Date: March 26, 2026

RFP Number: 270-20260216PBMS

RFP Description: Pharmacy Benefit Management Services

Addendum Number: 4

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Antonio Leathers

Opening Date / Time: March 2, 2026 @ 10:00 a.m. ET

INSTRUCTIONS:

1. This Addendum is issued in response to questions submitted.

2. RFP Section 8.0 “Deliverables, Performance Guarantees, and Fee Reductions” is amended to update contract compliance and performance requirements and is restated as 8.0 “First Amended and Restated Contract Performance, Deliverables, Performance Guarantees, and Fee Reductions”.

3. Return two (2) properly executed originals of this Addendum Number 4 with your Minimum Requirements Proposal. Failure to sign and return this Addendum Number 4 may result in the rejection of your proposal.

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Execute Addendum Number 4, RFP Number 270-20260216PBMS:

Vendor: _____

Authorized Signature: _____

Name and Title (Print): _____

_____

Date: _____

No.	Reference	Vendor Question	Answer
1	Attachment O-1, Q 16	Please define “logic sharing,” “data sharing,” and “program information” listed in in requirement 5.3.2.2.5 and provide examples for each.	Logic sharing refers to how systems, programs and/or data files are configured. The Plan included data sharing in this requirement to understand what data the Vendor will and will not provide to the Plan. Program information includes the details about how a Vendor’s program, or a program controlled by another entity, such as a manufacturer, operates. The Plan is looking for complete transparency.
2	Attachment O-1, Q 19	Please confirm that the BRD listed in the Business Requirement Document, which reflects 98% is correct, as it conflicts with section 5.3.4.2. b. which states “99% pass through for EDI loads.”	5.3.4.2.b. is correct. The BRD is a sample. Per 5.3.4.2.a., the requirements will be similar to those outlined in Attachment 1 PBM EES Business Requirements BRD.
3	Attachment O-3, Q 10	Please confirm that the requested list of Government Relations staff is limited to individuals who are registered lobbyists and does not extend to other employees who may have general public policy, regulatory, or governmental affairs responsibilities but are not registered lobbyists.	Confirmed.
4	Section 4.7, Background Checks pg 33	Section 4.7(e) requires disclosure of “any civil litigation, arbitration, proceeding, or judgments pending against the Vendor during the three years preceding submission of its proposal.” Please confirm that this requirement applies only to civil litigation pending against the Vendor entity itself and does not extend to civil litigation involving the Vendor’s individual employees, officers, directors, or other personnel, except to the extent such matters are expressly covered elsewhere in Section 4.7.	Yes, the civil litigation, arbitration, proceedings, or judgement being inquired about in Section 4.7 (e) relates to the Vendor entity.
5	Sections 4.7(e) and 5.3.1.2.4(c)	Please confirm that, when read together, Sections 4.7(e) and 5.3.1.2.4(c) require the Vendor to notify the Plan only of civil litigation, arbitration, proceedings, or other legal matters that impact the Plan or Plan Members, and that such notification is required within ten (10) State Business Days of the Vendor becoming aware of the matter. For clarity, please confirm that these provisions do not require disclosure of all	Yes, the civil litigation, arbitration, proceedings, or judgement being inquired about in Section 4.7 (e) relates to the Vendor entity.

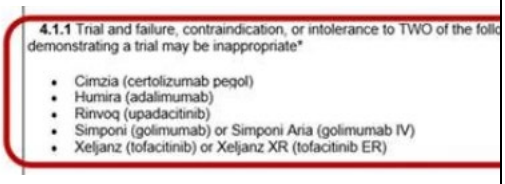
		civil litigation, arbitration, or proceedings involving the Vendor that do not impact the Plan or Plan Members.	
6	Section 5.3.1.1 Overview and Expectations, pg 42, second paragraph.	The section states, "...the primary Project Manager shall be housed within Module 1 Vendor and serve as the quarterback and ensure seamless integration." Please confirm that the Project Manager referenced in this statement is synonymous with the Project Manager referenced in Section 5.3.1.2 Account Management Requirements a.3).	Confirmed.
7	Section 5.3.1.1 Overview and Expectations (Module #1), pg 42, second paragraph; Also, Section 6.3.1.2.1.a. 2) Account Management Requirements (Module #2, pg 71; and Section, 7.3.1.2.b. 2) Account Managements Requirements (Module #3) pg 93	The section states, "Project Manager(s) - Responsible for the development and execution of the initial implementation plans by coordinating with the Plan and internal and external resources. The Project Manager shall remain dedicated to the Plan post Go-Live to track ongoing deliverables, oversee open enrollment testing and any other initiatives implemented by the Plan." Should a Vendor be awarded more than one module, please confirm that one Project Manager performing PM duties across multiple modules meets this requirement.	Confirmed.
8	Section 5.3.1.2 Account Management Requirements (Module #1) , Pg 42; Also, Section 6.3.1.2, Account Management Requirements (Module #2) pg 70 - 71; Also Section 7.3.1.2 Account Management Requirements (Module #3)	Each of these sections reference dedicated resources. Please confirm that should a Vendor be awarded more than one module, these same resources can be shared across multiple modules to support the contract.	Confirmed.
9	Section 5.3.1.2.3 Account Management Requirements (Module #1) pg 44. Additional references: 5.3.7.2.1 c (1) TPA and Other Vendor Integration Requirements pg 57. Attachment O-1, Q#8	The section states, "The Plan may determine after the award of the Contract that some Services should be carved out of this Module 1…." What are the services that the State envisions to be carved out of this module? Will the Plan consult with the selected Vendor(s) for input on downstream impacts, including data integration or costs, which may need to be adjusted accordingly?	Stronger Member engagement is an important focus for the Plan. If the Plan determines Vendor's Member touchpoints do not meet the Plan's expectations, these services may be outsourced to another vendor and/or platform. Similarly, if the Plan determines during the lifetime of the Contract that the Vendor is deficient in a certain area, the Plan may choose to seek a better solution. As noted, there will be sufficient runway to implement any such change. The Plan would expect the pricing to change if the

