Nutropin, Genotropin, Norditropin, Nutropin AQ, Saizen, Protropin, and Serostim), Alpha-1-proteinase inhibitor (Prolastin), Tretinoin (Retin-A, Avita, Altinac), Becaplermin (Regranex), Tazarotene (Tazorac)</i>	No additional charge	
◆ <i>*List subject to change at the discretion of Express Scripts, Inc.</i>		
◆ <i>Administrative Overrides (e.g., Vacation Overrides), Gender, High/Low Dose, Underuse/Overuse Edits</i>	No additional charge	
◆ <i>Clinical Overrides (e.g., Medical Exceptions, Step Therapy, QLL) and Non-standard Prior Authorization Medications.</i>	\$20.00 Per Decision	
◆ Custom Prior Authorization Criteria Development	\$1,000 per criteria	

Rate Guarantee

Express Scripts will guarantee the AWP discounts and the other fees over a three-year term. However, in the event of passage of federal or state regulations (e.g., "Favored Nations" law, Medicare legislation impacting pharmacy reimbursements) mandating minimal pharmacy reimbursement during any of the contract years, Express Scripts reserves the right to adjust AWP discounts and dispensing fees in accordance with the law, or pharmacy network reimbursement resulting from Medicare program legislation.

Certain injectible, biotech, and compounds drugs (e.g., Betaseron and Avonex) that become available on the market from time to time will be priced separately from the contracted rates proposed herein, due to specialized manufacturer processes, limited availability, or extraordinary shipping requirements.

Should a new clinical program gain manufacturer support during the life of the contract, it will be made available for State of Michigan at no additional charge. If a clinical program ceases to be supported by a manufacturer, the client has the choice of replacing it by another funded program or continuing the program at the client's cost.

In the event that changes in circumstances or in any applicable laws or regulations cause the formulary rebates to materially change, Express Scripts reserves the right to revise the rates.

Injectable Biotechnology Drug Pricing

**Discounts are available only through Express Scripts Specialty Distribution Facilities
State of Michigan**

Drug	Therapy Class	Exclusive Pricing AWP less	Disp Fee/Rx
Enbrel	A & IS	16.00%	\$1.50
Humira	A & IS	16.00%	\$1.50
Sandostatin	A & IS	16.00%	\$1.50
Zoladex	A & IS	16.00%	\$1.50
Hylagan	Arthritis	16.00%	\$1.50
Supartz	Arthritis	16.00%	\$1.50
Synvisc	Arthritis	16.00%	\$1.50
Aranesp	Erythroid Stimulant	16.00%	\$1.50
Epogen	Erythroid Stimulant	16.00%	\$1.50
Kineret	Erythroid Stimulant	16.00%	\$1.50
Procrit	Erythroid Stimulant	16.00%	\$1.50

Genotropin	Growth Hormone	17.00%	\$1.50
Geref	Growth Hormone	16.00%	\$1.50
Humatrope	Growth Hormone	16.00%	\$1.50
Norditropin	Growth Hormone	17.00%	\$1.50
Nutropin	Growth Hormone	18.00%	\$1.50
Nutropin AQ	Growth Hormone	18.00%	\$1.50
Nutropin Depot	Growth Hormone	18.00%	\$1.50
Protropin	Growth Hormone	18.00%	\$1.50
Saizen	Growth Hormone	17.00%	\$1.50
Serostim	Growth Hormone	16.00%	\$1.50
Alphanate	Hemostatic	19.00%	\$1.50
Alphanine SD	Hemostatic	19.00%	\$1.50
Bebulin	Hemostatic	19.00%	\$1.50
Benefix	Hemostatic	19.00%	\$1.50
Feiba VH	Hemostatic	19.00%	\$1.50
Helixate FS	Hemostatic	16.00%	\$1.50
Hemophil M	Hemostatic	19.00%	\$1.50
Humate P	Hemostatic	18.00%	\$1.50
Koate DVI	Hemostatic	18.00%	\$1.50
Koate HP	Hemostatic	18.00%	\$1.50
Kogenate FS	Hemostatic	16.00%	\$1.50
Monoclate P	Hemostatic	18.00%	\$1.50
Mononine	Hemostatic	16.00%	\$1.50
Novoseven	Hemostatic	18.00%	\$1.50
Proplex T	Hemostatic	18.00%	\$1.50
Profilnine SD	Hemostatic	20.00%	\$1.50
Fragmin	Heparin	16.00%	\$1.50
Lovenox	Heparin	16.00%	\$1.50
Bravelle	Infertility	16.00%	\$1.50
Cetrotide	Infertility	16.00%	\$1.50
Factrel	Infertility	16.00%	\$1.50
Fertinex	Infertility	16.00%	\$1.50
Follistim	Infertility	16.00%	\$1.50
Gonal-F	Infertility	16.00%	\$1.50
Humegon	Infertility	16.00%	\$1.50
Novarel	Infertility	16.00%	\$1.50
Ovidrel	Infertility	16.00%	\$1.50
Pergonal	Infertility	16.00%	\$1.50
Pregnyl	Infertility	16.00%	\$1.50
Profasi	Infertility	16.00%	\$1.50
Repronex	Infertility	16.00%	\$1.50
Synarel	Infertility	16.00%	\$1.50
Alferon N	Interferons	16.00%	\$1.50
Actimmune	Interferons	16.00%	\$1.50
Avonex	Interferons	16.00%	\$1.50
Betaseron	Interferons	16.00%	\$1.50
Copegus	Interferons	16.00%	\$1.50
Infergen	Interferons	16.00%	\$1.50
Intron A	Interferons	16.00%	\$1.50
Peg Intron	Interferons	16.00%	\$1.50
Pegasys	Interferons	16.00%	\$1.50
Rebetol	Interferons	16.00%	\$1.50
Rebetron	Interferons	16.00%	\$1.50

Rebif	Interferons		16.00%	\$1.50
Roferon A	Interferons		16.00%	\$1.50
Neumega	Interleukin		16.00%	\$1.50
Proleukin	Interleukin		16.00%	\$1.50
Gamimune - N	IVIG	*	16.00%	\$1.50
Carimune	IVIG	*	16.00%	\$1.50
Venoglobulin-S	IVIG	*	16.00%	\$1.50
Copaxone	MS		16.00%	\$1.50
Leukine	Myeloid Stimulant		16.00%	\$1.50
Neupogen	Myeloid Stimulant		16.00%	\$1.50
Lupron	OB/GYN		16.00%	\$1.50
Remicade	Other		16.00%	\$1.50
Arixtra	Other		16.00%	\$1.50
DDAVP	Other		16.00%	\$1.50
Forteo	Other		16.00%	\$1.50
Nabi-HB	Other		16.00%	\$1.50
Neulasta	Other		16.00%	\$1.50
Bay Rho-D	Other		16.00%	\$1.50
Rhogam	Other		5.00%	\$1.50
Synagis	RSV		16.00%	\$1.50

* Drug only, supplies and nursing not included.

Additional Billing and Payment Terms:

1. Fees, Billing. Contractor will bill State twice per month for all applicable fees specified in Appendix A, Price Proposal, and any applicable fees for clinical programs as follows:
 - (i) the reimbursement for Covered Drugs dispensed by the Mail Service Pharmacy, Specialty Pharmacy, Participating Pharmacies, and, if applicable, for Member-Submitted Claims, less applicable Copayments; and
 - (ii) for all other applicable administrative fees (Covered Drug reimbursement and administrative fees to be referred to collectively as “Fees”).
2. Payment. State shall be responsible to Contractor for timely payment of all Fees. State agrees to pay Contractor by wire, ACH transfer or pre-authorized debit from State’s designated bank account within two (2) business days from the date of State’s receipt of the Contractor invoice. Any amounts not paid by the due date thereof shall bear interest at the rate of eighteen percent (18%) per annum (1.5% per month) or, if lower, the highest interest rate permitted by law. If State disputes any item on any invoice, State shall state the amount in dispute in writing within thirty (30) days of the date of the invoice. State shall pay the full amount invoiced and shall notify Contractor of the disputed amount. If the disputed claim results in a refund owed to the State, the Contractor agrees to fully refund the amount, including interest. Any claims for Specialty Injectables that have been prior authorized or pre-certified by State shall not be subject to retroactive denial of payment for any reason.
6. 3. Payment by Member for Mail Service. Members shall pay their applicable Member Copayments to Contractor prior to the dispensing of a prescription through the Mail Service Pharmacy and Specialty Pharmacy.
4. MAC. The MAC definition refers to a list of multi-source generic drugs developed and maintained by the Contractor. Appendix A sets forth the effective discount rate offered for MAC’d drugs. Notwithstanding the provisions of Appendix A, the effective MAC rate (both retail and mail) is an annual average discount off AWP. The State understands that the MAC amounts Contractor pays Participating Pharmacies may be different from the amounts charged to the State.
5. The State will promptly notify the Contractor if it has reason to believe that it will not be able to pay invoices as required in this Section, for any reason. Upon such notice, Contractor may suspend performance of its duties at such time as payment actually stops if mutually agreeable arrangements for subsequent payments have not been made. If the State is late in payment by more than two weeks for each of any two invoices in any one-year period, the Contractor may give notice to the State that it will suspend performance of its duties after one week if mutually agreeable arrangements for payment have not been made.

APPENDIX B

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

7 State of Michigan

Please note, all guarantees, excluding the implementation guarantees, are for the initial term of the Contract.

The performance guarantees offered will become effective from the date of implementation if a contract is executed prior to the effective date.

In the event the plan is implemented without a signed contract the performance guarantees will become effective within 30 days of the signed contract.

Express Scripts (ESI) shall have no liability for the reporting of performance guarantees or performance guarantee penalties during any period ESI is administering the plan without an executed contract.

Terms and Conditions

All guarantees, excluding the implementation guarantees, are for the initial term of the contract. \$.25 per script will be put at risk for the financial and performance guarantees as set out below. The State of Michigan may allocate in advance the penalties to each guarantee with up to 10% of the total penalty towards any one guarantee. In no event, shall the sum of the payments to State of Michigan, as a result of ESI's failure to meet any performance guarantees, exceed \$.25 per claim annually (excluding clinical program guarantees). The performance guarantees are based on an enrollment of 135,000 members on June 1, 2003.