			Vendor is no longer required to provide a particular service. Bidders are encouraged to provide pricing for any customizations the Plan may request.
10	Sections 5.3.3.2.6, 5.3.3.2.8, 6.3.7.2.2, and 7.3.2.2.1	Please confirm these are not intended to require disclosure of other clients' pricing, contract terms, or confidential commercial information, and that the Vendor may instead support the Market Check through Plan specific data, objective market benchmarks, and/or third-party competitive analyses. Please confirm that nothing in these sections require the Vendor to violate confidentiality obligations owed to other clients or subcontractors, and that any Market Check will rely on nonidentifiable benchmarking or market data.	Vendors are not expected to disclose other clients' information. The Market Check will rely on unidentifiable benchmarking data.
11	Section 5.3.6.1 Overview and Expectations (Module #1), paragraph 2 last sentence pg 54	The section states, "the Vendor must also commit to supporting and assisting in the success of any third-party patient navigation tools selected by the Plan." Please provide examples or further clarification regarding the Plan's expectations for what activities are encompassed by "supporting and assisting in the success" of such tools and the anticipated scope of the Vendor's responsibilities.	The Plan is considering incorporating other vendors that offer adaptive engagement models to better support Plan Members. The need for such a vendor will be determined after the award of this Contract. The Plan will need to evaluate the Vendor's capabilities prior to making any decisions about what other vendor tools and resources may be needed. Should the Plan determine additional tools and/or resources are needed to support Plan Members, the Plan expects the Vendor/TPA to support whatever integration is required.
12	Section 5.3.7.2.1.b TPA and Other Vendor Integration Requirements, pg 57	The section notes, "This will require Vendor to enter into one or more agreements with Module 2 and/or Module 3 Vendor." Please confirm that the Vendor may use their own agreements to execute this requirement.	Confirmed.
13	Sections 5.3.9.2.2 or 6.3.10.3	Please confirm that nothing in these sections is intended to require the Vendor to disclose confidential or proprietary information relating to other clients or lines of business, and that the Plan's transparency expectations are limited to Plan specific data and revenue attributable to the Contract.	Confirmed.
14	Section 5.3.9.7, Reporting Requirements (Module 1) pg 62	Section 5.3.9.7.1(f) distinguishes between "noncomplex" ad hoc reports (which may be compiled within four (4) hours) and more	A non-complex report would be more of a widget counting exercise. For example, how

		"complex" ad hoc reports (subject to a longer turnaround). Please provide examples or additional clarification regarding the Plan's expectations for what constitutes a noncomplex versus a complex report, including the types of data sources, transformations, calculations, or integrations that would place a report into each category.	many knee replacement surgeries were performed by X provider during X period. A more complex report would require the Vendor to provide analysis. For example, to compare the knee replacement surgeries performed by multiple providers, at different locations and provide analysis on the total cost of care by provider.
15	Section 5.3.10.2 Part D Administration Requirements	Please confirm that the requirements outlined in this section, including the experience and track record referenced, are entirely optional for bidding Vendors, and that Vendors who do not propose Part D Administration services will not be evaluated, scored, or otherwise disadvantaged as a result of not offering these Optional Services.	Confirmed. This is an optional service. If the Vendor does not offer this service, no response is required and there is no negative consequence for not responding.
16	6.3.2.2(e)	Please confirm that Section 6.3.2.2(e) is not intended to require unrestricted participation in the Vendor's P&T Committee, and that participation is limited to topics directly impacting the Plan, consistent with the Plan's Formulary authority and the Vendor's confidentiality obligations to other clients.	Confirmed.
17	Section 6.3.5.2.1.a Audit and Other Review Requirements (Module #2) pg 76	This section provides the Plan and its auditors access to the Vendor's financial records, including manufacturer contracts, claims data, MAC Lists, remittance data, reports, and other information required to verify transparency and compliance with contractual terms. Please confirm that this access is limited to records, data, and contracts that relate to the Plan and the Services performed under this Agreement, and does not extend to financial records, manufacturer contracts, or data related to the Vendor's other clients or lines of business that are unrelated to the Plan.	Confirmed.
18	6.3.6.2(c)	Please confirm that Section 6.3.6.2(c) is not intended to require disclosure of unredacted books, records, or Rebate agreements unrelated to the Plan, and that the five (5) State Business Day production requirement applies only to Plan specific materials necessary to verify compliance with the Contract.	The intent is not to require disclosure of information that is not related to the Plan, but the Plan would expect access to documents that apply to the Plan as well as other Vendor customers.
19	Attachment O - 1 Module 1, Technical Requirements Response, Question #s: 7 - Plan Support, 8 - Carve-	Please confirm that Vendors can provide additional narrative in response to these Questions in addition to explaining any limitations related to the	Vendors can provide additional narrative in response to the RFP questions. Vendors should exercise due

	Outs,11 - Plan Authority, 12 - Requirements, 18 - Claims Adjudication and Transparency, 19 - Enrollment and EDI, 22 - Enrollment Audits, 24 - Group Set Up, 27 - Open Enrollment, 29 - Section 5.3.5.2.1, 31 - Call Center, 32 - Call Tracking & Recording, 35 - Custom Communication, 38 - Ongoing Testing and Implementation, 39 - Data Access & Transparency, 40 - Data Files, 41 - Data Matching and Identifiers, 43 - Retention and Access, 44 - Reporting Attachment O - 2 Module 2, Technical Requirements Response, Question #s: 16 - Pharmacy & Therapeutics Committee, 20 - General Audit Requirements, 21 - Standard and Annual Audits, 22 - Standard Quarterly Reviews, 24 - Vendor Contracts, 25 - Rebates, 29 - Data Files, 30 Data Access & Transparency, 31 - Data Matching & Identifier Requirements, 32 - Data Accuracy and Validation, 33 - Formulary and Financial, 34 - Retention & Access, 35 - Reporting Attachment O - 3 Module 3, Technical Requirements Response, Question #s: 11 - Plan Authority, 16 - Processing, Fulfillment and Delivery, 19 - Plan Audit Cooperation, 20 - Call Center, 21 - Call Tracking & Recording, 26 - Data Access and Transparency, 27 - Data Files, 28 - Data Matching and Identifier Requirements, 30 - Retention and Access, 31 - Standard Reports, 32 - Ad Hoc and Custom Reporting, 34 - Transition of Services,	requirements. Would the Plan please consider providing additional space for Vendors to provide narrative responses to each of the questions referenced? Alternatively, please confirm that it is appropriate for Vendors to provide additional narratives as supplemental attachments, as described in Section 5.3: “Vendor must confirm adherence to and describe its approach. This includes providing a detailed narrative, diagram, exhibits, examples, sketches, descriptive literature, and or detailed information, responsive to the questions. Vendor must clearly indicate the citation and location of these to demonstrate understanding of the ability to meet each specification."	diligence to ensure that its response is consistent with all instructions, clearly written and addressed the specific requirement and question of the RFP being addressed.
20	Attachment O- 1 Module 1, Technical Requirements Response, Questions #45, 46 and 47, Optional Services. Also, Attachment O -	Please confirm that Vendors who are not choosing to offer Optional Services may leave these questions blank in their response.	Confirmed.