Within 45 business days after the end of each calendar quarter, ESI shall provide State of Michigan with a report assessing ESI's performance under each performance guarantee. In the event ESI does not meet a performance guarantee, ESI will calculate the applicable amount due to State of Michigan within 90 days after the end of the contract year

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Implementation

Service Feature
Implementation and Start-up
Guarantees
<p>Express Scripts will guarantee the implementation of the State of Michigan to be completed in accordance within the mutually agreed upon timelines stated below. Each of the Express Scripts guarantees are dependent upon receiving specific information from the State of Michigan.</p> <p>Express Scripts Assumptions:</p> <ul style="list-style-type: none">• All Implementations are a 90 day implementation project.• Loading of eligibility and production of ID cards are dependent upon receiving group structure and benefit plan design sign off from the State of Michigan.• A delay in receipt of data or information from the State of Michigan may require rescheduling of all subsequent deliverable dates. <p>Group Structure, Benefit Plan Design The group structure and benefit plan design will be entered <i>in the Express Scripts system</i> by <u>05/13/2003</u>. This guarantee is dependent on receiving final sign-off from the State of Michigan on the Benefit Plan Design Summary Document by <u>05/09/2003</u>.</p> <p>Eligibility Load Participant eligibility will be loaded by <u>05/13/2003</u>. This guarantee is dependent upon receiving a test file from the State of Michigan's third party vendor, Blue Cross Blue Shield of Michigan by <u>04/15/2003</u> with all corrections, if necessary, completed and re-tested by <u>04/31/2003</u>.</p> <p>ID Cards Mailing of prescription ID cards will commence on <u>05/21/2003</u> to the State of Michigan Retirees. This guarantee is dependent on receiving the eligibility production file from the State of Michigan's third party vendor, Blue Cross Blue Shield of Michigan by <u>05/05/2003</u> and an updated address file for Retirees from the State of Michigan's Office of Retirement Services by <u>05/13/2003</u> to be used for the card production extract for Retirees. This guarantee is also dependent on the State of Michigan's sign-off on sample materials, if requested, by <u>05/01/2003</u>.</p> <p>Toll Free Telephone Number A single integrated and dedicated toll-free telephone number is currently activated for retail service assistance. This dedicated toll-free telephone number will also be maintained for mail service assistance effective <u>06/01/2003</u>.</p> <p>Communications The Express Scripts Implementation Project Manager will provide regular updates to the State of Michigan during scheduled weekly meetings tracking the status of the implementation.</p> <p>A completed State of Michigan implementation sign-off manual (post-implementation tool kit) will be provided to the State of Michigan five business days prior to the effective date.</p>

The Express Scripts Implementation Project Manager will conduct a post-implementation review meeting with the **State of Michigan** within 30 days after the effective date.

Penalty

ESI will put 10% of the penalty as a total amount at risk.

Penalties are paid annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Account Management

Service Feature
Account Management - Satisfaction
Guarantee
Express Scripts Inc. (ESI) guarantees that the State of Michigan satisfaction with the Account Management Services are rated as satisfactory. ESI and the State of Michigan will mutually agree on clearly defined and measurable metrics. The following categories may be measured annually: <ul style="list-style-type: none">• Timely issues resolution by the account management team (e.g. issues resolvable by account management are acknowledged, responded to within 24 hours and closed within a reasonable period of time). (25% of total amount of penalty at risk)• Consultative services. (25% of total amount of penalty at risk)• Timeliness of reporting and annual reviews (25% of total amount of penalty at risk)• Frequency of meetings/plan updates. (25% of total amount of penalty at risk)
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are annual measurements and paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Client Services Admin.

Service Feature
Satisfaction Survey
Guarantee
One random sample member survey will be completed annually on a client specific basis. ESI guarantees a satisfaction rate of 90% responses of satisfied or very satisfied.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are annual measurements and paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Call Center

Service Feature
Customer Service Call - Average Speed of Answer
Guarantee
Express Scripts Inc. (ESI) guarantees that calls will be answered in an annual average of 30 seconds or less with the exception of a failure in a third party communication system. Express Scripts Inc. (ESI) also guarantees that 90% of the calls will be answered in 30 seconds or less with the exception of a failure in a third party communication system. This guarantee is predicated on the installation of a toll free telephone number unique to the State of Michigan . This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are based on annual average measurements and are paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Call Center

Service Feature
Customer Service Response Time – Blockage Rate (Busy Signal)
Guarantee
Express Scripts Inc. (ESI) will guarantee an annual blockage rate of 2% or less with the exception of a failure in a third party communication system. Blockage is defined as a caller receiving a busy signal. This guarantee is predicated on the installation of a toll-free number unique to the State of Michigan . This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are based on the annual average blockage rate and are paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Call Center

Service Feature
Customer Service Response Time to Written Inquiries
Guarantee
Express Scripts Inc. (ESI) will guarantee that annually 95% or more of written inquiries will be responded to within 5 business days, and that annually 100% of written inquiries will be responded to within 10 business days. This standard will be measured and reported quarterly
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are based on annual average response times and are paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Call Center

Service Feature
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
Express Scripts Inc. (ESI) guarantees that the annual call abandonment rate will be 4% or less with the exception of a failure in a third party communication system. The abandonment rates do not include calls terminated by members in less than 30 seconds. This guarantee is predicated on the installation of a toll-free number unique to State of Michigan. This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are based on the annual average abandonment rate and are paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Mail Service

Service Feature
Turnaround Time for Prescriptions
Guarantee
Express Scripts Inc. (ESI) guarantees dispensing and shipping of prescriptions not subject to intervention with an annual average of 2 business days of receipt of the order at ESI's Pharmacy. Express Scripts Inc. (ESI) also guarantees dispensing and shipping of all prescriptions with an annual average of 5 business days of receipt of the order at ESI's Pharmacy. "Interventions" include all calls to members or prescribers to clarify the prescriber's direction, to obtain consent for formulary programs, generic or therapeutic substitution, or otherwise. This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the penalty as a total amount at risk. A 5% penalty will be incurred for prescriptions not subject to intervention that are not delivered within an average of 2 business days and a 5% penalty for all prescriptions not delivered within an average of 5 business days . Penalties are based on annual averages and are paid out annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Reporting

Service Feature
Timely Production of Management Reports
Guarantee
Express Scripts Inc. (ESI) guarantees the following time schedule for access to the agreed upon management report information: Standard Printed Management Reports <ul style="list-style-type: none">• The reports provided on a quarterly basis will be produced within an annual average of 45 days after the end of the quarter. This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the annual penalty as a total amount at risk. The penalty will be measured based on the quarterly result and paid out annually. Each quarter will equate to ¼ of the annual amount at risk. Penalties are measured quarterly and paid annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Electronic Adjudication

Service Feature
Point-of-Service (POS) Claims Accuracy
Guarantee
Express Scripts Inc. (ESI) guarantees that 100% of POS claims will be processed and paid accurately. This guarantee is contingent upon the claims adjudication system set-up being 100% accurate. Claims adjudication will be tested prior to the contract start date and acknowledged in writing as 100% accurate by the State of Michigan . Claims accuracy will be measured annually via a statistically valid sample of claims.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are measured and paid annually.

EXPRESS SCRIPTS, INC.

Performance Guarantees for:

STATE OF MICHIGAN

Paper Claims

Service Feature
Paper Claims Processing Time
Guarantee
Turnaround time will be within an annual average of ten business days for all retail member submitted claims. Turnaround time is measured beginning the day the claim is received by Express Scripts to the day the claim is processed. This standard will be measured and reported quarterly.
Penalty
ESI will put 10% of the penalty as a total amount at risk. Penalties are annual measurements and will be paid annually.

APPENDIX C

AUDIT PROTOCOL

1. Audit Principles

Express Scripts recognizes the importance of Sponsors ensuring the integrity of their business relationship by engaging from time to time in audits of their financial arrangements with Express Scripts, and will make every reasonable effort to address Sponsor concerns by facilitating a responsive and responsible audit process.

Subject to the provisions of the Agreement regarding Sponsor audits, Express Scripts and Sponsor agree that this Standard Audit Protocol is intended to facilitate Sponsor's audit of Express Scripts by: (a) clearly defining the scope of the review to be performed; (b) enabling production of timely and accurate results; (c) minimizing administrative burdens on both parties; and (d) ensuring that standard accounting and auditing practices are followed.

2. Audit Prerequisites and Procedures

- A. An audit involves a review of more than three months of claims data, and addresses broad operational areas including claim pricing accuracy, concurrent eligibility, formulary compliance and, when applicable, rebates. General claim inquiries, which do not require an audit, can be initiated by contacting Sponsor's Express Scripts Account Management team at any time.
- B. Sponsor agrees to supply a written request to begin an audit, which includes a clear definition of the intent and scope of the audit, after which Express Scripts will retrieve necessary data to perform the audit in a time frame not to exceed thirty (30) days.
- C. Due to the extraordinary demands placed on Express Scripts' staff during the annual renewal period of December and January, no audits may be initiated or conducted during these months.

3. Auditing Prescription Claims

- A. If requested, Express Scripts will supply Sponsor with claim detail history on CD-ROM in NCPDP standard fields.
- B. The initial audit scope will cover a period not to exceed eighteen (18) months immediately preceding the audit. Requests for older data may be subject to payment of fees for retrieval of data from off-site storage. Any request for payment of fees must be approved through a contract change notice by Acquisition Services.
- C. Most audits can be performed remotely via transfer of data on CD-ROM, hardcopy documents, etc. Any requested on-site audits shall be conducted during normal business hours at Express Scripts offices, during the months of February through November.
- D. Other Express Scripts documentation (e.g. policies and procedures) requested during the course of the audit, other than that needed to determine the accuracy of Sponsor claims payments, will be provided at Express Scripts' reasonable discretion.

- E. Sponsor will be given data reasonably sufficient for Sponsor to determine that Express Scripts has billed Sponsor in accordance with contract terms for claims processing.
- F. Results of Express Scripts' most recent SAS-70 audit conducted by a national accounting firm will be provided upon request. The Sponsor Audit may not duplicate a SAS-70 control audit regarding areas for which Express Scripts has obtained a SAS-70 audit. However, this does not preclude Sponsor from obtaining a reasonable understanding from Express Scripts personnel of any areas covered within the SAS-70 audit.
- G. During the course of an audit, all data, including claims detail and any copies of claims (or compilations thereof) supplied by Express Scripts may be retained by Sponsor.