	2 Module 2, Technical Requirements Response Question #36 - Optional Services. Also, Attachment O - 3 Module 3, Technical Requirements Response Question #33 - Optional Services.		
21	Attachment O-3, Q #34	Attachment O-3, Q #34 states "Vendor must confirm that it will meet the requirements set forth in Section 7.3.10.2." Please confirm that this question is meant to refer to 7.3.11.2, as there is no requirement numbered 7.3.10.2 in the RFP. Alternatively, please provide requirement 7.3.10.2 if it was accidentally omitted from the RFP.	Question #34 addresses the Transition of Services so the reference should be to Section 7.3.11.2 Transition of Services Requirement instead of 7.3.10.2.
22	Attachment O-3, Q 19.a (7.3.3)	The requirement reads "a. Vendor shall cooperate with the Plan in any audit it conducts of the Vendor. Such cooperation includes providing systems access to the Auditor and all data needed to complete the audit as determined by the Plan." Please describe the system access needed for the Auditor.	The Auditor must have view access to the claims adjudication systems; UM information and any other systems utilized by the Vendor to adjudicate the claim with the pharmacy and/or apply the manufacturer's coupon to the claim.
23	Section 7.3.3.2.1.c.	Section 7.3.3.2.1(c) references payment by check for mail order prescriptions. Please confirm whether the ability to accept payment by check is a mandatory requirement, or whether the Plan will accept alternative payment methods (e.g., credit cards or other electronic payment options). If payment by check is required, please clarify how the Plan would like Vendors to address this requirement if a Vendor's mail order operations do not support check payments, including whether an alternative accommodation or workflow would be acceptable.	Accepting a check is not mandatory. Vendor should describe what options are available to Plan Members.
24	Section 7.3.3.2.4.a	With regard to "customize existing audit programs," please confirm that the audit programs in question only include Plan member service calls and transactions.	Confirmed.
25	Section 5.3.2.2.1.u	Please clarify whether the Cash Pay Benefit program referenced in Section 5.3.2.2.1(u) is expected to be administered as part of the PBM's claims adjudication and reporting systems, or as a standalone program administered by a third party, and how the Plan anticipates coordination between such program and the PBM integrated cash benefit administered within the PBM	There are instances where a Member can save money by not using the Plan's pharmacy benefit when purchasing a medication. For example, GLP-1s for weight loss are less expensive for a Member when they buy direct than when they obtain them using the Plan's discounted price. Describe how the Vendor

		platform or a separate program administered by a third party?	could help the Plan track these claims.
26	Claims and formulary file	What is Tier 0? Is it considered excluded?	Tier 0 includes drugs that have no Member cost share such as preventive medications and insulin.
27	Claims and formulary file	Is Tier 3 considered disadvantaged to Tier 2 and Tier 6 considered disadvantaged to Tier 5?	Yes. These are mostly non-preferred tiers.
28	Claims and formulary file	Is Tier 7 Preferred Blood Glucose Meters (BGM) and Supplies?	Yes.
29	Claims and formulary file	Is Tier 9 Preventive Medications?	Preventive medications are in Tier 0.
30	Claims and formulary file	It looks like we only received GLP-1 detailed UM document. Can the Plan provide detailed UM documentation on other classes that have PA and ST edits? An example of detailed UM criteria in the Immuno class is below. 	This was simply an example of custom UM. The Plan will not be providing additional UM examples.
31	Claims and formulary file	How does the Plan intend, at this time, to manage GLP1/weight loss utilization? What is the client's outlook for preferring GLP1/weight loss products? Will there be more or less restriction than what is reflected in the formulary and UM documentation?	The State Health Plan does not cover GLP-1 (Glucagon-Like Peptide-1), GIP-GLP ((glucose-dependent insulinotropic polypeptide))-1 agonists, or other similar new molecular entities when used for the purpose of weight loss. This benefit exclusion applies to all FDA approved indications for these medications.
32	Claims and formulary file	What is the Plan's current strategy for Immuno biosimilar products (including adalimumab/Humira and ustekinumab/Stelara)? Is the client's objective to follow the lowest net cost strategy (covering only low WAC products), rebate maximizing strategy (covering only high WAC products), or something in between?	The Plan excluded Humira April 1, 2024, and Stelara was excluded January 1, 2026. Biosimilars are preferred for both of these medications (Hyrimoz & Yesintek). Where possible the Plan prefers a lowest net cost strategy.
33	Claims and formulary file	If a product is not listed on the formulary, should it be considered as "excluded"?	Yes. However, a formulary exceptions process is available to Members who have a medical necessity to obtain a non-covered/formulary excluded medication.
34	Claims and formulary file	If there is any misalignment between the formulary and UM documents, which document should be considered the source of truth?	The UM documents.

35	Claims and formulary file	In the formulary file provided (NCSHP Formulary 05 2025 (with UM indicators), there is only one formulary ID included. Please confirm whether additional formulary files are still forthcoming, or if this will be the only formulary provided?	There is only one formulary.
36	Claims and formulary file	We see references to Medicare lives in the RFP, but it looks like in the claims file there is not a way for us to know which claims are Commercial, Medicare or Medicaid. Please specify how to determine the data points reflect the Medicare population.	There is a Medicare indicator in the census file, but as noted, there is no Medicare indicator on the claims file. However, Group 002 is the 70/30 Med Prime Group where 99% of the Medicare primary Members are enrolled. There are approximately 36K Medicare Members but only approximately 2500 Members with Medicare COB claims on approximately 12 medications.
37	Claims and formulary file	Please provide a legend for the fields populated with Carrier, Account, Group and Plan, that define what the values mean.	The Carrier, Account and Plan codes were included in the file in error and are irrelevant. The Group codes are described in Exhibit A-1: Claims Data History File Layout.
38	Claims and formulary file	As the Record Layout file does not currently define the Medicare population, please provide an indicator/identifier for Medicare or specify if there is a particular Plan or Group ID in the current file that is specific to these members.	The Medicare identifiers are outlined in the answer to 37 above.
39	Section 6.3.6.2 Financial Transparency Requirements; Precedence of Agreements	In the event of a conflict between the PBM's negotiated manufacturer agreements and the Plan's direct manufacturer contracts, please confirm which agreement terms will govern claims adjudication and rebate administration for the Plan.	The Plan does not currently have any direct manufacturer contracts. However, if direct manufacturer contracts are executed by the Plan, the terms of the Plan's direct contracts would govern.
40	Attachment O-2, Q 20.h. (6.3.5.2.1)	What is the proposed scope of the quarterly audits referenced in this requirement?	6.3.5.2.1. includes general requirements related to all the audits, including the Standard Audits done on a quarterly basis.
41	Attachment O-2, Q 21.b (6.3.5.2.2)	What is the proposed scope of the quarterly audits referenced in this requirement?	The Standard Audits will include rebate and pricing guarantee audits. Standard Audits are also defined in 2.10.mmmm.
42	Attachment A-1, Attachment A-2, Attachment A-3	Please confirm the number of unique plan designs managed today.	There are only three Plan Designs today. The Standard PPO Plan, the Plus PPO Plan and the HDHP.
43	Attachment A-1, Attachment A-2, Attachment A-3	Please confirm the number of pharmacy networks managed today.	There is one retail network and one specialty network.
44	Attachment A-1, Attachment A-2, Attachment A-3	Please provide the historical Prior Authorization volumes. If available, please provide the following breakout:	The Plan does not have this information.