4. Auditing Rebates from Manufacturers

- A. The initial scope of any rebate audit may not exceed two (2) calendar quarters during the twelve month period immediately preceding the audit. In the event findings from the initial review period warrant an increase in calendar quarters to be reviewed, Express Scripts and Sponsor will mutually agree on a process by which additional calendar quarters may be reviewed by Sponsor.
- B. Express Scripts' contracts with pharmaceutical manufacturers for drug product rebates are highly confidential and proprietary. Nevertheless, Sponsor may audit payments under rebate contracts applicable to Sponsor, and may select five (5) initial manufacturer contracts to be audited, or such larger initial number of contracts that will enable Sponsor to audit fifty percent (50%) of total rebate payments due to Sponsor. In the event findings from the initial rebate contract audits warrant an increase in the number of contracts to be audited, Express Scripts and Sponsor will mutually agree on a process by which additional contracts may be reviewed by Sponsor.
- C. Express Scripts will use reasonable best efforts to obtain manufacturer consent to disclose such contracts when such consent is required. In the event that a selected manufacturer declines to permit Sponsor to review the applicable rebate rate components, then Express Scripts will use its best reasonable efforts to secure permission from one or more additional manufacturers of Sponsor's choice which will enable Sponsor to meet the initial targets of five (5) manufacturer contracts and fifty percent (50%) of total rebate payments as set forth in paragraph 4B above.
- D. Express Scripts will permit Sponsor to perform an on-site review of the applicable rebate rate components of the manufacturer rebate agreements which are relevant and necessary to audit the calculation of the rebate payments made to Sponsor by Express Scripts for the selected drugs.
- E. Sponsor should bring, or otherwise supply its independent auditor with, the most recent Allocation Report (PSG) or Sponsor Share Report (MS), which should be brought to the on-site rebate audit. Additional reasonable charges may occur if Express Scripts is asked to re-produce these reports.
- F. Sponsor will not be permitted to copy or retain any such manufacturer agreements (in part or in whole) or documents provided or made available by Express Scripts in connection with the rebate audit. Sponsor will be entitled, however, to take and retain

notes to the extent necessary to document any identified exceptions. Express Scripts shall be entitled to review any notes to affirm compliance with this paragraph.

5. Verification or Explanation of Disputed Claims

- A. After Express Scripts has supplied the claims data, Sponsor will provide Express Scripts with a written exception report stating the entire error population, if any, and dollar amount associated with such errors. In addition to the written report, Sponsor will provide an electronic extrapolation of errors representative of the entire population of errors not to exceed an initial compilation of 200 (hereafter referred to as “representative sample”).
- B. Express Scripts will research and investigate the “representative sample” within thirty (30) days. If additional time is reasonably required, Express Scripts will notify Sponsor within these thirty (30) days.
- C. In the event findings warrant an increase in the representative sample of drug claims or the scope of the rebate audit period, Express Scripts and Sponsor shall mutually determine the scope of such increase.
- D. Overpayments or underpayments shall be promptly paid and/or credited by Express Scripts (or the Sponsor, as the case may be).

APPENDIX C, ATTACHMENT I

CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT (the "Agreement") is made and entered into as of _____, 200__, by and between EXPRESS SCRIPTS, INC. ("ESI") and _____ ("Recipient").

RECITALS

1. ESI, either directly or through its subsidiaries, engages in a variety of health care businesses, including, among other things, pharmacy benefit management, disease and demand management, specialty pharmaceutical distribution and medical information management.
2. ESI has been administering a prescription drug benefits program for [employees] [members] and their eligible dependents of _____ (Sponsor) _____ (the "Prescription Drug Program").³⁷⁴
3. Recipient is an audit firm and has been engaged by _____ (Sponsor) _____ to conduct an audit of certain data in connection with the Prescription Drug Program. In connection therewith, it is necessary for ESI to provide Recipient with certain Confidential Information (as defined below).

TERMS AND CONDITIONS

1. As used in this Agreement, the term "Confidential Information" includes any information, written or oral, that Recipient receives from ESI or from one of ESI's subsidiaries or affiliates in connection with the audit described above, including all copies thereof; provided, that the Confidential Information shall not include any information that (a) is or becomes generally known to the public by a source other than Recipient or its employees or agents, (b) is in possession of Recipient prior to the date hereof, (c) is independently developed by Recipient under circumstances not involving a breach of this Agreement by Recipient, (d) is acquired by Recipient from a third party who is not under an obligation of confidentiality to ESI or without a breach of this or a similar agreement, or (e) is publicly disclosed pursuant to a lawful requirement or request from a governmental agency acting within its jurisdiction, or nonconfidential disclosure is otherwise required by law. "Confidential Information" is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, et seq..
2. Recipient shall use the Confidential Information it receives pursuant to this Agreement for the sole purpose of auditing the prescription drug management services, and in no event shall disseminate or communicate the Confidential Information in any form to any other person or entity without the express written consent of ESI.
3. Recipient shall disclose Confidential Information only to persons within its organization who (a) are required to protect and otherwise not disclose or use the Confidential Information except as provided in this Agreement, and (b) need to know the Confidential Information. Such persons who receive any Confidential Information shall be made aware of the terms of this Agreement and shall agree to be bound thereby.

4. Any reports, documents or other information in whatever form or medium which are derived or result from the receipt of Confidential Information shall be governed by the same terms and conditions respecting confidentiality and use as is the Confidential Information itself.

5. All Confidential Information of ESI shall be and remain the property of ESI. Recipient shall not obtain any rights in or to the Confidential Information as a result of such disclosure. Upon ESI's request, Recipient shall promptly destroy or return to ESI all of ESI's Confidential Information, including all copies thereof. Upon ESI's request, an authorized representative of Recipient shall certify to ESI that all Confidential Information has been destroyed or returned to ESI.

6. Recipient shall indemnify, defend and hold ESI harmless from any and all claims, penalties, liabilities, losses, damages, settlements or costs which may arise (i) from ESI's provision of Confidential Information to Recipient, or (ii) from Recipient's use of Confidential Information. Such indemnification only applies to third party auditors. The State of Michigan and its employees do not agree to indemnification.

6. This Agreement shall remain in full force and effect for a period of three years from the date hereof. This Agreement may not be amended except in writing, signed by both parties.

7. This Agreement shall be governed by and construed in accordance with the internal laws of Michigan.

8. Each of ESI's affiliates are intended third party beneficiaries of this Agreement, and may enforce this Agreement in their own name.

EXPRESS SCRIPTS, INC.

By: _____

Name: Kelley R. Elliott

Title: Director, Internal Audit

STATE OF MICHIGAN

By: _____

Name: _____

Title: _____

APPENDIX D

FINANCIAL DISCLOSURE TO ESI PBM CLIENTS

In addition to the administrative fees paid to us by our clients we derive our margin in one or more of the following ways. These other revenue sources have allowed us to keep our administrative fees to our clients low. The specific terms of our contracts with our clients will affect the relative importance of these sources of margin with respect to that client.

1. Network Pharmacy Contracts. – We contract with retail pharmacies in our networks to provide prescription drugs to members of health plans sponsored by our clients. The rates paid to these pharmacies differ from network to network, and among pharmacies within a network. We generally contract with our clients to be paid an ingredient cost for drugs dispensed in a retail network at a uniform rate that applies to all pharmacies in the network that the client has selected for its plan. Thus, we may realize a positive or negative margin on any given prescription.

2. Mail Pharmacy Rates. – We purchase prescription drugs to be dispensed from our mail service pharmacies either from a prescription drug wholesaler or directly from the manufacturer. Our contracts with our clients contain rates that we will be paid for dispensing these drugs that may be greater or less than our acquisition cost on any given prescription. In general we realize an overall positive margin between our acquisition cost and the amount we are paid.

3. Manufacturer Rebate Contracts and Associated Administrative Fees. – Under our contracts with many of our clients we contract with pharmaceutical manufacturers for retrospective discounts, or rebates, on certain branded prescription drugs. We typically pay a portion of the rebate to the client, and in such cases our contract specifies the times within which we must pay these rebates to the client. We usually receive rebates from the manufacturer before we have to pay this amount to our client, and we retain the benefit of the use of these funds until we pay these amounts to the client. If a client has contracted to receive a portion of the rebate, the client has rights to audit our computation of these payments. We maintain extensive systems and processes to manage the rebate program and the formularies they support. We charge manufacturers administrative fees in connection with these programs. These fees, which we retain, do not exceed 3.5% of the AWP of the drugs for which rebates are payable under our agreements. For a complete description of our formulary development process, go to www.express-scripts.com.

4. Other Pharmaceutical Manufacturer Revenues. We currently receive other payments from pharmaceutical manufacturers that are not part of our rebate program. These payments help support certain programs, such as our Drug Choice Management Program and our Therapy Adherence Program, that support our client's formulary choices. When we receive manufacturer financial support for these programs we disclose in our program communications that one or more

manufacturers have provided financial support for the program. We have been reducing manufacturer funding for drug-specific programs, and the amounts we receive for these programs are not material to our revenues. Manufacturer funding of these programs will be fully phased out by October 1, 2003. We will continue to provide formulary support programs to our clients without this targeted manufacturer funding.

5. Other Companies. Separate from our PBM services, our subsidiaries, Phoenix Marketing Services and ESI Specialty Distribution Services, contract with pharmaceutical manufacturers to provide sample accountability and distribution services and specialty pharmaceutical distribution, respectively.

THIS EXHIBIT REPRESENTS ESI'S CURRENT FINANCIAL POLICIES. THIS EXHIBIT MAY NOT BE REVISED OR MODIFIED. ESI MAY PERIODICALLY UPDATE ITS FINANCIAL DISCLOSURES TO REFLECT CHANGES IN ITS BUSINESS PROCESSES. IN THE EVENT OF AN UPDATE, ESI SHALL PROVIDE THE NEW FINANCIAL DISCLOSURE TO SPONSOR.

APPENDIX E

HIPAA BUSINESS ASSOCIATE ADDENDUM

The parties to this Business Associate Addendum (“Addendum”) are the State of Michigan, acting by and through the Department of Management and Budget, on behalf of the Department of _____ (“State”) and Express Scripts, Inc., (“Contractor”). This Addendum supplements and is made a part of the existing contract(s) or agreement(s) between the parties including the following Contract(s): _____ (“Contract”).

For purposes of this Addendum, the State is (check one):

- Covered Entity (“CE”)
- Business Associate (“Associate”)

and Contractor is (check one):

- Covered Entity (“CE”)
- Business Associate (“Associate”)

RECITALS

- A. Pursuant to the terms of the Contract, CE wishes to disclose certain information to Associate, some of which may constitute Protected Health Information (“PHI”) (defined below). In consideration of the receipt of PHI, Associate agrees to protect the privacy and security of the information as set forth in this Addendum.
- B. CE and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to the Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the “HIPAA Regulations”) and other applicable laws, as amended.
- C. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) requires CE to enter into a contract containing specific requirements with Associate prior to the disclosure of PHI, as set forth in, but not limited to, 45 CFR §§ 160.103, 164.502(e), 164.504(e), and 164.314 and contained in this Addendum.

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

1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum shall have the definitions set forth in the HIPAA Regulations at 45 CFR Parts 160, 162 and 164, as amended, including, but not limited to, subpart A, subpart C (“Security Rule”) and subpart E (“Privacy Rule”). The applicable effective date of the provisions of this Addendum relating to the Privacy Rules shall be April 14, 2003, and April 21, 2005 for provisions relating to the Security Rules.

b. “Agreement” means both the Contract and this Addendum.

c. “Contract” means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added.

d. “Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR § 164.501.

e. “Protected Information” shall mean PHI provided by CE to Associate or created or received by Associate on CE’s behalf.