		• Annual manual PA's (phone/fax) (# or %) • Annual ePA's (# or %) - split by # ePA auto-approvals vs # requiring intervention	
45	Attachment A-1, Attachment A-2, Attachment A-3	Please provide the historical annual real time benefit check transaction volume. Please include the monthly average number of unique active NPI's with a real time benefit check each month.	The Plan does not have this information.
46	Attachment A-1, Attachment A-2, Attachment A-3	Please provide the historical annual eligibility transactions for ePrescribing (formulary, medication history and eligibility).	The Plan does not have this information.
47	Attachment A-1, Attachment A-2, Attachment A-3	Please confirm if pharmacy help desk is delegated to the PBM. If so, please provide the historical annual pharmacy call center volumes.	The pharmacy help desk is delegated to the PBM. The Plan does not have statistics for the service.
48	Attachment A-1, Attachment A-2, Attachment A-3	If applicable, please provide details around expectations for DMR handling; will this purely be data entry, will member outreach be required? Etc.	The Plan does not track this information.
49	Attachment A-1, Attachment A-2, Attachment A-3	Please provide the following historical claim service volumes: 1.) DMR 2.) Subrogation 3.) Reprocessing	The Plan does not track this information.
50	Attachment A-1, Attachment A-2, Attachment A-3	Please confirm the current number of unique reports & file processes between the plan and the PBM today.	The Plan receives a detailed claims file twice a month from the PBM that corresponds to the claims invoices which are also received twice a month.
51	Section 5.3.4.2	In the RFP Section 5.3.3 Financial Terms, under Section 5.3.4.2 “Enrollment Group Set-Up & EDI Requirements” 1.a. references Attachment 1: PBM – ESS Business Requirements BRD. What are **ESS** Business Requirements BRD?	There is a typographical error in the attachment name. It should read as follows: “Attachment 1: PBM – **EES** Business Requirements BRD.
52	Attachment A, Page 117 to 121	Attachment A notes that vendors must use claims history, UM criteria (Exhibit A-2), and plan design parameters (Exhibit A-3) to develop guarantees, as well as document assumptions (biosimilar pipeline, trend by category, etc.). Please confirm whether the Plan will provide any updated interim data (e.g., more recent claims or plan design changes) between the Minimum Requirements pass notice and final Cost Proposal due date, and if not, whether vendors should assume no material change from the provided datasets.	The Plan’s claims data will be provided to bidders that meet minimum requirements. No material changes from that data are anticipated as outlined in the RFP.
53	Attachment A, Page 117 to 121	Attachments A and module-specific cost sections require that Administrative Fees be the primary (or sole) source of revenue and	Confirmed, the listed methods are prohibited.

		that no “additional or hidden revenue streams” be embedded in other components. Please confirm whether the following are considered prohibited “hidden revenue” under this requirement: spread on MAC pricing, network differentials, pharmacy admin fees, data or access fees from manufacturers, and any per-script “performance” payments that are not explicitly disclosed in the Cost Proposal workbook.	For Module 1, Vendors shall not receive, directly or indirectly, any compensation, revenue, remuneration, incentive, or financial benefit in connection with Services provided under this Contract or relating to utilization of prescription drugs by Members from any source other than: (I) the Administrative Fees paid directly by the Plan; and (II) the Dispensing Fee paid to Affiliated Pharmacies. For Modules 2 and 3, Vendors shall not receive, directly or indirectly, any compensation, revenue, remuneration, incentive, or financial benefit in connection with Services provided under this Contract or relating to utilization of prescription drugs by Members from any source other than the Administrative Fees paid directly by the Plan.
54	Attachment A-1 and A-3, Page 117 to 121	For Module 1 and Module 3 pricing, the Cost Proposal requires that guarantees account for known legislation (e.g., Maximum Fair Price, Inflation Reduction Act, AMP cap removal) and prohibits adjusting guarantees except as explicitly allowed under the Contract. Please confirm whether any mechanism is contemplated for mutually agreed adjustments if future legislation materially alters pharmacy reimbursement, list prices, or rebate structures beyond the laws listed.	Vendor shall have no unilateral right to modify any financial terms during the Contract term. In the event of a material change in federal or state law or regulation that directly and unavoidably impacts the Vendor's ability to perform under the agreed financial guarantees, the Parties may negotiate in good faith a modification to services, reimbursement rates, and/or administrative fees solely to restore the Parties to their relative economic positions prior to the event. Any proposed modification must be initiated by the Vendor in writing, with detailed evidence of the qualifying event and its impact and requires the Plan's express written approval. For clarity, no modification shall increase the Plan's costs or reduce its benefits unless explicitly agreed by the Plan in writing.
55	Attachment A-2 and A-3, Page 117 to 121	For A-2 and A-3, do you want vendors to use the same table as A-1 (Module 1)? All 3 documents have the same Module 1 Table.	Vendors that meet the minimum requirements should use the Attachment A-1, A-2, and A-3 Excel worksheets to

			respond. Although the files have similarities, they are not the same.
56	Attachment A-2, Page 117 to 121	Module 2 explicitly prohibits fees based on shared savings or similar models contingent on cost reductions or utilization changes. Please clarify whether any value-based or pay-for-performance administrative fee components (e.g., upside/downside based on clinical outcome targets) are allowed if they are fully disclosed in the Administrative Fees Worksheet and not tied directly to drug-spend savings.	Module 2 entries should assume no shared savings or other value- or performance-based fees. Vendors can propose alternate value- or performance-based administrative fees to be paid on a PMPM basis or through a guaranteed maximum PMPM rate, but the Plan retains the option to accept or reject the alternative approach.
57	Attachment A-3 – Page 117 to 121	Module 3 requires NDC-level guarantees plus New-to-Market and Default Discount guarantees, with no changes allowed except as explicitly permitted. Please clarify how you will handle situations where a drug transitions from New-to-Market to being on the NDC guarantee list during the term and whether any mid-term repricing is allowed if the NDC moves to a different therapeutic class or site of care.	For new-to-market drugs, the Vendor shall apply a default Discount guarantee off AWP, as indicated in Attachment A-3 - Module 3 Cost Proposal Response, until a specific minimum guaranteed Disc ount is negotiated at the quarterly meeting. Other mid-term repricing is not anticipated unless it directly and unavoidably impacts the Vendor's ability to perform under the agreed financial guarantees, in which case the Parties may negotiate in good faith a modification to services, reimbursement rates, and/or administrative fees solely to restore the Parties to their relative economic positions prior to the event. Any proposed modification must be initiated by the Vendor in writing, with detailed evidence of the qualifying event and its impact and requires the Plan's express written approval. For clarity, no modification shall increase the Plan's costs or reduce its benefits unless explicitly agreed by the Plan in writing.

58	Attachment A-1, Attachment A-2, Attachment A-3	In Attachment A-3 Module 3 Cost Proposal Response, there is only one tab for pricing. How would the Plan recommend Vendor differentiate traditional mail order / home delivery pricing vs Specialty pricing? The current tab is labeled Mail Order but appears to align better to a specialty pricing proposal since traditional mail order/ home delivery pricing is not contracted at a drug level.	The Plan requests NDC-level guarantees for all drugs that are available to be dispensed via mail order. The Vendor should provide NDC-level guarantees for all drugs the Vendor is willing to guarantee at the NDC-level. For any drugs the Vendor is not willing to guarantee at the NDC-level, the Vendor should provide Minimum Brand and Generic Rate Effective Rate Guarantees in cells E9:F10 of Attachment A-3 “Mail Order Pricing” sheet.

8.0 FIRST AMENDED AND RESTATED CONTRACT PERFORMANCE, DELIVERABLES, PERFORMANCE GUARANTEES, AND FEE REDUCTIONS

8.1 Audits of Records and Performance

The Plan reserves the right to conduct an audit of Vendor's records as specified in Attachment C. 1. "Access to Persons and Records" to validate the results of Vendor's performance. Vendor will be required to resolve any material discrepancies identified to the satisfaction of the Plan.

8.2 Contract Compliance and Performance

a) Vendor shall comply with all terms, conditions, requirements, performance standards, and applicable laws as set forth in the Contract and any amendments thereto

b) The Plan reserves the right to impose any and all remedies available under the terms of the Contract, at law, or in equity, including remedial actions, fee reductions, and/or termination of the Contract, in the event that the Plan determines, in its sole discretion, that Vendor has violated any provision of the Contract or that Vendor has not complied with any applicable North Carolina or federal law or regulation.
Violations of the Contract and noncompliance with applicable North Carolina or federal law or regulation shall include the following:
   i. Vendor fails substantially to provide a service outlined in the Contract;
   ii. Vendor misrepresents or falsifies information that it furnishes to the Plan;
   iii. Vendor misrepresents or falsifies information that it furnishes to Plan Members or Providers; or
   iv. Vendor distributes directly, or indirectly through any agent or independent Vendor, Marketing Materials that have not been approved by the Plan or that contain false or misleading information.

c) Risk Level Assignment
   i. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or any other noncompliance by the Vendor, the Plan shall assign the violation into one of four risk levels:
      1) **Level 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or jeopardize the integrity of the Plan's PBM program.
      2) **Level 2:** Action(s) or inaction(s) that jeopardize the integrity of PBM program but does not necessarily jeopardize Member(s) health, safety, and welfare or reduces access to care.
      3) **Level 3:** Action(s) or inaction(s) that diminish the effective oversight and administration of PBM Services.
      4) **Level 4:** Action(s) or inaction(s) that inhibit the efficient operation of PBM program.
   ii. The Plan may impose additional remedial actions, fee reduction, and/or elevate the violation to a higher Risk Level if the same noncompliant behavior continues or if the Vendor fails to comply with the originally imposed action.
   iii. The Plan's decision to impose specific remedial action(s) and/or fee reduction against the Vendor will include consideration of some or all of the following factors:
      1) Risk Level assignment;
      2) The nature, severity, and duration of the violation;
      3) The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, program integrity);
      4) Whether the Violation resulted from negligent or willful conduct;
      5) Whether the violation (or one that is substantially similar) has previously occurred;
      6) The timeliness in which the Vendor self-reports a violation;
      7) The Vendor's history of compliance;
      8) The good faith exercised by the Vendor in attempting to stay in compliance of ; or
      9) Any other factor the Plan deems relevant based on the nature of the violation.

8.3 Notice of Deficiency

a) Prior to the imposition of any remedial action or fee reduction against the Vendor or termination of the Contract for cause, the Plan will provide the Vendor with written notice detailing the nature of the violation or noncompliance, the risk level assigned to the violation, any actions the Plan seeks to impose against the Vendor, and, if applicable, the method and timeframes by which the Vendor may appeal applicable claim of noncompliance and the imposed actions.

b) Within three (3) Business Days of the Vendor's full remediation of the identified violation(s) in the Notice of Deficiency, or within another timeframe set by the Plan, the Vendor shall provide the Plan with written notice confirming the date that the noncompliant behavior was resolved and the actions the Vendor took to remediate the noncompliance.

8.4 Remedial Actions

a) Remedial Actions: Prior to the imposition of fee reduction or contemporaneously there with, the Plan may require Vendor to take the following actions to address identified violation(s) or other noncompliance:

i. Immediate remediation of the violation or noncompliant behavior or practice, as determined by the Plan, in a manner consistent with the nature of the violation or noncompliance.

ii. Submission and implementation of a Corrective Action Plan; or

iii. Participation in additional education or training.

b) Corrective Action Plans ("CAPs"):

i. CAPS developed by Vendor:

1) Following notification of the original violation giving rise to the CAP, Vendor shall immediately cease the noncompliant behavior and mitigate the harm caused by the violation until a CAP approved by the Plan is implemented.
2) If any CAP is required to be submitted to the Plan, Vendor shall, at a minimum, identify the following:
   a. The finding resulting in a request for corrective action by the Plan;
   b. A description of how the finding resulting in a request for corrective action will be remediated;
   c. The timeline for the implementation and completion of the corrective action(s); and
   d. The name of the person(s) who will lead all corrective action activities.
3) Any CAP submitted by Vendor to the Plan shall be subject to approval by the Plan.
4) Vendor shall submit the CAP within fifteen (15) Calendar Days, or within a time determined by the Plan, from the date on the written notice requesting the CAP.
5) Upon receipt, the Plan may accept the CAP as submitted, accept the CAP with Plan-specified modifications, or reject the CAP.
6) If the Plan specifies modifications or rejects the CAP, Vendor shall revise and submit a new CAP within ten (10) Calendar Days of the Plan's rejection of specification of modification, or within a time determined by the Plan, that addresses the concerns and modifications identified.
7) The Vendor shall complete the corrective action(s) contained in the CAP within the time period approved by the Plan.
8) Vendor shall provide updates to the Plan on the remediation of all findings resulting in a request for corrective action at the interval requested by the Plan.

ii. CAPS defined by the Plan

1) The Vendor shall accept and implement a Plan defined CAP.

8.5 Reduction in Fees

a) Vendor shall be subject to reductions in fees or payments based on performance and delivery of contracted Services outlined in Section 5.0, 6.0, and 7.0 and the schedules in Section86.14, Section 8.15 and Section 8.16. Unless otherwise specified, the reductions in fees shall be calculated as a flat dollar amount or as a percentage (%) of administrative fees paid by the Plan, as each is stated below.

b) Following receipt of a Notice of Deficiency assessing fee reductions, the Plan may continue to assess damages in accordance with the Contract until such time as the Plan, in its sole discretion, determines the Violation(s) has been cured.

c) The Plan, in its sole discretion, reserves the right to assess a general reduction of two thousand five hundred dollars ($2500.00) per day, per occurrence, as applicable, for any violation not specifically listed in this Section 8.0 First Amended and Restated Contract Performance, Deliverables, Performance Guarantees, and Fee Reductions.

d) Fee reductions assessed by the Plan do not affect the Vendor's rights or obligations with respect to any third party, including Members or Providers.

e) Failure of Vendor to accept reductions in fees according to the schedules in Section 6.14 Section 8.15, and Section 8.16 for any non-compliant Contract Deliverable outlined in this Section 6.0 shall be, at the Plan's discretion, grounds for imposition of other remedies available to the Plan under the Contract, including immediate termination of the Contract.

f) Reductions in fees may be waived by the Plan, in its sole discretion, in the event there are circumstances outside Vendor's control which result in failure to meet the established timeframe or Deliverable. However, as specified in Attachment C. 23. "No Waiver," the waiver by the State of any right or remedy on any one occasion or instance shall not constitute or be interpreted as a waiver of that or any other right or remedy on any other occasion or instance.

g) Any delay in the submission of any Contract Deliverable requires a written explanation by the Vendor, no later than thirty (30) days prior to the due date of any Deliverable, and written approval by the Plan's Executive Administrator. Such explanation and approval will not constitute automatic waiver of any associated reduction in fee and shall not relieve Vendor of its responsibility for completion of Deliverables in accordance with the Contract.

8.6 Payment of Fee Reduction

a) If the Vendor elects not to appeal or request a waiver of the assessment of fee reduction, the assessed amounts shall be due and payable within thirty (30) days of the date on the written Notice of Deficiency assessing the fee reduction.

b) If the Vendor elects to request a waiver of the assessment of fee reduction but such waiver is not granted by the Plan, the fee reduction/monetary risk shall be due and payable within ten (10) days of the date on the written notice of the final decision issued by the Plan upholding its original decision to impose the fee reduction (including a final decision modifying the amount owed).

c) Vendor shall remit payment associated with any reductions in fees through the Automated Clearing House (ACH) and include a copy of the Plan's request for payment letter. Prior to the remittance of payment, Vendor shall notify the Plan of the forthcoming payment via email. Any such Performance Guarantee payment shall be due to the Plan within thirty (30) days of the request. Credit memo or invoice adjustment is prohibited.

d) The Plan shall have the right to recoup any monies owed to the Plan from assessed fee reductions or other monetary sanctions by withholding the amount from future payments owed to the Vendor. The Plan shall provide written notice to the Vendor prior to withholding a portion of the payment for assessed PG or other monetary sanctions.

8.7 Contract Performance Dispute Resolution

a) Vendor may appeal certain Contract performance actions arising under this Contract. Vendor may also request a waiver of the imposition of fee reduction as provided in Section 8.7 (b), except that the Vendor shall not have the right to contest a requirement imposed by the Plan to perform a remedial action.

b) Appeal of Noncompliance Finding(s) and Waiver Procedures

i. To appeal the finding of noncompliance or request a waiver, the Vendor shall submit a written request to the Plan's Executive Administrator, or the Executive Administrator's designee, for appeal and waiver within fifteen (15) Calendar Days of the date of the written notice imposing the Plan's intended action. The Plan may extend the Vendor's deadline to request appeal and waiver for good cause if the Vendor requests an extension within ten (10) days of the date on the written notice.

ii. Vendor shall include in the written request for appeal and waiver, all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

iii. Vendor waives any dispute not raised within fifteen (15) days of the date on the written notice imposing any proposed action by the Plan (unless the Plan grants an extension).

iv. Vendor also waives any arguments it fails to raise in writing within fifteen (15) days (unless the Plan grants an extension) of the date of the written notice imposing the proposed action, and waives the right to use any materials, data, and information not contained in or accompanying the Vendor's written request for dispute resolution in any subsequent legal proceeding.

v. The Plan will review the appeal and waiver request including submitted evidence and information and issue a written final decision within forty-five (45) State Business Days of the Vendor's request for appeal and waiver. The Plan shall have the right to extend its deadline to issue the final decision for good cause and shall notify Vendor of any extension and the reason for such extension.

vi. The final decision issued by the Plan following appeal and waiver shall not be subject to further review or Appeal within the Plan.

8.8 Notice to External Agencies

a) The Plan may provide notice to any other state or federal agency for violations of the terms, conditions, or requirements of this Contract or for any other violation of applicable laws or regulations by Vendor.

8.9 Publication of Contract Compliance Issues

a) The Plan may publish on its website a list of Vendors that were subject to remedial action(s), and/or fee reduction, the risk level assigned to Violation(s), the type of actions imposed on the Vendor, and the basis for the actions taken by the Plan.

b) The Plan shall not publish, as final, any actions that are under dispute with the Vendor or any remedial action(s) and/or fee reduction that have been waived or lifted by the Plan.

8.10 Right to Waive or Modify

a) The Plan, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Vendor for any good cause as determined by the Plan, which includes the right of the Plan to suspend the imposition of a remedial action, fee reduction, while the Vendor works to resolve the underlying issue that resulted in the action taken by the Plan.

8.11 Performance Guarantee on Reporting Timeliness

Attachment 6. "Standard Reports: Claims Processing and Customer Service Module" outlines the due dates for reports. Reports without a specific time of day noted on the report are due by 5:00 p.m. ET. If any report due date falls on a weekend or holiday, the due date is the first State Business Day after the scheduled date.

8.12 Summary of Performances Guarantees

The Performance Guarantee section is comprised of schedules indicating the measure, description, standard, and fees at risk for each Performance Guarantee. Included are one-time Performance Guarantees around implementation of Services and additional Performance Guarantees measured on a quarterly basis throughout the term of the Contract. The Performance Guarantees for all Services have been set by the Plan.

8.13 Performance Guarantee Accuracy Definitions

a) Risk percentages for the Ongoing Services Performance Guarantees are a percentage of the total quarterly Standard Services Administrative Fees outlined in Section 4.2.1 Administrative Fees Applicable to Modules 1, 2 and 3.

b) EDI Load Rate is the number of enrollment transactions that successfully pass the EDI edits and load automatically into Vendor's system without manual intervention. The enrollment transaction should be counted at the contract, or family level.

c) Manual entry accuracy shall be calculated at the contract, or family level. There should be one (1) point assigned at the Subscriber enrollment level. If any field on the family enrollment is inaccurately entered, the score for that enrollment is zero. (Example: Ten (10) enrollments are pulled for audit. Five (5) contain enrollments for more than one (1) Member of a family and five (5) are for individual enrollments. Total points available for this audit are ten

(10) points. Upon audit, it is determined that an address was misspelled on one (1) enrollment and two (2) family Members were inaccurately enrolled on one (1) enrollment. Eight (8) out of 10 enrollments were completed accurately; therefore, the accuracy score is 80%. The audit sample size will be determined by the Plan during the implementation and the ongoing audits will be performed by Vendor. If additional inaccurate updates are identified (by the Group, Member, Plan or Plan vendors, etc.), the additional error and transaction should be included in the month's accuracy score.

8.14 Module 1 Schedules of Performances Guarantees: Claims Processing, Customer Service, and Retail Network

Module 1 Schedule I. Initial Implementation Performance Guarantees		
Measure	**Initial Implementation**	**Monetary Risk**
Timeliness	**Insurance** Vendor shall provide proof of insurance required in Attachment C: 19. "Insurance" to the Plan within fifteen (15) days of award of Contract.	Vendor shall pay $10,000.00 for each day the proof of insurance is late.
Timeliness	**Enrollment Data File** Vendor shall process in its system the initial Enrollment Data File from the Plan's EES Vendor by 5:00 p.m. ET on the second State Business Day after receipt. The target delivery date of the Enrollment Data File shall be determined during implementation and documented in the Implementation Plan.	Vendor shall pay $10,000.00 for each day beyond the initial file load date in the Implementation Plan.
Timeliness	**Call Center** Vendor shall have the Call Center fully operational by the first day of the Plan's 2028 Open Enrollment which includes having the Plan's toll-free phone number operational, the IVR established with custom language and prompts, and all cold and warm transfers in place. Open Enrollment is generally in October. The exact dates shall be finalized during implementation and documented in the Implementation Plan.	Vendor shall pay $10,000.00 for each day the Call Center is not operational beyond Go-Live date in the Implementation Plan. The Go-Live dates will be determined during the Implementation.
Timeliness	**All Other Services** Vendor shall ensure all other services under the Contract are fully implemented by the applicable "Go-Live" dates which shall be determined during implementation and documented in the Implementation Plan.	Vendor shall pay $5,000.00 for each day a service is not operational by the Go-Live Dates in the Implementation Plan.

Module 1 Schedule II. Ongoing Performance Guarantees			
Measure	**Enrollment, Group Set-Up, & EDI**	**Target**	**Risk**
Timeliness	Vendor shall add new Employing Units ≤ five (5) State Business Days of receipt of the necessary documents.	100%	$2,500.00 for each additional day it takes to set up a new Employing Unit.
Timeliness	Enrollment Files are loaded in in Vendors' system(s) and Members are fully enrolled within twelve (12) hours of receipt from the Plan's EES Vendor. This does not include Members that fall out of processing for manual review. A Member is considered "enrolled" when he/she is able to obtain a prescription at a retail, specialty or mail pharmacy without intervention by Vendor or the Plan.	100%	$1,000.00 per hour delay per file
Timeliness	EDI Load Rate	98%	0.5%
Timeliness	Vendor shall complete the monthly enrollment audit within three (3) days. Vendor has two (2) days to process and report audit results and one (1) day to make any manual updates needed. The audit schedule shall be confirmed during implementation and documented in the Implementation Plan. The audit schedule may be altered throughout the life of the Contract via ADM.	100%	$2,500.00 per day for each extra day it takes to complete the audit.
Accuracy	Vendor shall accurately configure new Employing Units ≤ five (5) State Business Days of receipt of the necessary documents. To be considered accurate the naming and organizational structure (Group number or other data elements that are required to set-up a new Group in Vendor's system) must be accurate.	100%	0.5%
Accuracy	Manual Entry Accuracy Rate	99%	2%
	Clinical		
Timeliness	**Utilization Management** Vendor shall complete UM Reviews (prior authorization, Step Therapy, and/or quantity limits) ≤ seventy-two (72) hours after receipt.	95%	0.25%
Timeliness	**Formularies** Vendor shall implement changes to the Plan's Formulary by the effective date of the change.	100%	1.0%
Measure	**Customer Experience**	**Target**	**Risk**
Timeliness	**Average Speed of Answer (ASA)** The Member Services Call Center ASA shall be on average ≤ thirty (30) seconds each month.	100%	0.5%
Timeliness	**First Call Resolution Rate** First Call Resolution Rate shall be defined as: (i) the total number of telephone calls made by a Member and resolved by Vendor's Customer service representatives on the first call as measured by the Member not calling back the Vendor Customer service center within five (5) State Business Days regarding the same inquiry, divided by (ii) the total number of telephone calls made by Members and received by the Vendor.	93%	1.0%

Module 1 Schedule II. Ongoing Performance Guarantees Continued			
Measure	**Claims and Financial Audits & Reconciliation**	**Target**	**Risk**
Timeliness	***Claims Audit Reconciliation** Vendor shall complete the final reconciliation and remit any and all reimbursement to the Plan within sixty (60) days of the final report being issued by the Plan's Auditor.	100%	$5,000.00 for each day after day sixty (60) that the payment is late.
Measure	**Reporting**	**Target**	**Risk**
Timeliness	**Financial Guarantee Reporting** Vendor shall provide the Plan a report that captures all financial guarantees (e.g., Discounts, fees, and rebates) within forty-five (45) days of the end of each quarter.	100%	$2,500.00 for each day the report is late.
Timeliness	**Performance Guarantee Reporting** Vendor shall provide the Plan a report that captures Performance Guarantees quarterly within forty-five (45) days of the end of each quarter.	100%	$2,500.00 for each day the report is late.

8.15 Module 2 Schedules of Performances Guarantees: Formulary and Utilization Management and Rebate Management/Aggregation

Module 2: Schedule I. Initial Implementation Performance Guarantees		
Measure	**Initial Implementation**	**Monetary Risk**
Timeliness	**Insurance** Vendor shall provide proof of insurance required in Attachment C: 19. "Insurance" to the Plan within fifteen (15) days of award of Contract.	Vendor shall pay $10,000.00 for each day the proof of insurance is late.
Timeliness	**Project Initiation**: Vendor shall have a fully assembled implementation team ready to begin work within two (2) weeks of Contract execution.	Vendor shall pay $10,000.00 for each day after the two-week mark that the full team is not ready to meet.
Timeliness	**Operating Model Development**: Vendor to complete plan blueprint to document "current state" model and established "future state" operational model no later than sixty (60) days after the kickoff date. The format and scope of the blueprint require approval by Plan prior to starting the documentation.	Vendor shall pay $10,000.00 for each day the operating model is late.
Timeliness	**Project Planning** – Milestone Development: Vendor will create and provide the initial project plan including key or critical implementation milestones within thirty (30) days after the kickoff date. A mutually agreed upon integrated project plan (between Vendor and Plan) will be baselined within three (3) months after project initiation.	Vendor shall pay $10,000.00 for each day the project plan is late.

Module 2: Schedule I. Initial Implementation Performance Guarantees Continued		
Timeliness	**Plan's P&T Committee Meeting Support** Vendor shall support and participate in the Plan's P&T Committee meeting in the fall of 2027 to finalize any Formulary, utilization management, or prior approval policies to take effect January 1, 2028. To support this meeting, Vendor must have all Formulary and policy changes documented in a consumable format prior to the meeting. The specific due dates for each Deliverable, shall be established during implementation and documented in the Implementation Plan.	Vendor shall pay $10,000.00 for each day the Deliverables are late.
Timeliness	**Documents Posted on Plan's Website** Vendor shall provide final copies of all documents that must be posted on the Plan's website including the comprehensive Formulary list, the Preferred Drug List, and all utilization and PA policies by the date established in the Implementation Plan., which can be no later than December 20, 2027.	Vendor shall pay $10,000.00 for each day the Deliverables are late.
Timeliness	**All Services** Vendor shall ensure all other services under the Contract are fully implemented by the applicable "Go-Live" dates which shall be determined during implementation and documented in the Implementation Plan, but in no instance will a Go-Live date be post January 1, 2028. Any open defects or issues that cannot be remediated prior to January 1, 2028, will require the Plan's approval to move forward with the January 1, 2028, date.	Vendor shall pay $25,000.00 for each day the program is not fully operational after January 1, 2028.

Module 2: Schedule II. Ongoing Performance Guarantees – Reviewed & Accessed Quarterly			
Measure	**Formulary Management**	**Target**	**Risk**
Timeliness	**Formulary Change**: All data required to implement any Formulary changes recommended by the Plan's P&T Committee and approved by the Plan's Executive Administrator will be delivered to the Plan's Module 1 Vendor in the agreed upon consumable format within five (5) days after the Plan provides written, final approval/notification of the changes to Vendor. The "consumable" format will be determined during the implementation period and documented in an ADM.	**100%**	**2% of quarterly Admin Fees**
Measure	**Utilization Management**	**Target**	**Risk**
Timeliness	**UM Documentation:** All data required to implement any UM changes recommended by the Plan's P&T Committee or the Plan will be delivered to the Plan's Module 1 Vendor in the agreed upon consumable format within five (5) days after the Plan provides written, final approval/notification of the changes to Vendor. The "consumable" format will be determined during the implementation period and documented in an ADM.	**100%**	0.5% of Quarterly Admin Fees

Module 2: Schedule II. Ongoing Performance Guarantees – Reviewed & Accessed Quarterly Continued			
Measure	**Audits**	**Target**	**Risk**
Timeliness	**Audit Responses:** Vendor shall submit a reply to quarterly audits within fourteen (14) days after the final report/audit issued by the Plan's Auditor.	100%	0.05% of Quarterly Admin Fees
Timeliness	**Audit Response:** Vendor shall submit a reply to annual audits within forty-five (45) days of the final report/audit being issued by the Plan's Auditor	100%	0.05% of Quarterly Admin Fees
Timeliness	**Payments/Reimbursements:** Vendor shall make any adjustments, payments, and/or reimbursements determined necessary by the audit within thirty (30) days of the audit close out in accordance with Section 6.3.5 Audits.	100%	0.05% of Quarterly Admin Fees
Measure	**Reporting**	**Target**	**Risk**
Timeliness	**Standard Reports- Accuracy and Timeliness**: Vendor shall deliver all Standard Reports by 5:00 p.m. ET, no later than the due date. The reports and delivery schedule will be documented via ADM during the implementation and may be updated throughout the lifetime of the Contract.	100%	0.05% of Quarterly Admin Fees

8.16 Module 3 Schedules of Performances Guarantees: Specialty and Mail Order Pharmacy Services

Module 3 Schedule I. Initial Implementation Performance Guarantees		
Measure	**Initial Implementation**	**Monetary Risk**
Timeliness	**Insurance** Vendor shall provide proof of insurance required in Attachment C: 19. "Insurance" to the Plan within fifteen (15) days of award of Contract.	Vendor shall pay $10,000.00 for each day the proof of insurance is late.
Timeliness	**All Other Services** Vendor shall ensure Services under the Contract are fully implemented by the applicable "Go-Live" dates which shall be determined during implementation and documented in the Implementation Plan.	Vendor shall pay $5,000.00 each day for services that are not operational by the Go-Live Dates in the Implementation Plan.

Module 3 Schedule II. Ongoing Performance Guarantees			
Measure	**Customer Experience**	**Target**	**Risk**
Timeliness	**Average Speed of Answer (ASA)** The Member Services Call Center ASA shall be on average ≤ thirty (30) seconds each month.	100%	0.5%
Timeliness	**First Call Resolution Rate** First Call Resolution Rate shall be defined as: (i) the total number of telephone calls made by a Member and resolved by Vendor's Customer service representatives on the first call as measured by the Member not calling back the Vendor Customer service center within five (5) State Business Days regarding the same inquiry, divided by (ii) the total number of telephone calls made by Members and received by the Vendor.	93%	1.0%
Measure	**Reporting**	**Target**	**Risk**
Timeliness	**Financial Guarantee Reporting** Vendor shall provide the Plan a report that captures all financial guarantees (e.g., Discounts, fees, and rebates) within forty-five (45) days of the end of each quarter.	100%	$2,500.00 for each day the report is late.