2. Obligations of Associate.

a. Permitted Uses. Associate shall not use Protected Information except for the purpose of performing Associate’s obligations under the Contract and as permitted under this Agreement. Further, Associate shall not use Protected Information in any manner that would constitute a violation of the HIPAA Regulations if so used by CE, except that Associate may use Protected Information: (i) for the proper management and administration of Associate; (ii) to carry out the legal responsibilities of Associate; or (iii) for Data Aggregation purposes for the Health Care Operations of CE. Additional provisions, if any, governing permitted uses of Protected Information are set forth in Attachment A to this Addendum.

b. Permitted Disclosures. Associate shall not disclose Protected Information in any manner that would constitute a violation of the HIPAA Regulations if disclosed by CE, except that Associate may disclose Protected Information: (i) in a manner permitted pursuant to the Contract and this Addendum; (ii) for the proper management and administration of Associate; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; or (v) to report violations of law to appropriate federal or state authorities, consistent with 45 CFR § 164.502(j)(1). To the extent that Associate discloses Protected Information to a third party, Associate must obtain, prior to making any such disclosure: (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third

party; and (ii) an agreement to implement reasonable and appropriate safeguards to protect the Protected Information; and (iii) an agreement from such third party to immediately notify Associate of any breaches of confidentiality of the Protected Information or any Security Incident, to the extent it has obtained knowledge of such breach. Additional provisions, if any, governing permitted disclosures of Protected Information are set forth in Attachment A.

c. Appropriate Safeguards. Associate shall implement appropriate Security Measures as are necessary to protect against the use or disclosure of Protected Information other than as permitted by the Contract or this Addendum. Associate shall maintain a comprehensive written information privacy and security program that includes Security Measures that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of Protected Information relative to the size and complexity of the Associate's operations and the nature and scope of its activities.

d. Reporting of Improper Use or Disclosure. Associate shall report to CE in writing any use or disclosure of Protected Information, whether suspected or actual, other than as provided for by the Contract and this Addendum within ten (10) days of becoming aware of such use or disclosure.

e. Associate's Agents. If Associate uses one or more subcontractors or agents to provide services under this Agreement, and such subcontractors or agents receive or have access to Protected Information, each subcontractor or agent shall sign an agreement with Associate containing substantially the same provisions as this Addendum and further identifying CE as a third party beneficiary of the agreement with such subcontractors or agents in the event of any violation of such subcontractor or agent agreement. Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

f. Access to Protected Information. Associate shall make Protected Information regarding an Individual or CE maintained by Associate or its agents or subcontractors in Designated Record Sets available to such Individual for inspection and copying in order to meet the requirements of 45 CFR § 164.524.

g. Amendment of Protected Information. Associate agrees to make any amendment(s) to Protected Information in a Designated Record Set to meet the requirements of 45 CFR § 164.526 at the request of an Individual or CE.

h. Accounting Rights. Associate agrees to respond to a request by an Individual or CE for an accounting of disclosures of Protected Information in accordance with, 45 CFR § 164.528. Associate agrees to document such disclosures of Protected Information and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of Protected Information in accordance with 45 CFR § 164.528.

i. Governmental Access to Records. Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), in a

time and manner designated by the Secretary, for purposes of determining CE's compliance with the HIPAA Regulations. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

j. Minimum Necessary. Associate (and its agents or subcontractors) shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure, in accordance with the Minimum Necessary requirements of the Privacy Rule, including, but not limited to 45 CFR §§ 164.502(b) and 164.514(d).

k. Reserved.

l. Retention of Protected Information. Notwithstanding Section 5(d) of this Addendum, Associate and its subcontractors or agents shall retain all Protected Information throughout the term of the Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) years from the date of creation or the date when it last was in effect, whichever is later, or as required by law. This obligation shall survive the termination of the Contract.

m. Destruction of Protected Information. Associate agrees to implement policies and procedures for the final disposition of electronic Protected Information and/or the hardware and equipment on which it is stored, including but not limited to, removal before re-use.

n. Notification of Breach. During the term of the Contract or this Addendum, Associate shall notify CE within ten (10) business days of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations. CE and Associate will cooperate to mitigate the effects on any breach, Security Incident, intrusion, or unauthorized use and document the Security Incident and its outcome.

Audits, Inspection and Enforcement. Within ten (10) business days of a written request by CE, Associate and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE or Associate shall execute a nondisclosure agreement, if requested by Associate or CE. The fact that CE inspects, or fails to inspect, or has the right to inspect,

Associate's systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under this Agreement.

Safeguards During Transmission. Associate shall be responsible for using Security Measures to reasonably and appropriately maintain and ensure the Confidentiality, Integrity, and Availability of Protected Information transmitted to CE pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Regulations, until such Protected Information is received by CE, and in accordance with any specifications set forth in Attachment A.

3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using Security Measures to reasonably and appropriately maintain and ensure the Confidentiality, Integrity, and Availability of Protected Information transmitted to Associate pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Regulations, until such Protected Information is received by Associate, and in accordance with any specifications set forth in Attachment A.

b. Notice of Changes. CE shall provide Associate with a copy of its notice of privacy practices produced in accordance with 45 CFR § 164.520, as well as any subsequent changes or limitation(s) to such notice, to the extent such changes or limitations may effect Associate's use or disclosure of Protected Information. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent it may affect Associate's permitted or required uses or disclosures. To the extent that it may affect Associate's permitted use or disclosure of Protected Information, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 CFR § 164.522.

4. Term. This Addendum shall continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Regulations, whichever first occurs. However, certain obligations will continue as specified in this Addendum.

5. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of the Agreement and shall provide grounds for termination of the Contract by CE pursuant to the provisions of the Contract covering termination for cause after thirty (30) days' notice to cure. If the Contract contains no express provisions regarding termination for cause, the following shall apply to termination for breach of this Addendum, subject to 5.b.:

(1) Default. If Associate refuses or fails to timely perform any of the provisions of this Addendum, CE may notify Associate in writing of the non-performance, and if not corrected within thirty (30) days, CE may immediately terminate the Agreement. Associate shall continue performance of the Agreement to the extent it is not terminated.

(2) Associate's Duties. Notwithstanding termination of the Agreement, and subject to any directions from CE, Associate shall take timely, reasonable and necessary action to protect and preserve property in the possession of Associate in which CE has an interest.

(3) Compensation. Payment for completed performance delivered and accepted by CE shall be at the Contract price.

(4) Erroneous Termination for Default. If after such termination it is determined, for any reason, that Associate was not in default or that Associate's action/inaction was excusable, such termination shall be treated as a termination for convenience, and the rights and obligations of the parties shall be the same as if the contract had been terminated for convenience, as described in this Addendum or in the Contract.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement and does not terminate this Agreement pursuant to Section 5(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate this Agreement, if feasible or (ii) if termination of this Agreement is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Reserved.

d. Effect of Termination.

(1) Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Associate shall return or destroy all Protected Information that Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If Associate elects to destroy the Protected Information, Associate shall certify in writing to CE that such Protected Information has been destroyed.

(2) If Associate believes that returning or destroying the Protected Information is not feasible, including but not limited to, a finding that record retention requirements provided by law make return or destruction infeasible, Associate shall promptly provide CE notice of the conditions making return or

destruction infeasible. Upon mutual agreement of CE and Associate that return or destruction of Protected Information is infeasible, Associate shall continue to extend the protections of Sections 2(a), 2(b), 2(c), 2(d) and 2(e) of this Addendum to such information, and shall limit further use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible.

6. Reserved.

7. No Waiver of Immunity. No term or condition of this Agreement shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Michigan Governmental Immunity Act, MCL 691.1401, *et seq.*, the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.*, or the common law, as applicable, as now in effect or hereafter amended.

8. Reserved.

9. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Addendum, HIPAA or the HIPAA Regulations will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of Protected Information.

10. Reserved.

11. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the Privacy Rule, the Security Rule and other applicable laws relating to the security or privacy of Protected Information. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Agreement when requested by CE pursuant to this Section or (ii) Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws.

b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

12. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, to the extent that the time required of them is reasonable under the circumstances, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy of Protected Information, except where Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract shall remain in force and effect. This Addendum is incorporated into the Contract as if set forth in full therein. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Associate and CE expressly waives any claim or defense that this Addendum is not part of the Agreement between the parties under the Contract.

15. Interpretation and Order of Precedence. This Addendum is incorporated into and becomes part of each Contract identified herein. Together, this Addendum and each separate Contract constitute the "Agreement" of the parties with respect to their Business Associate relationship under HIPAA and the HIPAA Regulations. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Regulations. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations. This Addendum supercedes and replaces any previous separately executed HIPAA addendum between the parties. In the event of any conflict between the mandatory provisions of the HIPAA Regulations and the provisions of this Addendum, the HIPAA Regulations shall control. Where the provisions of this Addendum differ from those mandated by the HIPAA Regulations, but are nonetheless permitted by the HIPAA Regulations, the provisions of this Addendum shall control.

16. Effective Date. Subject to the provisions of Section 1a hereof, this Addendum is effective upon receipt of the last approval necessary and the affixing of the last signature required.

17. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate's obligations under Section 5(d) and record retention laws ("Effect of Termination") and Section 13 ("No Third Party Beneficiaries") shall survive termination of this Agreement and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate.

18. Representatives and Notice.

a. Representatives. For the purpose of this Agreement, the individuals identified in the Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby designated as the parties' respective representatives for purposes of this Agreement. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____

Business Associate Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____

Any notice given to a party under this Addendum shall be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third (3rd) Business Day after being sent by certified or registered mail.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

Associate

Covered Entity

[INSERT NAME]

[INSERT NAME]

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

ATTACHMENT A

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum dated _____, between _____ and _____ (“Addendum”) and is effective as of _____ (the “Attachment Effective Date”). This Attachment applies to the specific contracts listed below covered by the Addendum. This Attachment may be amended from time to time as provided in Section 11(b) of the Addendum.

1. Specific Contract Covered. This Attachment applies to the following specific contract covered by the Addendum: _____

2. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may use Protected Information as follows: _____

3. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may disclose Protected Information as follows: _____

4. Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Information in the course of assisting Associate in the performance of its obligations under the Contract and the Addendum: _____

5. Receipt. Associate’s receipt of Protected Information pursuant to the Contract and Addendum shall be deemed to occur as follows, and Associate’s obligations under the Addendum shall commence with respect to such PHI upon such receipt:

6. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the use and disclosure of Protected Information:
