

<b>tAWARD / CONTRACT</b>		1. This Contract is a rated order under DPAS 9 (15 CFR 700)	Rating C9	Page 1	of Pages 90	
2. Contract (Proc., Inst., Ident.) No. H9400208C0003		3. Effective Date Jun 27, 2008	4. Requisition / Purchase Request / Project No. See Schedule			
5. Issued By DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066 WILLIAM H. COFFENBERRY K35 303-676-3764 william.coffenberry@tma.osd.mil		Code H94002	6. Administered By (if other than item)		Code CMB	
7. Name and address of Contractor (No., Street, City, state and Zip Code) EXPRESS SCRIPTS, INC. ONE EXPRESS WAY ST LOUIS MO 63121		Vendor ID: 00000276 DUNS: 173490459 CEC: Cage Code: 1WPW1 TIN: 431420563	8. Delivery <input type="checkbox"/> FOB Origin <input type="checkbox"/> Other (See below)		9. Discount for prompt payment Net 30	
Code		Facility Code	10. SUBMIT INVOICES (4 copies unless otherwise specified) Address shown in:		Item	
11. Ship To / Mark For DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code H94002	12. Payment will be made by DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY (CRM) 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code CRM	
13. Authority for using other than full and open competition <input type="checkbox"/> 10 U.S.C 2304(C) ( ) <input type="checkbox"/> 41 U.S.C. 253 (C) ( )		14. Accounting and Appropriation Data See Section G.99				
15A ITEM NO.	15B SUPPLIES/SERVICES	15C QUANTITY	15D UNIT	15E UNIT PRICE	15F AMOUNT	
	This Contract is for TRICARE Pharmacy Program Services (TPharm). The Total Estimated Value of Awarded CLINs, Including Base Period and All Un-excluding Highest Phase-Out) is (b)(4) Exclud al Costs.					
<b>15G. TOTAL AMOUNT OF CONTRACT</b>					\$ (b)(4)	
16. Table of Contents						
(x)	Sec.	Description	Pages	(x)	Sec. Description Pages	
<b>Part I – The Schedule</b>				<b>Part II – Contract Clauses</b>		
X	A	Solicitation/Contract	1-1	X	I	Contracts Clauses 84-90
X	B	Supplies or Services and Prices/Cost	2-26	<b>Part III –List of Documents, Exhibits and other attach.</b>		
X	C	Description/Specs/Work Statement	27-46	X	J	List of Attachments 91-91
X	D	Packaging and Marking	47-47	<b>Part IV – Representations and Instructions</b>		
X	E	Inspection and Acceptance	48-48	X	K	Representations, Certifications and other statements of Offerors 92-91
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Contracting Officer will complete item 17 or 18 as applicable						
17. <input checked="" type="checkbox"/> CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return 1 copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligation of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attached are listed herein.)			18. <input type="checkbox"/> AWARD (Contractor is not required to sign this document.) Your offer on Solicitation number including the additions or changes made by you which additions or changes are set forth above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.			
19A. Name and Title of Signer (Type or Print)			20A. Name of Contracting Officer WILLIAM H. COFFENBERRY 303-676-3764 william.coffenberry@tma.osd.mil			
19B. Name of Contractor		19C. Date Signed	20B. United States of America		20C. Date Signed	
By _____ (Signature of person authorized to sign)			By _____ (Signature of Contracting Officer)			

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0001	BASE PERIOD Date of Award through November 3, 2009 Phase-In, Mail Order and Specialty Pharmacy  PR #: 08-PR-0075	1	LT	(b)(4)	
0002	Defense Information Assurance Certification and Accreditation Process (DIACAP)  PR #: 08-PR-0075	1	LT	0.00	0.00
0003	Phase-In, Department of Veterans Affairs Requirements (NOTE: This CLIN represents effort from award through March 31, 2010)  PR #: 08-PR-0075	1	LT	(b)(4)	
0004	Phase-In. Retail Pharmacy  PR #: 09-POD-0007	1	LT	(b)(4)	
1001	OPTION PERIOD 1 November 4, 2009 through October 31, 2010 NOTE: The number in the Quantity column for Administrative Fee Line Items is the estimated number of prescriptions to be filled.  Mail Order and Specialty Pharmacy Services Administrative Fees  PR #: 07-CMB-0200	1	LT	NSP	NSP
1001AA	Mail Order Prescription, Medicare Dual-Eligible  PR #: 07-CMB-0200	11000000	EA	(b)(4)	
1001AB	Mail Order Prescription, TRICARE-Only Eligible  PR #: 07-CMB-0200	3600000	EA	(b)(4)	
1001AC	Specialty Pharmacy Services, Medicare Dual-Eligible  PR #: 07-CMB-0200	34300	EA	(b)(4)	
1001AD	Specialty Pharmacy Services, TRICARE-Only	29600	EA	(b)(4)	

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount		
	Eligible						
	PR #: 07-CMB-0200						
1002	Member Choice Center (MCC) - Contractor obtained Prescriptions to be filled by MOP at Beneficiary request	1	LT	NSP	NSP		
	PR #: 07-CMB-0200						
1002AA	New Prescription from Provider, Medicare Dual-Eligible	50000	EA	(b)(4)			
	PR #: 07-CMB-0200						
1002AB	Transfer Prescription from MTF, Medicare Dual-Eligible	50000	EA				
	PR #: 07-CMB-0200						
1002AC	New Prescription from Provider, TRICARE-Only Eligible	50000	EA				
	PR #: 07-CMB-0200						
1002AD	Transfer Prescription from MTF, TRICARE-Only Eligible	50000	EA	(b)(4)			
	PR #: 07-CMB-0200						
1003	Un-Replenished MOP Pharmaceutical Agents & Supplies	NTE 1	LT			NTE 1,000,000.00	1,000,000.00
	PR #: 07-CMB-0200						
1004	Retail Prescription Administrative Fees, Medicare Dual-Eligible	1	LT			NSP	NSP
	PR #: 07-CMB-0200						
1004AA	Electronic Media Claims	39300000	EA	(b)(4)			
	PR #: 07-CMB-0200						

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit		
1004AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	1215000	EA	(b)(4)	
1005	Retail Prescription Administrative Fees, TRICARE-Only Eligible PR #: 07-CMB-0200	1	LT	NSP	NSP
1005AA	Electronic Media Claims PR #: 07-CMB-0200	36977778	EA		
1005AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	1146111	EA	(b)(4)	
1006	Retail Prescription Administrative Fees, DVA Beneficiaries (NOTE: This CLIN is for the period March 31, 2010 through October 31, 2010) PR #: 07-CMB-0200	168750	EA		
1007	Prior Authorizations PR #: 07-CMB-0200	1	LT	NSP	NSP
1007AA	Medicare Dual-Eligible PR #: 07-CMB-0200	26833	EA	(b)(4)	
1007AB	TRICARE-Only Eligible PR #: 07-CMB-0200	55217	EA		
1008	Medical Necessity Determinations PR #: 07-CMB-0200	1	LT	NSP	NSP
1008AA	Medicare Dual-Eligible	2950	EA	(b)(4)	



**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
1014	Phase-In, Retail Pharmacy (NOTE: This CLIN represents effort for September 1, 2009 through November 30, 2009 Only)  PR #: 07-CMB-0200	1	LT	(b)(4)	
2001	OPTION PERIOD 2 November 1, 2010 through October 31, 2011 Mail Order and Specialty Pharmacy Services Administrative Fees  PR #: 07-CMB-0200	1	LT		
2001AA	Mail Order Prescription, Medicare Dual-Eligible  PR #: 07-CMB-0200	12700000	EA	(b)(4)	
2001AB	Mail Order Prescription, TRICARE-Only Eligible  PR #: 07-CMB-0200	4200000	EA		
2001AC	Specialty Pharmacy Services, Medicare Dual-Eligible  PR #: 07-CMB-0200	39500	EA		
2001AD	Specialty Pharmacy Services, TRICARE-Only Eligible  PR #: 07-CMB-0200	34100	EA		
2002	Member Choice Center (MCC) - Contractor obtained Prescriptions to be filled by MOP at Beneficiary request  PR #: 07-CMB-0200	1	LT		
2002AA	New Prescription from Provider, Medicare Dual-Eligible  PR #: 07-CMB-0200	50000	EA	(b)(4)	
2002AB	Transfer Prescription from MTF, Medicare Dual-Eligible  PR #: 07-CMB-0200	50000	EA		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
2002AC	New Prescription from Provider, TRICARE-Only Eligible PR #: 07-CMB-0200	50000	EA	(b)(4)	
2002AD	Transfer Prescription from MTF, TRICARE-Only Eligible PR #: 07-CMB-0200	50000	EA		
2003	Un-Replenished MOP Pharmaceutical Agents & Supplies PR #: 07-CMB-0200	NTE 1	LT	NTE 1,000,000.00	1,000,000.00
2004	Retail Prescription Administrative Fees, Medicare Dual-Eligible PR #: 07-CMB-0200	1	LT	NSP	NSP
2004AA	Electronic Media Claims PR #: 07-CMB-0200	42150000	EA	(b)(4)	
2004AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	1301667	EA		
2005	Retail Prescription Administrative Fees, TRICARE-Only Eligible PR #: 07-CMB-0200	1	LT	NSP	NSP
2005AA	Electronic Media Claims PR #: 07-CMB-0200	395333333	EA	(b)(4)	
2005AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	1220000	EA		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit		
2006	Retail Prescription Administrative Fees, DVA Beneficiaries  PR #: 07-CMB-0200	225000	EA	(b)(4)	
2007	Prior Authorizations  PR #: 07-CMB-0200	1	LT		
2007AA	Medicare Dual-Eligible  PR #: 07-CMB-0200	29483	EA	(b)(4)	
2007AB	TRICARE-Only Eligible  PR #: 07-CMB-0200	60783	EA		
2008	Medical Necessity Determinations  PR #: 07-CMB-0200	1	LT	NSP	NSP
2008AA	Medicare Dual-Eligible  PR #: 07-CMB-0200	3250	EA	(b)(4)	
2008AB	TRICARE-Only Eligible  PR #: 07-CMB-0200	14633	EA		
2009	Defense Information Assurance Certification and Accreditation Process (DIACAP)  PR #: 07-CMB-0200	12	MO		
2010	Beneficiary Mailing (NOTE: Quantities are estimates and reflect the entire option period)  PR #: 07-CMB-0200	1000000	EA	(b)(4)	
2011	Award Fee Pool	1	LT		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
2011AA	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool November 1 2010 through April 30, 2011	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
2011AB	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool May 1, 2011 through October 31, 2011	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
2012	PR #: 07-CMB-0200 Retail Network Cost Control Incentive Fee (NOTE: Maximum amount that can be earned)	NTE 1	LT	NTE 5,000,000.00	5,000,000.00
2013	PR #: 07-CMB-0200 Phase-Out	1	LT	(b)(4)	
3001	PR #: 07-CMB-0200 OPTION PERIOD 3 November 1, 2011 through October 31, 2012 Mail Order and Specialty Pharmacy Services Administrative Fees	1	LT	NSP	NSP
3001AA	PR #: 07-CMB-0200 Mail Order Prescription, Medicare Dual-Eligible	13900000	EA	(b)(4)	
3001AB	PR #: 07-CMB-0200 Mail Order Prescription, TRICARE-Only Eligible	4600000	EA	(b)(4)	
3001AC	PR #: 07-CMB-0200 Specialty Pharmacy Services, Medicare Dual-Eligible	43400	EA	(b)(4)	
3001AD	PR #: 07-CMB-0200 Specialty Pharmacy Services, TRICARE-Only Eligible	37500	EA	(b)(4)	

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
3002	PR #: 07-CMB-0200 Member Choice Center (MCC) - Contractor obtained Prescriptions to be filled by MOP at Beneficiary request	1	LT	NSP	NSP
3002AA	PR #: 07-CMB-0200 New Prescription from Provider, Medicare Dual-Eligible	50000	EA	(b)(4)	
3002AB	PR #: 07-CMB-0200 Transfer Prescription from MTF, Medicare Dual-Eligible	50000	EA		
3002AC	PR #: 07-CMB-0200 New Prescription from Provider, TRICARE-Only Eligible	50000	EA		
3002AD	PR #: 07-CMB-0200 Transfer Prescription from MTF, TRICARE-Only Eligible	50000	EA		
3003	PR #: 07-CMB-0200 Un-Replenished MOP Pharmaceutical Agents & Supplies	NTE 1	LT	NTE 1,000,000.00	1,000,000.00
3004	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, Medicare Dual-Eligible	1	LT	NSP	NSP
3004AA	PR #: 07-CMB-0200 Electronic Media Claims	444266667	EA	(b)(4)	
3004AB	PR #: 07-CMB-0200 Paper Claims (Per Prescription)	1370000	EA		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
3005	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, TRICARE-Only Eligible	1	LT	NSP	NSP
3005AA	PR #: 07-CMB-0200 Electronic Media Claims	41533333	EA	(b)(4)	
3005AB	PR #: 07-CMB-0200 Paper Claims (Per Prescription)	1281667	EA		
3006	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, DVA Beneficiaries	225000	EA		
3007	PR #: 07-CMB-0200 Prior Authorizations	1	LT	NSP	NSP
3007AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	32433	EA	(b)(4)	
3007AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	66800	EA		
3008	PR #: 07-CMB-0200 Medical Necessity Determinations	1	LT	NSP	NSP
3008AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	3567	EA	(b)(4)	
3008AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	16067	EA		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
3009	PR #: 07-CMB-0200 Defense Information Assurance Certification and Accreditation Process (DIACAP)	12	MO		
3010	PR #: 07-CMB-0200 Beneficiary Mailing (NOTE: Quantities are estimates and reflect the entire option period)	1000000	EA		
3011	PR #: 07-CMB-0200 Award Fee Pool	1	LT	NSP	NSP
3011AA	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool November 1, 2011 through April 30, 2012	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
3011AB	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool May 1, 2012 through October 31, 2012	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
3012	PR #: 07-CMB-0200 Retail Network Cost Control Incentive Fee (NOTE: Maximum amount that can be earned)	NTE 1	LT	NTE 5,000,000.00	5,000,000.00
3013	PR #: 07-CMB-0200 Phase-Out	1	LT		

(b)(4)

(b)(4)

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
4001	OPTION PERIOD 4 November 1, 2012 through October 31, 2013 Mail Order and Specialty Pharmacy Services Administrative Fees	1	LT	NSP	NSP
	PR #: 07-CMB-0200				
4001AA	Mail Order Prescription, Medicare Dual-Eligible	15300000	EA	(b)(4)	
	PR #: 07-CMB-0200				
4001AB	Mail Order Prescription, TRICARE-Only Eligible	5000000	EA		
	PR #: 07-CMB-0200				
4001AC	Specialty Pharmacy Services, Medicare Dual-Eligible	47800	EA		
	PR #: 07-CMB-0200				
4001AD	Specialty Pharmacy Services, TRICARE-Only Eligible	41200	EA		
	PR #: 07-CMB-0200				
4002	Member Choice Center (MCC)- Contractor obtained Prescriptions to be filled by MOP at Beneficiary request	1	LT	NSP	NSP
	PR #: 07-CMB-0200				
4002AA	New Prescription from Provider, Medicare Dual-Eligible	50000	EA	(b)(4)	
	PR #: 07-CMB-0200				
4002AB	Transfer Prescription from MTF, Medicare Dual-Eligible	50000	EA		
	PR #: 07-CMB-0200				
4002AC	New Prescription from Provider, TRICARE-Only Eligible	50000	EA		
	PR #: 07-CMB-0200				
4002AD	Transfer Prescription from MTF, TRICARE-Only Eligible	50000	EA		

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	PR #: 07-CMB-0200				
4003	Un-Replenished MOP Pharmaceutical Agents & Supplies	NTE 1	LT	NTE 1,000,000.00	1,000,000.00
	PR #: 07-CMB-0200				
4004	Retail Prescription Administrative Fees, Medicare Dual-Eligible	1	LT	NSP	NSP
	PR #: 07-CMB-0200				
4004AA	Electronic Media Claims	46483333	EA	(b)(4)	
	PR #: 07-CMB-0200				
4004AB	Paper Claims (Per Prescription)	1433333	EA	(b)(4)	
	PR #: 07-CMB-0200				
4005	Retail Prescription Administrative Fees, TRICARE-Only Eligible	1	LT	NSP	NSP
	PR #: 07-CMB-0200				
4005AA	Electronic Media Claims	43566667	EA	(b)(4)	
	PR #: 07-CMB-0200				
4005AB	Paper Claims (Per Prescription)	1350000	EA	(b)(4)	
	PR #: 07-CMB-0200				
4006	Retail Prescription Administrative Fees, DVA Beneficiaries	225000	EA	(b)(4)	
	PR #: 07-CMB-0200				
4007	Prior Authorizations	1	LT	NSP	NSP

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
4007AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	35683	EA	(b)(4)	
4007AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	73500	EA		
4008	PR #: 07-CMB-0200 Medical Necessity Determinations	1	LT	NSP	NSP
4008AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	3917	EA	(b)(4)	
4008AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	17517	EA		
4009	PR #: 07-CMB-0200 Defense Information Assurance Certification and Accreditation Process (DIACAP)	12	MO	(b)(4)	
4010	PR #: 07-CMB-0200 Beneficiary Mailing (NOTE: Quantities are estimates and reflect the entire option period)	1000000	EA		
4011	PR #: 07-CMB-0200 Award Fee Pool	1	LT	NSP	NSP
4011AA	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool November 1, 2012 through April 30, 2013	NTE 1	EA	NTE 2,500,000.00	2,500,000.00

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
4011AB	Semi-Annual Award Fee Pool May 1, 2013 through October 31, 2013  PR #: 07-CMB-0200	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
4012	Retail Network Cost Control Incentive Fee (NOTE: Maximum amount that can be earned)  PR #: 07-CMB-0200	NTE 1	LT	NTE 5,000,000.00	5,000,000.00
4013	Phase-Out  PR #: 07-CMB-0200	1	LT	(b)(4)	
5001	OPTION PERIOD 5 November 1, 2013 through October 31, 2014 Mail Order and Specialty Pharmacy Services Administrative Fees  PR #: 07-CMB-0200	1	LT	NSP	NSP
5001AA	Mail Order Prescription, Medicare Dual-Eligible  PR #: 07-CMB-0200	16500000	EA	(b)(4)	
5001AB	Mail Order Prescription, TRICARE-Only Eligible  PR #: 07-CMB-0200	5400000	EA		
5001AC	Specialty Pharmacy Services, Medicare Dual-Eligible  PR #: 07-CMB-0200	51400	EA		
5001AD	Specialty Pharmacy Services, TRICARE-Only Eligible  PR #: 07-CMB-0200	44300	EA		
5002	Member Choice Center (MCC) - Contractor obtained Prescriptions to be filled by MOP at Beneficiary request	1	LT	NSP	NSP

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
5002AA	PR #: 07-CMB-0200 New Prescription from Provider, Medicare Dual-Eligible	50000	EA	(b)(4)	
5002AB	PR #: 07-CMB-0200 Transfer Prescription from MTF, Medicare Dual-Eligible	50000	EA		
5002AC	PR #: 07-CMB-0200 New Prescription from Provider, TRICARE-Only Eligible	50000	EA		
5002AD	PR #: 07-CMB-0200 Transfer Prescription from MTF, TRICARE-Only Eligible	50000	EA		
5003	PR #: 07-CMB-0200 Un-Replenished MOP Pharmaceutical Agents & Supplies	NTE 1	LT		
5004	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, Medicare Dual-Eligible	1	LT	NSP	NSP
5004AA	PR #: 07-CMB-0200 Electronic Media Claims	48803941	EA	(b)(4)	
5004AB	PR #: 07-CMB-0200 Paper Claims (Per Prescription)	1511557	EA		
5005	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, TRICARE-Only Eligible	1	LT	NSP	NSP

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount	
5005AA	PR #: 07-CMB-0200 Electronic Media Claims	45770439	EA	(b)(4)		
5005AB	PR #: 07-CMB-0200 Paper Claims (Per Prescription)	1412440	EA			
5006	PR #: 07-CMB-0200 Retail Prescription Administrative Fees, DVA Beneficiaries	225000	EA			
5007	PR #: 07-CMB-0200 Prior Authorizations	1	LT		NSP	NSP
5007AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	39245	EA		(b)(4)	
5007AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	80829	EA			
5008	PR #: 07-CMB-0200 Medical Necessity Determinations	1	LT		NSP	NSP
5008AA	PR #: 07-CMB-0200 Medicare Dual-Eligible	4065	EA		(b)(4)	
5008AB	PR #: 07-CMB-0200 TRICARE-Only Eligible	18372	EA			
5009	PR #: 07-CMB-0200 Defense Information Assurance Certification and Accreditation Process (DIACAP)	12	MO			

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
5010	PR #: 07-CMB-0200 Beneficiary Mailing (NOTE: Quantities are estimates and reflect the entire option period)	1000000	EA	(b)(4)	
5011	PR #: 07-CMB-0200 Award Fee Pool	1	LT	NSP	NSP
5011AA	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool November 1, 2013 through April 30, 2014	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
5011AB	PR #: 07-CMB-0200 Semi-Annual Award Fee Pool May 1, 2014 through October 31, 2014	NTE 1	EA	NTE 2,500,000.00	2,500,000.00
5012	PR #: 07-CMB-0200 Retail Network Cost Control Incentive Fee (NOTE: Maximum amount that can be earned)	NTE 1	LT	NTE 5,000,000.00	5,000,000.00
5013	PR #: 07-CMB-0200 Phase-Out	1	LT	(b)(4)	
6004	PR #: 07-CMB-0200 OPTION PERIOD 6 September 1, 2014 through November 30, 2014 Retail Prescription Administrative Fees, Medicare Dual-Eligible	1	LT	NSP	NSP
6004AA	PR #: 07-CMB-0200 Electronic Media Claims	12200000	EA	(b)(4)	
	PR #: 07-CMB-0200			(b)(4)	

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	
6004AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	380000	EA	(b)(4)
6005	Retail Prescription Administrative Fees, TRICARE-Only Eligible PR #: 07-CMB-0200	1	LT	NSP NSP
6005AA	Electronic Media Claims PR #: 07-CMB-0200	11500000	EA	(b)(4)
6005AB	Paper Claims (Per Prescription) PR #: 07-CMB-0200	360000	EA	(b)(4)
6006	Retail Prescription Administrative Fees, DVA Beneficiaries PR #: 07-CMB-0200	56250	EA	(b)(4)
6007	Prior Authorizations PR #: 07-CMB-0200	1	LT	NSP NSP
6007AA	Medicare Dual-Eligible PR #: 07-CMB-0200	10600	EA	(b)(4)
6007AB	TRICARE-Only Eligible PR #: 07-CMB-0200	21900	EA	(b)(4)
6008	Medical Necessity Determinations PR #: 07-CMB-0200	1	LT	NSP NSP
6008AA	Medicare Dual-Eligible PR #: 07-CMB-0200	1000	EA	(b)(4)
6008AB	TRICARE-Only Eligible PR #: 07-CMB-0200	4700	EA	(b)(4)
6009	Defense Information Assurance Certification and Accreditation Process (DIACAP) PR #: 07-CMB-0200	3	MO	(b)(4)

**Supplies or Services and Prices/Costs**

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
6010	Beneficiary Mailing (NOTE: Quantities are estimates and reflect the entire option period)  PR #: 07-CMB-0200	250000	EA	(b)(4)	
6011	Award Fee Pool  PR #: 07-CMB-0200	1	LT	NSP	NSP
6011AA	Final Award Fee Pool September 2014 through November 2014  PR #: 07-CMB-0200	NTE 1	EA	NTE 1,250,000.00	1,250,000.00
6012	Retail Network Cost Control Incentive Fee (NOTE: Maximum amount that can be earned)  PR #: 07-CMB-0200	NTE 1	LT	NTE 1,250,000.00	1,250,000.00
6013	Phase-Out  PR #: 07-CMB-0200	1	LT	(b)(4)	

## B.1

**Section B - CLIN DESCRIPTIONS**

*Note: An "X" identifier indicates the same Contract Line Item Number (CLIN) or Sub-Line Item Number (SLIN) for all applicable option periods (example: CLIN X004 refers to CLINs 1004, 2004, 3004, 4004, 5004 and 6004)*

**CLIN 0001 (Phase In, Mail Order and Specialty Pharmacy)** – This CLIN is only for the cost of phase-in efforts for mail order and specialty pharmacy. This effort is to be priced during the base period only. See Sections C.5.3 and C.5.19 for technical requirements. Note: There are separate CLINs for phase-in of Retail Pharmacy (see CLIN 0004) and Department of Veterans Affairs (DVA) requirements (see CLIN 0003). Contract type for this CLIN is Firm Fixed Price (FFP).

**CLIN 0002 (Defense Information Assurance Certification and Accreditation Process (DIACAP))** – This CLIN is for DIACAP certification costs. This effort is to be priced during the base period only. Other DIACAP CLINs (X009) are for ongoing training and maintenance costs. Costs for the Health Insurance Portability and Accountability Act (HIPAA) compliance are not to be included in this CLIN. See Section C.5.11 and the TRICARE Systems Manual (TSM), Chapter 1, Section 1.1 for technical requirements. Contract type for this CLIN is FFP.

**CLIN 0003 (Phase-In, Department of Veterans Affairs Requirements)** – This CLIN is only for the cost of phase-in efforts related to DVA beneficiaries using retail pharmacy services. This effort is to be priced during the base period only and reflects effort from date of award through March 31, 2010. See Section C.5.2.5 for technical requirements. Contract type for this CLIN is FFP.

**CLIN 0004 (Phase-In, Retail Pharmacy)** – This CLIN is for the phase-in efforts for retail pharmacy for the TRICARE-Only and Medicare Dual-Eligible. This effort is to be priced in base period only and reflects effort from date of award through November 3, 2010. See Section C.5.19 for technical requirements. Contract type for this CLIN is FFP.

**CLIN X001 (Mail Order and Specialty Pharmacy Services Administrative Fees)** – This overarching CLIN is for mail order prescription and specialty pharmacy services administrative fees only. This CLIN applies to Option Periods 1 through 5. See Section C.5.3 for technical requirements for Mail Order Pharmacy (MOP) and Specialty Pharmacy Services. Note: There are separate CLINs for retail pharmacy efforts (see CLINs X004, X005, and X006). This CLIN is not separately priced, but does have the following separately priced sub-CLINs (SLINs):

**SLIN X001AA (Mail Order Prescription, Medicare Dual-Eligible)** – This SLIN is for the costs of dispensing pharmaceuticals, including specialty pharmaceuticals identified in TOM Chapter 23, Addendum A, when no specialty pharmacy services are provided, for **Medicare Dual-Eligible** beneficiaries. It includes all costs (excluding pharmaceuticals) associated with dispensing a prescription through the mail order pharmacy, including adjudicating each claim and mailing each prescription. Contract type for this SLIN is Indefinite-Delivery/Requirements (ID/R).

**SLIN X001AB (Mail Order Prescription, TRICARE Only Eligible)** – This SLIN is for the cost of dispensing pharmaceuticals, including specialty pharmaceuticals identified in TOM Chapter 23, Addendum A, when no specialty pharmacy services are provided for **TRICARE Only Eligible** beneficiaries. It includes all costs (excluding pharmaceuticals) associated with dispensing a prescription through the mail order pharmacy, including adjudicating each claim and mailing each prescription. Contract type for this SLIN is ID/R.

**SLIN X001AC (Specialty Pharmacy Services, Medicare Dual-Eligible)** – This SLIN is for the cost of dispensing specialty pharmaceuticals identified in TOM Chapter 23, Addendum A through the mail order pharmacy and for providing specialty pharmacy services to **Medicare Dual-Eligible beneficiaries** who

agreed to receive those specialty services. It includes all costs (excluding pharmaceuticals) associated with dispensing a specialty prescription through the mail order pharmacy, including adjudicating each claim and mailing each prescription, and all costs associated with providing specialty pharmacy services. See Section C.5.3.7 for additional definitions and other information pertaining to specialty pharmacy services. Contract type for this SLIN is ID/R.

**SLIN X001AD (Specialty Pharmacy Services, TRICARE Only Eligible)** – This SLIN is for the cost of dispensing specialty pharmaceuticals identified in TOM Chapter 23, Addendum A through the mail order pharmacy and for providing specialty pharmacy services to **TRICARE Only Eligible beneficiaries** who agreed to receive those specialty services. It includes all costs (excluding pharmaceuticals) associated with dispensing a specialty prescription through the mail order pharmacy, including adjudicating each claim and mailing each prescription, and all costs associated with providing specialty pharmacy services. See Section C.5.3.7 for additional definitions and other information pertaining to specialty pharmacy services. Contract type for this SLIN is ID/R.

**CLIN X002 (Member Choice Center (MCC) – Contractor obtained Prescriptions to be filled by the MOP at Beneficiary request)** – This CLIN is to provide support to eligible beneficiaries as specified in the sub-CLINs below. This CLIN applies to Option Periods 1 through 5. See Section C.5.8. for technical requirements. This CLIN is not separately priced, but does have the following separately priced SLINs:

**SLIN X002AA (New Prescription from Provider, Medicare Dual Eligible)** – This SLIN is for the cost of contacting the prescriber to obtain a new prescription to assist **Medicare Dual Eligible** beneficiaries, upon their request, in transferring a prescription from a retail pharmacy to a Mail Order Pharmacy. Contract type for this SLIN is ID/R.

**SLIN X002AB (Transfer Prescription from MTF, Medicare Dual Eligible)** – This SLIN is for assisting **Medicare Dual Eligible** beneficiaries, upon their request, to transfer a prescription from a Military Treatment Facility pharmacy to the Mail Order Pharmacy. Contract type for this SLIN is ID/R.

**SLIN X002AC (New Prescription from Provider, TRICARE-Only Eligible)** – This SLIN is for contacting the prescriber to obtain a new prescription to assist **TRICARE-Only Eligible** beneficiaries, upon their request, in transferring a prescription from a retail pharmacy to a Mail Order Pharmacy. Contract type for this SLIN is ID/R.

**SLIN X002AD (Transfer prescriptions from MTF, TRICARE Only Eligible)** – This SLIN is for assisting **TRICARE-Only Eligible** beneficiaries, upon their request, to transfer a prescription from Military Treatment Facility to the Mail Order Pharmacy. Contract type for this SLIN is ID/R.

**CLIN X003 (Un-Replenished MOP Pharmaceutical Agents & Supplies)** – This CLIN is for reimbursement of the contractor for the value of all pharmaceutical agents and supplies dispensed at the MOP that could not be replenished through the National Prime Vendor (see Section C.3). This CLIN applies to Option Periods 1 through 5. This CLIN contains un-definitized Not To Exceed (NTE) amounts subject to billing audits. See Section G.11 for contract administration and payment information. Contract type for this CLIN is Cost Reimbursable.

**CLIN X004 (Retail Prescription Administrative Fee, Medicare Dual-Eligible)** – This overarching CLIN is for administrative fees associated with prescriptions dispensed at retail pharmacies for **Medicare Dual-Eligible** beneficiaries. This CLIN applies to Option Periods 1 through 5. See Section C.5.2 for technical requirements for Retail Pharmacy Services. This CLIN is not separately priced, but does have the following separately priced SLINs:

**SLIN X004AA (Electronic Media Claims)** – This SLIN is for the cost of processing electronic prescription claims, including adjudication, for prescriptions dispensed through a retail for **Medicare Dual-Eligible** beneficiaries. This SLIN also applies to the processing of claims received on CD's or in a batch format. Contract type for this SLIN is ID/R.

**SLIN X004AB (Paper Claims (Per Prescription))** – This SLIN is for the cost of processing a paper claim for prescriptions dispensed through a retail or non-TRICARE mail order pharmacy for **Medicare Dual-Eligible** beneficiaries. A single administrative fee will be applied to each adjudicated prescription submitted on an authorized paper claim form. Contract type for this SLIN is ID/R.

**CLIN X005 (Retail Prescription Administrative Fee, TRICARE-Only Eligible)** – This overarching CLIN is for administrative fees associated with prescriptions dispensed at retail pharmacies for **TRICARE-Only Eligible** beneficiaries. This CLIN applies to Option Periods 1 through 5. See Section C.5.2 for technical requirements for Retail Pharmacy Services. This CLIN is not separately priced, but does have the following separately priced SLINs:

**SLIN X005AA (Electronic Media Claims)** – This SLIN is for the cost of processing electronic prescription claims, including adjudication, for prescriptions dispensed through a retail pharmacy for **TRICARE-Only Eligible** beneficiaries. This SLIN also applies to the processing of claims received on CD's or in a batch format. Contract type for this SLIN is ID/R.

**SLIN X005AB (Paper Claims (Per Prescription))** – This SLIN is for the cost of processing a paper claim for prescriptions dispensed through a retail or non-TRICARE mail order pharmacy for **TRICARE-Only Eligible** beneficiaries. A single administrative fee will be applied to each adjudicated prescription submitted on an authorized paper claim form. Contract type for this SLIN is ID/R.

**CLIN X006 (Retail Prescription Administrative Fee, DVA Beneficiaries)** – This CLIN is for is for administrative fees associated with processing electronic point of sale Department of Veterans Affairs beneficiary claims, including adjudication, through a retail pharmacy. This CLIN applies to Option Periods 1 through 5. See Section C.5.2.5 for technical requirements. Note: The Option Period 1 amount reflects effort for March 31, 2010 through October 31, 2010 only. Contract type for this CLIN is ID/R.

**CLIN X007 (Prior Authorizations)** – This overarching CLIN is for administrative fees associated with processing prior authorization determinations for specific pharmaceuticals. This CLIN applies to Option Periods 1 through 6. See Section C.5.7.1 for technical requirements of prior authorizations. This CLIN is not separately priced, but does have the following separately priced SLINs:

**SLIN X007AA (Medicare Dual-Eligible)** – This SLIN is for the cost of processing prior authorizations for **Medicare Dual-Eligible** beneficiaries. Contract type for this SLIN is ID/R.

**SLIN X007AB (TRICARE-Only Eligible)** – This SLIN is for the cost of processing prior authorizations for **TRICARE-Only Eligible** beneficiaries. Contract type for this SLIN is ID/R.

**CLIN X008 (Medical Necessity Determinations)** – This overarching CLIN is for is for administrative fees associated processing initial determinations of medical necessity for the purpose of providing a non-formulary drug at the formulary co-payment. This CLIN applies to Option Periods 1 through 6. See Section C.5.7.2 for technical requirements for medical necessity determinations. This CLIN is not separately priced, but does have the following sub-separately priced CLINs:

**SLIN X008AA (Medicare Dual-Eligible)** – This SLIN is for the cost of processing medical necessity determinations for **Medicare Dual-Eligible** beneficiaries. Contract type for this SLIN is ID/R..

**SLIN X008AB (TRICARE-Only Eligible)** – This SLIN is for processing medical necessity determinations for **TRICARE-Only Eligible** beneficiaries. Contract type for this SLIN is ID/R.

**CLIN X009 (Defense Information Assurance Certification and Accreditation Process (DIACAP))**. This CLIN is for ongoing DIACAP training and maintenance costs. This CLIN applies to Option Periods 1 through 5. See Section C.5.11 and the TSM, Chapter 1, Section 1.1 for technical requirements. NOTE: Costs for HIPAA compliance are not to be included in this CLIN. Contract type for this CLIN is FFP.

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**CLIN X010 (Beneficiary Mailing)** - This CLIN is for the cost of mailing beneficiaries notices in accordance with Sections C.5.12.2.4. and C.5.12.2.4.1. This CLIN applies to Option Periods 1 through 6. Note: Due to the nature of these notices, the quantity for each mailing may fluctuate significantly. The estimated quantities provided in Schedule B reflect the entire option period. Contract type for this CLIN is ID/R.

**CLIN X011 (Award Fee Pool)** – This CLIN is for an award fee pool, to be administered semi-annually (SLINs X0011AA and X0011AB). There are two semi-annual award fees administered each for Option Periods 1 through 5. See Section H.4 for the special provision for award fee. Note: The amounts posted in Schedule B reflect the maximum amount of the award fee possible for each semi-annual period.

**CLIN X012 (Retail Network Cost Control Performance Incentive Fee)** – This CLIN is for a performance incentive fee the contractor may earn based the network reimbursement cost guarantee provision at Section H.1. This CLIN applies to Options 1 through 5. Note: The amounts posted in Schedule B are the maximum amounts possible for each period.

**CLIN X013 (Phase-Out)** – This CLIN is for the cost of phase-out activities in accordance with Section C.5.20, and the TOM, Chapter 23. This CLIN applies to Option Periods 1 through 5. Note: Although this CLIN is priced at each option period, phase-out activities will only occur once during the life of the contract. Contract type for this CLIN is FFP.

**C.1**

**PROGRAM DESCRIPTION**

The Department of Defense (DoD) administers an integrated TRICARE Pharmacy Benefits Program which offers pharmacy services to eligible beneficiaries through direct care pharmacies located at Military Treatment Facilities (MTFs), through the current TRICARE Mail Order Pharmacy (TMOP) contract, and through the current TRICARE Retail Pharmacy (TRRx) contract. The TRRx contract allows eligible beneficiaries to obtain pharmacy services through either TRICARE retail network pharmacies or otherwise authorized retail non-network pharmacies. The TMOP and TRICARE retail network pharmacies are part of a system for the delivery and distribution of pharmaceuticals by DoD in filling prescriptions for eligible beneficiaries. When pharmacy services are obtained by eligible beneficiaries from otherwise authorized retail non-network pharmacies, DoD reimburses the allowable costs for covered pharmaceuticals and supplies less the applicable beneficiary deductibles and cost shares. Under this TRICARE Pharmacy (TPharm) contract which, replaces the TMOP and TRRx program contracts, the contractor will function as a Pharmacy Benefits Manager (PBM) to provide the Mail Order Pharmacy (MOP) (including specialty pharmacy) services, provide a TRICARE retail pharmacy network, and perform as a fiscal intermediary on behalf of DoD to pay for all authorized pharmaceuticals and supplies dispensed for eligible beneficiaries at retail pharmacies. Mail Order (including specialty pharmacy) services and retail pharmacy services will be implemented on November 4, 2009. DVA services will be implemented March 31, 2010. The TMOP and TRRx programs supported by TPharm are open to all eligible beneficiaries under TRICARE, the Continued Health Care Benefit Program (CHCBP), certain Senior Pharmacy beneficiaries, and TRICARE Reserve Select. Eligible beneficiaries need not enroll in order to use the program(s). Certain patients of the Department of Veterans Affairs (DVA) will also be eligible to have prescriptions filled at TRICARE retail network pharmacies as described in C.5.2.5 in circumstances when the patient requires immediate therapy and there is no DVA pharmacy in close proximity to provide the medication. This occurs with outlying Community Based Outpatient Clinics (CBOCs) and at off hours, where a supply of medication is needed to initiate therapy until the remainder of therapy can be mailed from the DVA's Consolidated Mail Outpatient Pharmacy (CMOP). DVA beneficiaries are not eligible to obtain prescriptions from the TRICARE Mail Order Pharmacy or from retail pharmacies that are not part of the TRICARE retail pharmacy network.

**C.1.1.** Government funds, either appropriated or derived from the Medicare-eligible Retiree Health Care Fund, will be used by the contracted PBM to pay for all TRICARE prescriptions dispensed by network and non-network retail pharmacies. The PBM will be paid fees at the contracted rate for performing administrative services under the contract, such as functioning as a fiscal intermediary for the Government. The fees paid to the PBM will not be related directly or indirectly to the Government's acquisition costs of pharmaceuticals under Section 603 of the Veterans Health Care Act of 1992, or Section 201(a) of the Federal Property and Administrative Services Act of 1949. The PBM will issue payment using Government funds to pay each TRICARE prescription dispensed at retail network pharmacies after receiving the Government's verification of the individual beneficiary's eligibility and authorization for payment. Therefore, the Government will be acquiring covered drugs and procuring them for the use of the Federal Government in support of this contract with Government funds. The PBM will issue payment using Government funds to reimburse each prescription dispensed at otherwise authorized retail non-network pharmacies after receiving the Government's verification of the individual beneficiary's eligibility and authorization for payment.

**C.1.2.** The contracted PBM will provide Mail Order Pharmacy (MOP) (including specialty pharmacy) services to eligible beneficiaries, and will be paid fees at the contracted rate for performing administrative services under the contract. MOP and specialty pharmacy prescriptions will be filled using contractor-furnished, contractor-managed inventory, with DoD furnishing replenishment pharmaceutical agents through a DoD-contracted National Prime Vendor. The PBM administrative fees for MOP services will not be related directly or indirectly to DoD's acquisition cost of pharmaceutical agents.

**C.2. STATEMENT OF OBJECTIVES** The following objectives identify the desired outcomes of this contract and are supported by the technical requirements in Section C:

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**C.2.1.** Uniformly, consistently, and equitably provide a prescription drug benefit to meet patients' clinical needs in an effective, efficient, and fiscally responsible manner.

**C.2.2.** Influence beneficiaries and prescribers to increase utilization of the mail order pharmacy.

**C.2.3.** Promote patient safety through the utilization of best commercial practice.

**C.2.4.** Establish and maintain a high level of beneficiary satisfaction.

**C.2.5.** Use a cost-effective management approach to provide the necessary services, incorporating commercial practices consistent with the requirements of the contract.

**C.3. GOVERNMENT-FURNISHED PROPERTY AND SERVICES**

**C.3.1.** The contractor shall provide the inventory of pharmaceutical agents for the Mail Order Pharmacy (MOP) for dispensing to TRICARE beneficiaries. The contractor shall request replenishment pharmaceutical agents dispensed to TRICARE beneficiaries by using the Managed Care Pricing File (MCPF) to obtain pharmaceuticals from a Defense Supply Center Philadelphia (DSCP) contracted National Prime Vendor (NPV). DSCP compiles the MCPF from Federal Supply Schedules (FSS), Distribution and Pricing Agreements (DAPA), joint Department of Defense/Department of Veterans Affairs (DoD/DVA) national contracts, DoD contracts, and Blanket Purchase Agreements (BPA). The contractor shall use the MCPF to identify, select, and price orders from the DSCP NPV for products in package sizes that are most economical to the Government. Orders shall be rounded down to the nearest whole package size of product needed to replenish product dispensed through the MOP. The pharmaceuticals or products will be shipped to the contractor's MOP. DSCP is responsible for reimbursement of the NPV.

**C.3.1.1.** Prior to the beginning of the first option period, by a date mutually agreed upon during the post award meeting, and during each successive exercised option period within 60 days of Contracting Officer notification, the contractor will submit a baseline listing of multi-source generic or branded products by 11 digit National Drug Code (NDC) for Contracting Officer approval. Each baseline listing will identify the therapeutically equivalent NDC that is the most economical to the Government, and will be dispensed for each product whenever substitution is permitted by the prescriber. Following the start of Option Period 1, the contractor shall continuously monitor product availability and pricing of all products to provide recommendations to the Government for the most cost-effective agents to be dispensed through the MOP. The contractor shall identify the recommended change by 11 digit NDC for Government approval and the anticipated annual savings to the Government based on current utilization trends. The Contracting Officer may direct the contractor to make additional changes due to: 1) significant changes in drug prices, 2) the Government's award of a pharmaceutical procurement contract, or 3) other circumstances that necessitate a change. Authorization for switches must be obtained from the Contracting Officer or Contracting Officer's Representative (COR) in writing. The contractor shall complete each NDC change not later than thirty calendar days after being notified by the Government. The contractor shall submit a written request for extension to the COR within ten days of receiving initial notification if the NDC change is expected to take longer than thirty calendar days. The request shall state the date the NDC change will be made and include the rationale for the extension. The contractor shall attempt to deplete current prime vendor inventory prior to implementing the NDC change.

**C.3.1.2.** The contractor shall track and report volume of dispensed pharmaceutical agents, replenishment pharmaceutical agents ordered and received from the NPV, and provide auditable reconciliation reporting by 11 digit NDC number, in accordance with Section F.3.3.6.

**C.3.1.3.** The contractor shall not deviate from the procedures described above when ordering products from the DSCP NPV without prior written authorization from the Contracting Officer or COR. Requests to do so shall include the 11 digit NDC number, nomenclature of the product(s), package size, anticipated purchase

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quantity, unit cost per package, and anticipated total cost of the order for both the requested product and the product it will replace.

**C.3.1.4.** In limited cases, the contractor may be required to order certain pharmaceutical agents and supplies through the NPV to be drop shipped directly from the manufacturer to the TPharm contractor. The quantities ordered shall not exceed the amount to be dispensed.

**C.3.1.5.** In limited cases, the contractor may be required to order pharmaceutical agents and supplies from commercial sources other than the NPV, when not available from the NPV. The contractor shall only proceed in this manner with the written approval of the Contracting Officer. The Government will reimburse the contractor for these items in accordance with Section G.11.

**C.3.1.6.** The contractor shall enter/acknowledge the item quantity received for all purchase orders placed with the Prime Vendor in a DoD directed database/system/or webpage within two business days of the product being delivered to the contractor's facility. The contractor, by performing the quantity receipt acknowledgement process, will not be responsible for the cost of the product received from the DSCP to the extent that receipts represent replenishment of authorized quantities dispensed at the MOP.

**C.3.2.** The contractor shall use Pharmacy Data Transaction Service (PDTS) for automated concurrent drug utilization review. Connectivity to PDTS is described in the Interface Control Document (ICD) incorporated at Section C.4.3. Physical connectivity will be accomplished via a contractor-provided, dedicated, high-speed data link, e.g., a T1/T3 line.

**C.3.3.** The Government will provide licenses for the contractor to access and use SelectRx (PDTS' proprietary helpdesk tool), General Inquiry to DEERS (GIQD), CC&D website, and Other Health Insurance Standard Insurance Table (OHI/SIT).

**C.3.4.** The contractor shall connect to the Defense Enrollment Eligibility Reporting System (DEERS) to verify eligibility, update the Catastrophic Cap and Deductible Database (CCDD) file, and check for Other Health Insurance (OHI). Connectivity to DEERS shall be in accordance with the TRICARE Systems Manual.

**C.3.5.** The Government will provide prior authorization criteria for pharmaceuticals that require prior authorization (PA) and medical necessity (MN) criteria for pharmaceutical agents designated as non-formulary by the DoD. The contractor shall design the PA and MN forms and incorporate its best business practices. These forms shall be provided by the contractor and approved by the Government.

**C.3.6.** The Government will provide a beneficiary zip code file on a monthly basis identifying the number of beneficiaries residing in each zip code for evaluating and reporting on compliance with network access standards.

**C.3.7.** On a quarterly basis, the Government will provide a file of newly eligible beneficiaries to the contractor to support the educational requirements specified at C.5.12.2.3.

#### **C.4. REQUIREMENT DOCUMENTS**

**C.4.1. Statutory Requirements.** 10 U.S.C. § 1074g, 38 U.S.C. § 8126 (Veterans Health Care Act of 1992), 32 C.F.R. 199, and 45 C.F.R. 160 and 164 (security and privacy standards, requirements and implementation specifications) are incorporated by reference and made a part of the contract.

**C.4.2. TRICARE Manuals.** Additionally, the following TRICARE manuals are incorporated by reference:

- **TRICARE Policy Manual (TPM) 6010.57-M dated February 1, 2008, through change 4**
- **TRICARE Reimbursement Manual (TRM) 6010.58-M dated February 1, 2008, through change 4**

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- **TRICARE Systems Manual (TSM) 7950.2-M dated February 1, 2008, through change 4**
- **TRICARE Operations Manual (TOM) 6010.56-M dated February 1, 2008, through change 4**

The TRICARE Policy Manual takes precedence over the other three TRICARE Manuals. The TRICARE Reimbursement Manual takes precedence over the TRICARE Systems Manual and the TRICARE Operations Manual. The TRICARE Systems Manual takes precedence over the TRICARE Operations Manual.

These documents form an integral part of this contract and have the same force and effect as if set forth in full text.

**C.4.2.1. DEFINITIONS.** Definitions are included in the TRICARE Operations Manual, Appendix B.

**C.4.3.** Section J attachments, PDTS Interface Control Document (ICD) dated 12 March 2008, TPharm Surveillance Plan dated October 31, 2007, Service Contract Act Wage Determinations At Award, and Subcontract Plan dated May 30, 2008, are incorporated and made a part of the contract.

**C.4.4.** In addition to contract requirements contained or incorporated in this contract section C, certain requirements regarding contract administration and payments to and/or recoupments from retail pharmacies and beneficiaries, are contained at contract Section G.

## **C.5. PERFORMANCE REQUIREMENTS**

The contractor shall provide mail order pharmacy (including specialty pharmacy) services, a retail pharmacy network, and related Pharmacy Benefit Management (PBM) services as specified herein. The contractor shall not negotiate or collect any pharmaceutical rebates, data-use rebates, or vendor charge-backs of any type from pharmaceutical manufacturers, wholesalers, and/or network pharmacies on behalf of the Government or for itself in regard to the services performed under this contract.

**C.5.1. Defense Enrollment Eligibility Reporting System (DEERS).** The contractor shall interface with DEERS for eligibility verification, OHI status, and the CCDD file.

**C.5.1.1. Eligibility Verification.** The contractor shall verify eligibility prior to providing any of the services required under this contract.

**C.5.1.2. Other Health Insurance (OHI).** When the contractor identifies beneficiary OHI through sources other than DEERS (e.g., claim forms, beneficiary declarations, contractor's internal files), it shall forward the OHI information to DEERS in accordance with the TRICARE Systems Manual.

**C.5.1.2.1.** A beneficiary with OHI cannot use the MOP, unless the OHI does not cover the prescribed pharmaceutical or the beneficiary has exhausted the benefits under the OHI. To receive TRICARE coverage of pharmaceuticals dispensed through the MOP, the beneficiary must submit documentation from the OHI to the contractor showing that the OHI does not cover the prescribed item or an Explanation of Benefits (EOB) indicating that coverage has been exhausted.

**C.5.1.2.2.** The contractor shall complete real-time, on-line coordination of benefits in accordance with National Council for Prescription Drug Programs (NCPDP) 5.1 standards (or most current version) for those claims filed in retail network pharmacies where OHI has been identified, to include Medicare Part D claims. The Government will provide the COB and Medicare Part D billing transaction segments to include the required values. The contractor is required to track Medicare Part D true out-of-pocket expenses (TROOP) and total drug expenditures for each TRICARE beneficiary who is also enrolled in Medicare Part D. The contractor shall provide this information to the Centers for Medicare & Medicaid Services (CMS) designated TROOP facilitator. Claims shall be reimbursed in accordance with the TRICARE Reimbursement Manual (TRM), Chapter 4.

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**C.5.1.3.** The contractor shall query the CCDD file in DEERS to determine the beneficiary's catastrophic cap and deductible status in order to apply the correct co-payment and deductible. The contractor will update the CCDD file in accordance with the TSM.

**C.5.2. Retail Pharmacy Services.**

**C.5.2.1.** The contractor shall establish and maintain a retail pharmacy network throughout the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Northern Mariana Islands, and Guam. The contractor shall provide network retail pharmacy services in American Samoa, when there are pharmacies in American Samoa with NCPDP numbers which are then eligible to become TRICARE network pharmacies. The contractor shall establish a pharmacy network which meets the minimum access standards at C.5.18.1.

**C.5.2.1.1.** At the Government's discretion, the contractor may be required to include DVA, Public Health Service (PHS), and Indian Health Service (IHS) pharmacies in its network. Reimbursement for pharmaceuticals dispensed through these pharmacies will be directed by the Government. These Pharmacies will be reimbursed at acquisition cost plus a Government negotiated dispensing fee. These pharmacies shall not be included in the measuring of performance under the network access standards nor in the calculation of the guaranteed reimbursement rates.

**C.5.2.1.2.** The contractor will identify beneficiaries who, during the six months prior to the letter mailing date, used pharmacies that are not in the contractor's pharmacy network. The contractor will inform these beneficiaries by letter that the pharmacy they previously used is not in the retail pharmacy network, and provide information that enables the beneficiary to identify network pharmacies. This letter will be mailed so that beneficiaries will receive it 30 to 40 days prior to the start-up of retail pharmacy services. The contractor shall ensure that the number of pharmacies included in its network is never less than 90% of the total number of pharmacies originally proposed for its network. The number of pharmacies in the network will be measured monthly throughout the life of the contract using the reports identified at Section F.3.3.1.

**C.5.2.2.** All network pharmacies shall be fully licensed in accordance with applicable Federal and State laws, credentialed according to the contractor's criteria, and have a current NCPDP number. Pharmacies providing pharmaceuticals solely through Internet or mail order pharmacies shall not be included in the retail network. Retail pharmacies who offer to mail prescriptions to beneficiaries as part of their business may be included in the network subject to the retail pharmacy specifications listed herein. The contractor shall ensure that network pharmacies have procedures to reasonably assess the validity of prescriptions ordered by telephone.

**C.5.2.3. Retail Network Agreements.** The contractor shall ensure that the following requirements are included in their retail network agreements:

**C.5.2.3.1.** At a minimum, the retail pharmacies shall provide TRICARE beneficiaries the same quality of services provided to beneficiaries of other commercial clients to the extent allowed by Federal regulation and TRICARE policy.

**C.5.2.3.2.** All pharmacies shall maintain a process to document receipt of the medication by the beneficiary or the individual authorized by the beneficiary.

**C.5.2.3.3.** The contractor shall ensure that retail network pharmacies collect beneficiary co-payments in accordance with the TRM, Chapter 2, Addendum B. The contractor shall reimburse pharmacies in accordance with its network agreements. The contractor shall not collect any additional fees, rebates, discounts, or premiums specific to processing TRICARE prescriptions other than recoveries (payable to the U.S. Treasurer, TMA/Contract Resource Management) resulting from audits of network pharmacies.

**C.5.2.4. Retail Pharmacy Prescription Claims.**

**C.5.2.4.1.** The contractor shall accept and process all claims for pharmaceutical agents and diabetic supplies covered under the TRICARE pharmacy benefit, and purchased from a licensed pharmacy in the 50 United States.  
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States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa and Guam. Claims received for pharmaceutical agents and diabetic supplies furnished in geographical locations not covered under this contract shall be forwarded to the TRICARE contractor responsible for processing claims for those locations within 72 hours as specified in the TOM, Chapter 8, Section 2. Network pharmacies may submit claims for covered supply items using the NDC numbers or NDC-like numbers assigned to them. . Claims for pharmaceutical agents (e.g. injectables) ordered by and administered by an authorized provider or clinic shall be provided in accordance with the TPM, Chapter 8, Section 9.1.

**C.5.2.4.2.** The contractor shall process batch claims in the most current NCPDP batch format. The contractor may receive batch claims from a variety of sources (e.g., State Medicaid agencies, clearinghouses, DVA).

**C.5.2.4.3.** Claims for prescriptions filled but not dispensed (non-compliant) shall be reversed within ten calendar days of the date the original claim was submitted to the maximum extent possible. Reversals processed more than ten calendar days after the date the original claim was submitted will require an adjusted or cancelled TED record. The TED adjustment/cancellation must maintain an accurate clinical record on PDTS. The contractor will not be eligible for cancellation fees unless submitted in accordance with the TRICARE Systems Manual (TSM).

**C.5.2.4.4.** The contractor shall process paper claims for prescriptions filled in non-network pharmacies, OHI claim balances (e.g., split-billing), assignment of benefit claims, and covered pharmaceutical agents and diabetic supplies purchased in a pharmacy without a prescription. A properly completed, acceptable claim form must be submitted to the contractor before payment may be considered. The contractor shall accept the following claim forms for TRICARE benefits: Department of Defense DD Form 2642, Health Care Financing Administration HCFA 1500, and the Uniform Billing UB-04. Upon request, the contractor shall mail the current version of the DD 2642 claim form to beneficiaries. The contractor shall also make the form available for downloading by linking its TPharm web site to the DD 2642 on the TMA website. Paper claims for non-network pharmacy services shall be reimbursed in accordance with the TRM, Chapter 1, Section 15, minus applicable co-payments and deductibles. The contractor shall process these claims, by prescription, using the most current NCPDP format. For denied paper claims, notification to the beneficiary must be in writing, and must explain why the order or claim was denied, detailing the beneficiary's appeal rights. Each prescription processed will generate an individual TRICARE Encounter Data (TED) record in accordance with the TSM.

**C.5.2.5. Retail Network Pharmacy Services for DVA Beneficiaries.**

**C.5.2.5.1.** The contractor shall utilize the DVA's eligibility database to verify eligibility prior to authorizing retail network pharmacies to dispense prescriptions to DVA beneficiaries. The contractor shall bear the cost and burden of establishing the communications interface with DVA's eligibility database and shall ensure that the interface meets DVA security requirements. Eligibility queries will utilize NCPDP standards as required under the Health Insurance Portability and Accountability Act (HIPAA). DVA beneficiaries are only authorized the dispensing of emergent need medications when prescribed on a DVA prescription blank stating "Authorized for Emergent Need." Therefore the contractor shall ensure that network pharmacies verify that the prescription is on a DVA prescription blank that includes this statement. If a DVA beneficiary has questions about eligibility for services, the contractor shall tell the beneficiary to contact their primary care provider at the DVA facility.

**C.5.2.5.2.** The contractor shall authorize network pharmacies to fill prescriptions for DVA beneficiaries for any pharmaceutical agent that is covered under the TRICARE retail pharmacy benefit regardless of the status of the pharmaceutical agent on the DoD Uniform Formulary. The status of a pharmaceutical agent on the DoD Uniform Formulary, the DoD co-payment requirements, the DoD prior authorization requirements, the DoD Medical Necessity Determination requirements, and DoD recoupment requirements do not apply to prescriptions filled for DVA beneficiaries. The contractor shall ensure that network pharmacies do not collect co-payments from DVA beneficiaries.

**C.5.2.5.3.** The contractor shall apply the DoD quantity limits and the DoD mandatory generic policy to prescriptions filled for DVA beneficiaries, except that Coumadin® will be dispensed for prescriptions for warfarin sodium, Dilantin® will be dispensed for prescriptions for phenytoin sodium, Synthroid® will be dispensed for prescriptions for levothyroxine and Cordarone® will be dispensed for prescriptions for amiodarone.

**C.5.2.5.4.** DVA beneficiaries are not eligible for non-network retail pharmacy prescription services. The contractor shall deny paper claims received for prescriptions filled for DVA beneficiaries at non-network pharmacies. If a non-network retail pharmacy fills a prescription for a DVA beneficiary, the DVA beneficiary is responsible for payment to the pharmacy in full.

**C.5.2.5.5.** The contractor shall not mail TPharm educational materials to DVA beneficiaries, unless specifically authorized to do so by the DVA through the TPharm Contracting Officer.

### **C.5.3. Mail Order Pharmacy and Specialty Pharmacy Services**

**C.5.3.1. MOP Prescription Processing.** The contractor shall support MOP registration submitted in writing, via telephone, or via the contractor's web site. The contractor shall accurately process prescription orders received at the MOP for eligible beneficiaries. The contractor shall accept prescription orders at the mail order pharmacy by written (original or facsimile), electronic (supporting digital signature including e-prescribing), or telephonic submission. The contractor shall ensure that the mail order pharmacy has procedures in place to reasonably assess the validity of prescription orders submitted by telephone. MOP prescription orders shall only be mailed to beneficiaries living in the 50 United States, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Northern Mariana Islands, American Samoa and Guam; to beneficiaries with an Army Post Office (APO), Fleet Post Office (FPO), or U.S. Embassy address; and to troops in deployed theatres of operation. Beneficiaries in deployed theatres of operation will be identified by the Government.

**C.5.3.1.1.** Upon receipt of a Dispense as Written prescription for a brand name product for which a generic equivalent is available, the contractor shall contact the prescriber to change the prescription to a generic equivalent. If the prescriber refuses to switch, then the prescription shall be referred to the prior authorization department. If the prior authorization is denied, the prescription shall be returned to the beneficiary. If the contractor cannot contact the prescriber, the contractor shall call the beneficiary, notify them that their prescription will be returned, and the reason why. For all denied mail order prescriptions, notification to the beneficiary must be in writing explaining why the order was denied and detailing the beneficiary's appeal rights.

**C.5.3.1.2.** For each MOP prescription received requiring clarification, intervention, or denial that will not be mailed to the beneficiary within seven calendar days of receipt of the prescription, the contractor shall telephonically contact the beneficiary. The contractor shall provide order status and request beneficiary direction to either hold the prescription for fill or to cancel. The contractor shall document the call, and the beneficiary's direction. If the beneficiary directs the contractor to hold the prescription, the contractor shall restart the shipping clock for that prescription from the date the contact was completed. Contact shall be made as soon as a determination is made that the prescription cannot be filled within seven calendar days of receipt, but not later than seven calendar days after receipt of the prescription.

**C.5.3.2.** MOP prescriptions shall be shipped or mailed postage paid to the beneficiary in a manner which provides, at a minimum, a delivery time equivalent to first class U.S. Mail. The contractor shall automatically provide next day delivery service at no additional charge to the beneficiary for any non-intervention prescription that is not mailed to the beneficiary within seven calendar days of receipt of the prescription order. Tracking and dispensing procedures shall be in accordance with Federal and State law. The contractor shall comply with U.S., Military, and U.S. Embassy Postal Service regulations. The contractor shall include a pre-addressed envelope with each order shipped so the beneficiary may order refills or new prescriptions. Upon request by the beneficiary, the contractor shall provide next day delivery service to beneficiaries residing in the continental United States (CONUS). The beneficiary shall be responsible for the additional

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shipping cost in accordance with the contractor's current prevailing commercial shipping charges. The Contracting Officer shall be notified at least 30 days in advance of any change in the amount of expedited shipping charges to beneficiaries.

**C.5.3.3.** For MOP prescription orders, the contractor shall allow beneficiaries to provide a credit card for the co-payment amount. The contractor shall establish individual accounts for family members, and shall allow for more than one credit card to be on record for collection purposes. The contractor shall ensure that if a beneficiary overpays a co-payment amount, the beneficiary is notified that the excess has been credited to the beneficiary's account for future prescriptions, or the overpayment is refunded to the beneficiary along with an explanation of the refund, whichever the beneficiary prefers. As a result of its own business judgment, and at its own risk, the contractor may choose to extend credit to beneficiaries so that when an insufficient co-payment is received, the contractor may fulfill the prescription order up to the amount of the contractor established credit limits and credit aging parameters. As the contractor is not acting as an agent of the Government in extending credit to beneficiaries, none of the recoupment procedures set forth in this contract shall be available to the contractor to collect beneficiary co-payments. Likewise, any uncollected debts from beneficiaries resulting from the extension of credit are not reimbursable under this contract. The contractor shall return the prescription to the beneficiary and notify the beneficiary of the correct co-payment amount required if the contractor does not extend credit or the beneficiary has exceeded the contractor's established credit parameters.

**C.5.3.4.** Beneficiary Pended Prescriptions. The contractor shall have the ability to electronically pend prescriptions in lieu of rejecting early submissions.

**C.5.3.4.1.** The contractor's system shall have the ability to pend such prescriptions to be filled at a future date. For beneficiaries registered with the MOP, the contractor's web site will allow the beneficiary to log in, view pended prescriptions, update their shipping address, request pended prescriptions be shipped or cancel a pended prescription.

**C.5.3.4.2.** For beneficiaries in deployed theatres of operation the contractor shall distribute an email reminder to beneficiaries who are registered with the MOP and have a "pended" prescription in the contractor's system. This message will remind the beneficiary to access the MOP website and select whether the prescription order should be filled or cancelled. The contractor shall not ship pended prescriptions until the beneficiary has confirmed the order.

**C.5.3.4.3.** For beneficiaries not in deployed theatres of operation the contractor shall provide notification (by email or telephone based on beneficiary preference) of prescriptions received, placed in a pended status, and the anticipated processing date for each.

**C.5.3.5.** The contractor shall segregate all returned pharmaceuticals under this contract from all other pharmaceuticals in its facility. The contractor will hold all returned pharmaceutical agents for processing by the DoD Pharmaceutical Returns Management Program contracted reverse distributor. The contractor will contact the DoD contracted reverse distributor no less frequently than quarterly to arrange for a return shipping date. The contractor will provide the DoD contracted reverse distributor access to its facility for on-site inventory, packaging, and shipment of returns to the reverse distributor's central location. The TPharm contractor is not responsible for the cost of packaging or shipment of returns to the DoD contracted reverse distributor. For all pharmaceutical agents returned to the MOP, the TED record will be adjusted or cancelled as necessary to properly reflect co-payment, administrative fee, and replenishment. The TED adjustment/cancellation must maintain an accurate clinical record on PDTs.

**C.5.3.6** Dispensed ingredients shall be priced on the TED record (see C.5.10.5.) at the DSCP-provided MCPF burdened Unit of Measure Price.

**C.5.3.7.** Specialty Pharmacy Services. Specialty pharmaceuticals are high-cost injectable, infused, oral or inhaled drugs that are generally more complex to distribute, administer and monitor than traditional drugs. The contractor shall provide specialty pharmaceuticals through the mail order and retail pharmacy venues.  
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The contractor shall operate programs to maximize the extent to which beneficiaries obtain specialty pharmaceuticals from mail order rather than from retail pharmacies.

**C.5.3.7.1.** The contractor shall provide a dedicated toll free number for beneficiaries and [redacted] or assistance relating to specialty pharmaceuticals and services [redacted] will be [redacted] (b)(4) (ET) at a minimum. A Pharmacist shall be accessible [redacted] (b)(4) The [redacted] provide specialty pharmacy services in conjunction with [redacted] provides through the mail order pharmacy for beneficiaries who have agreed to receive specialty pharmacy services. The contractor shall document the beneficiary's agreement to receive these services and shall document the services provided. Specialty pharmacy services shall include, but are not limited to: Consultations and communications with prescribing providers and educating beneficiaries regarding specialty pharmaceuticals in a manner that optimizes therapeutic outcomes, minimizes unnecessary and/or inappropriate use, maximizes beneficiary compliance with prescribed drug regimens, minimizes waste, minimizes adverse clinical events, and achieves a high level of beneficiary satisfaction. The identification of pharmaceuticals subject to the specialty pharmacy services is contained in the TOM Chapter 23, Addendum A. Final decisions of the Director, TRICARE Management Activity regarding changes to the identification of pharmaceuticals subject to specialty pharmacy services and change implementation dates are published in the quarterly DoD Pharmacy and Therapeutic Committee Minutes at [http://www.tricare.mil/pharmacy/PT\\_Cmte/default.htm](http://www.tricare.mil/pharmacy/PT_Cmte/default.htm)

**C.5.3.7.2.** The contractor shall ensure that beneficiaries have access to specialty pharmaceuticals that are subject to limited distribution channels established by the pharmaceutical manufacturer or the Food and Drug Administration.

**C.5.3.8.** The contractor shall provide a report of all mail order pharmacy users in accordance with Section F.3.4.1.

**C.5.4. Recoupments.** The contractor shall implement a recoupment program in compliance with the TOM, Chapter 10, to recoup erroneously paid Government funds and funds not properly collected at the time the prescription was dispensed. Prescriptions subject to recoupment may be identified by the Government, or by the contractor through its audit procedures. This provision does not apply to the collection of debts resulting from the contractor granting credit to beneficiaries under C.5.3.3. Such debts are not owed to the Government. Therefore, the contractor's collection of unpaid copayments is at the contractor's own risk utilizing practices separate and apart from any recoupment procedures under this contract.

**C.5.5. Uniform Formulary.** The contractor shall comply with the provisions of the DoD Uniform Formulary and its three-tier co-payment structure. Uniform Formulary changes are generally announced quarterly. Additional information may be found at [www.tricare.osd.mil/pharmacy](http://www.tricare.osd.mil/pharmacy).

**C.5.6. Co-payment Collection.** Co-payments shall be charged to beneficiaries in accordance with the TRM, Chapter 2, Addendum B. The contractor shall be responsible for collecting beneficiary co-payments when dispensing prescriptions through the mail order pharmacy, and ensuring that the appropriate co-payment is collected at retail pharmacies. The contractor shall make changes to its systems to implement the pharmacy co-payment specified in the TRM, Chapter 2, Addendum B, within 14 calendar days of receiving notice from the Government that the co-payment dollars amount and/or percentage has changed. All co-payment changes will be effective for pharmaceuticals dispensed on and after the implementation date specified by the Government.

**C.5.7. Clinical Services.** The contractor will check PDTS for Drug Utilization Review (DUR), and to determine if a prior authorization (PA) or medical necessity (MN) determination has previously been completed as a result of an MTF dispensing. PA/MN records for MTF dispensings will be made available by one of two methods as described in the PDTS ICD (Section J, Attachment 1). The contractor may choose whichever method best meets its processing needs in order to verify if a PA/MN review has previously been completed. The contractor is not required to perform a PA/MN review if one has previously been completed for an MTF dispensing or for a mail order or retail dispensing. If no PA or MN is on file, the contractor shall perform the determination and transmit an NCPDP compliant P2/P4 transaction to PDTS to document in H94002-08-C-0003

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PDTS an approval or denial of the prior authorization or medical necessity determination. Additionally, TED records will be submitted for all approved or denied prior authorizations and medical necessity determinations performed, in accordance with the TRICARE Systems Manual. If additional information is received for denied PAs and MNs within ten business days of the initial denial, the contractor shall not bill the Government a second time and no change shall be made to the previously submitted TED for the revised PA or MN. Additional information related to clinical services may be found at [www.tricare.osd.mil/pharmacy](http://www.tricare.osd.mil/pharmacy).

**C.5.7.1. Prior authorization.** The contractor shall perform prior authorization determinations for pharmaceuticals designated by the DoD Pharmacy and Therapeutics (P&T) Committee as requiring prior authorization, and based upon DoD P&T Committee established criteria. The DoD P&T Committee will provide prior authorization criteria for these pharmaceuticals. A current listing of pharmaceuticals requiring prior authorization may be found at [http://www.tricare.osd.mil/pharmacy/prior\\_auth.cfm](http://www.tricare.osd.mil/pharmacy/prior_auth.cfm). The contractor shall receive prescriber-completed prior authorization requests from beneficiaries, physicians, and pharmacies by facsimile, electronically, and mail. The contractor may receive prescriber-completed prior authorization requests electronically, by facsimile, or telephonically. Telephonic requests may only be received from a prescriber or a prescriber's authorized representative. The contractor shall notify beneficiaries in writing of all denied prior authorizations and advise the beneficiary of their appeal rights. An appeal of the contractor's initial determination and further appeals shall be processed in accordance with the TOM, Chapter 12.

**C.5.7.1.1.** The contractor shall perform prior authorization determinations regarding off-label use of pharmaceuticals in accordance with the TRICARE Policy Manual (TPM), Chapter 8, Section 9.1.

**C.5.7.1.2.** The contractor shall perform prior authorizations using contractor - developed, Government-approved criteria to determine when there is a clinical justification to use a brand name drug in lieu of a generic equivalent.

**C.5.7.1.3.** The contractor shall perform prior authorizations for exceptions to age limitations (e.g., pre-natal vitamins and tretinoin). Contractor approval of quantity limit overrides for vacations, deployments, or medication dosage changes do not require the same level of effort as other prior authorization determinations, and will not be reimbursed under the prior authorization CLIN.

**C.5.7.2. Medical necessity determinations.** The contractor shall use Government-provided criteria in making initial determinations of medical necessity for the purpose of providing a non-formulary drug at the formulary co-payment. The contractor shall receive prescriber-completed medical necessity requests from beneficiaries, physicians, and pharmacies by facsimile, electronically, and mail. Telephonic requests may only be received from a prescriber or a prescriber's authorized representative. The contractor shall review the requests, and approve or deny them in accordance with Government-provided medical necessity criteria. The contractor shall notify beneficiaries in writing of all denied medical necessity determinations and advise the beneficiary of their appeal rights. An appeal of the contractor's initial determination and further appeals shall be processed in accordance with the TOM, Chapter 12.

**C.5.8. Member Choice Center (MCC).** The contractor shall establish a Member Choice Center designed to maximize beneficiary utilization of mail order pharmacy services. At a minimum, the MCC shall be staffed from 7:00 a.m. to 12:00 a.m. ET, Monday through Friday, and 7:00 a.m. to 9:00 p.m. ET on weekends and holidays. The contractor shall establish a dedicated toll-free phone number for the MCC. Communications with beneficiaries shall be in accordance with Section C.5.12. At the request of eligible beneficiaries, the MCC shall provide the following services:

**C.5.8.1.** Facilitate beneficiary registration to the MOP via telephone or other electronic means. Unless requested by the beneficiary, registrations initiated via telephone will not be deviated to other electronic means.

**C.5.8.2** Obtain a new prescription from the beneficiary's provider to be filled by the Mail Order Pharmacy or transfer prescriptions from Military Treatment Facilities to the Mail Order Pharmacy.

**C.5.8.3** The contractor shall provide a **Member Choice Center Report** in accordance with Section F.3.3.15.

**C.5.9. Quality Control.** The contractor shall implement and continuously operate a quality control program in accordance with the TOM, Chapter 1, Section 4. Additionally, the contractor shall provide a monthly report of dispensing errors for the Mail Order Pharmacy (including specialty pharmaceuticals) in accordance with Section F.3.3.10. The contractor will maintain a quality control program to ensure that its retail network pharmacies are compliant with its network agreement and applicable Federal and State Laws.

**C.5.10. Information Technology.**

**C.5.10.1.** In addition to Government data requirements specified herein and in Section F, the contractor shall provide the Government read-only access to the contractor's system that stores TRICARE claims system data to facilitate Government beneficiary service support. This database is to include claim information for the following: retail network pharmacies, member submitted paper claims, clearinghouse and State Medicaid agency submitted claims, specialty pharmacy claims, mail order claims, and prior authorization and medical necessity approvals/denials. Access will be provided for a minimum of 20 Government personnel, specified by the Contracting Officer, through a web-based tool beginning not later than the start of Opti eriod 1 and continue through contract closeout. The number of Government users can be increased up to (b)(4) at no additional cost to the Government.

**C.5.10.2.** The contractor shall transmit and receive messaging with retail pharmacies and PDTS using NCPDP Version 5.1 (or most current version) compliant systems. The contractor shall implement future NCPDP versions as coordinated with PDTS.

**C.5.10.3.** The contractor shall verify eligibility, check for OHI, check and update the CCDD file with DEERS in accordance with the TRICARE Systems Manual.

**C.5.10.4.** The contractor shall execute a Memorandum of Understanding and Data Use Agreement with the Defense Manpower Data Center (DMDC) to receive quarterly beneficiary address updates.

**C.5.10.5. TED Submittal and Requirements.** The contractor shall submit a TRICARE Encounter Data (TED) record for each prescription claim and each Specialty Pharmacy Services claim processed to completion, and for each completed Prior Authorization and Medical Necessity Review in accordance with TSM, Chapter 2, and the TOM, Chapter 1. Adjustments, cancellations, or corrections to clear edit errors to the TED records shall be made as required to ensure financial transactions are complete and correctly recorded in TED records by fiscal year and by bank account (i.e., Medicare Dual eligible or TRICARE only) for retail, mail order, and specialty pharmacy claims. Adjustments made to TED records must not create any inaccuracies in the PDTS record of the prescription claims.

**C.5.10.6.** The contractor shall develop a Continuity of Operations Plan in accordance with the TSM, Chapter 1, Section 1.1. The plan shall be written to meet or exceed the performance standards listed in C.5.18.

**C.5.11. INFORMATION ASSURANCE**

**C.5.11.1. System Security.** The Contractor shall acquire, develop and maintain the DoD Information Assurance Certification and Accreditation Process (DIACAP) documentation to ensure both initial and continued DIACAP Certification and Accreditation (C&A) for all contractor systems/networks processing or accessing Government sensitive information (SI) as required by TSM, Chapter 1, Section 1.1. (See DODI 8510bb (DRAFT)). The Contractor shall cooperate with and assist the Government's (MHS) DIACAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DIACAP C&A team schedule. The Contractor shall also implement processes that meet the requirements of the TSM, Chapter 1, Section 1.1 to ensure at least a MAC III Sensitive level of security protection for systems/networks that process MHS SI information under this contract. DIACAP certification generally takes H94002-08-C-0003

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6 to 9 months to achieve and the Contractor shall plan the certification activity that results, at a minimum, in an Interim Authority To Operate (IATO) prior to accessing DoD data or interconnectivity with the Government systems and testing. (See DoD 8500.2 (Information Assurance Implementation) and DoD 5200.40.)

**C.5.11.2.** The Contractor shall comply with DoD Information Assurance (DoD Directive 8500.01E), MAC III, Sensitive Requirements found in DoD Information Assurance Implementation (DoD Instruction 8500.2), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R) and the MHS AIS Security Policy Manual. The Contractor shall also comply with OMB M-06-16, Protection of Sensitive Agency Information. The Contractor shall comply with DoD Minimum Security Requirements as outlined in the TSM, Chapter 1, Section 1.1.

**C.5.11.3.** Pursuant to FAR Part 24 the requirements of the Privacy Act (5 U.S.C. 552a) and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the contractor on behalf of the TRICARE Management Activity (TMA). These systems of records are found at 65 Federal Register 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 Federal Register 43775 (USTF Managed Care System), 69 Federal Register 50171 and 71 Federal Register 16127 (Military Health Information System), and 64 FR 22837 (Health Affairs Survey Data Base). The records systems operated and maintained by TMA contractors are records systems operated and maintained by a DoD Component TMA). (See TRICARE Operations Manual 6010.56-M, Chapter 1, Section 5, Chapter 2, Section 1, and Chapter 2, Section 2).

**C.5.11.4.** The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy Regulation (DoD 6025.18- R) the Health Insurance Portability and Accountability Act Security Compliance Memorandum (HA Policy 06-010), the Security Standards for the Protection of Electronic Protected Health Information and the requirements in the TOM, Chapter 19, and the TSM, Chapter 1, Section 1.1.

**C.5.11.5.** The Contractor shall ensure that all electronic transactions comply with HIPAA rules and regulations and TMA requirements in the TSM, Chapter 1, Section 1.1. and the TOM, Chapter 19.

**C.5.11.6.** The contractor shall digitally submit fingerprints required in the TSM, Chapter 1, Section 1.1.

**C.5.12. Beneficiary Education.**

**C.5.12.1.** TMA Communication and Customer Service (C&CS) will design, develop, and print all educational materials, including written materials, briefings, and other methods of publicizing the TPharm. The contractor will provide input to C&CS to support the development of the content of the educational materials. All educational materials shall be submitted to the Contracting Officer for approval prior to printing. The contracting officer will approve or disapprove the educational materials within 10 calendar days of receiving them. C&CS will ship all materials to the contractor; the contractor is responsible for all storage, handling, and distribution of printed materials. The Government shall have title and unrestricted rights to and use of any and all beneficiary and provider marketing/education materials produced by the contractor and/or its subcontractor(s).

**C.5.12.2.** The contractor shall support TPharm educational activities that are designed to assist beneficiaries in using the TRICARE Pharmacy Program (TPharm) effectively, economically, and efficiently as follows:

**C.5.12.2.1.** The contractor shall assemble and mail an information packet to announce the start-up of the new Mail Order Pharmacy (including specialty pharmacy services) and Retail Pharmacy programs. The information packet shall be sent to households of eligible covered TRICARE beneficiaries who have filled prescriptions in the TRICARE Mail Order Pharmacy, a TRICARE retail network pharmacy, or a non-network  
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pharmacy within the six-month period prior to the date the information packet is mailed. The packet will be mailed so that beneficiaries will receive the packet 30 to 40 calendar days prior to the start of mail order services (including specialty pharmacy services) and retail pharmacy services under this contract. At a minimum, the information packet shall contain:

- A description of the mail order and specialty pharmacy programs
- Contractor supplied MOP registration form, and postage paid return envelope
- The process required to fill prescriptions in the MOP
- The process required for beneficiaries to agree to receive specialty pharmacy services.
- The beneficiary appeals process
- Information regarding the uniform formulary and benefit coverage
- Information regarding beneficiary co-payments
- The contractor's contact information, including mailing address, beneficiary service telephone numbers, the toll-free number for overseas beneficiaries, and the contractor's e-mail addresses
- The contractor's TPharm web site address
- An explanation of the limited opportunity for a beneficiary to obtain prescriptions from the MOP when the beneficiary has OHI
- The process required to fill prescriptions at retail network pharmacies
- List of major chain pharmacies
- How to locate a network pharmacy
- Explanation of the process for obtaining prescriptions from retail pharmacies when the patient has OHI
- The process for filing a paper claim

**C.5.12.2.2.** The contractor shall mail TPharm educational materials to newly-eligible beneficiaries on a quarterly basis. The materials will include the information in paragraphs C.5.12.2.1 and C.5.12.2.2.

**C.5.12.2.3.** On a quarterly basis, the contractor shall mail notices to beneficiaries who within the past year have received prescriptions for pharmaceutical agents that are being newly designated non-formulary by the Director, TRICARE Management Activity. Formulary decisions are available at [http://www.tricare.mil/pharmacy/PT\\_Cmte/default.htm](http://www.tricare.mil/pharmacy/PT_Cmte/default.htm). The notice shall explain the changes and identify formulary alternatives as well as any additional information required to ensure continuity of care. The notice shall be approved by the Contracting Officer's Representative prior to being mailed.

**C.5.12.2.3.1.** At the direction of the Contracting Officer, the contractor shall mail notices to beneficiaries identified by the Government regarding changes to the prescription drug benefit or other prescription drug information. The contractor shall ensure that these notices are mailed to beneficiaries within five calendar days of receiving direction from the Contracting Officer. The notice shall be approved by the Contracting Officer's Representative prior to being mailed.

**C.5.12.2.4.** The contractor shall attend the annual C&CS/Beneficiary Counseling and Assistance Coordinators-BCAC meeting. This meeting is held in the Washington, DC, area and runs approximately three days. The contractor shall provide representation that can address issues involving marketing, communications, customer service, and the Web.

**C.5.12.2.5.** The contractor shall provide monthly updates, news articles, or items of interest to TMA(C&CS) as determined in the MOU required in C.5.12.3. This material will be submitted in accordance with Section F.3.3.11.

**C.5.12.3.** The contractor shall meet with and establish a Memorandum of Understanding (MOU) with TMA (C&CS) within 60 calendar days of contract award. The MOU will specify timeframes required to support design, development, printing, and distribution of marketing materials. The MOU will be effective within 30

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days of the meeting between TMA/C&CS and the contractor. The content of the MOU will be coordinated with the Contracting Officer's Representative prior to execution.

**C.5.13. Management.** The contractor shall ensure that its staff and subcontractors (if any) are thoroughly trained and knowledgeable regarding the requirements of this contract. The contractor shall provide to the Contracting Officer an updated management organization chart identifying key personnel at contract award and at the time of any change of key personnel or management structure.

**C.5.14. Contract Review Requirements.**

**C.5.14.1.** The contractor shall support Government claims review requirements and efforts in accordance with Section H.3.

**C.5.14.2.** The contractor shall develop a Monitoring and Auditing Work plan that includes, but is not limited to:

Implementation of an effective method for fraud, waste and abuse prevention and detection utilizing an automated data analysis tool (TOM Chapter 13). Examples of audits that shall be included, but are not limited to, are:

Inappropriate billing practices: Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:

- Incorrectly billing for secondary payers to receive increased reimbursement.
- Billing for NDCs that were not dispensed.
- Billing for incorrect quantity or days supply.
- Billing for non-existent prescriptions.
- Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
- Billing for brand when generics are dispensed.
- Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
- Inappropriate use of dispense as written ("DAW") codes.
- Prescription splitting to receive additional dispensing fees.
- Drug diversion.

Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud. An automated review of 100% of all new claims will be accomplished daily.

Data analysis shall include but are not limited to:

- Establish baseline data to enable TRICARE to recognize unusual trends, changes in drug utilization over time, physician referral or prescription patterns, and plan formulary composition over time;
- Analyze claims data to identify potential errors, inaccurate TrOOP accounting, and provider billing practices and services that pose the greatest risk for potential fraud, waste and abuse to the TRICARE program;
- Identify items or services that are being over utilized;
- Identify problem areas within the plan such as enrollment, finance, or data submission;
- Identify problem areas at the pharmacy and pharmacist level and at the prescriber level; and
- Use findings to determine where there is a need for a change in policy.

**C.5.14.3.** The contractor shall provide to the Government (or its designee) all claims data for retail and mail order pharmacy services, on a monthly basis, in accordance with F.3.3.12. Discrepancies identified by the Government shall be subject to contractor desktop or on-site audits at the direction of the Government. In  
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addition to any contractor initiated on-site audits for which TRICARE is the primary focus of the audit, the Government may direct up to 50 on-site audits per option year.

**C.5.14.4.** The contractor will perform all necessary research and will resolve all discrepancies for each claim identified under C.5.15.2 or C.5.14.3 within 60 days from date the claim is identified. The contractor shall perform offsets or recoupments of any identified discrepancies in accordance with TOM Chap 10.

**C.5.14.5.** On the 15<sup>th</sup> of each month, the contractor will submit a report, in accordance with F.3.3.16. to include audit findings, status of all claims in research, outcomes of completed research, and status of offsets or recoupments.

**C.5.14.6.** The Government will withhold the pharmaceutical cost, dispensing fees and administrative fees, from future administrative fee payments, for any research not completed and resolved within 60 calendar days. The withhold will apply to the specific claims, identified by either party, that caused the audit to be initiated.

**C.5.15. Beneficiary Service.**

**C.5.15.1.** The contractor shall operate a beneficiary service program that provides accurate, complete and timely responses in a courteous manner to questions from beneficiaries about the TRICARE retail, mail order, specialty pharmacy services, paper claims processing, prior authorizations, medical necessity determinations and any other aspect of the TRICARE Pharmacy Program. The contractor shall operate the beneficiary service program with personnel predominantly dedicated to the TRICARE Pharmacy Program.

**C.5.15.1.1.** The contractor shall provide domestic toll free telephone number(s) for beneficiaries throughout the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa and Guam to contact the beneficiary service program. The contractor shall also provide commercial toll-free telephone service for the following OCONUS locations in support of the MOP: Germany, the United Kingdom, Italy, Turkey, Japan, and South Korea.

(b)(4) Beneficiary service centers shall be staffed to respond to beneficiary inquiries (b)(4) in accordance with the contract requirements and performance standards state

**C.5.15.1.3.** When the contractor cannot resolve a specific issue which is unrelated to a functional requirement under this contract, the contractor will provide the caller with the telephone number of the appropriate organization (e.g., TRICARE Management Activity, other designated Government office, etc.) and then transfer the caller to that organization. The contractor's representative shall remain on the line until the call is properly transferred to the appropriate organization.

**C.5.15.1.4.** The contractor's Automated Response Unit (ARU) shall have an option for beneficiaries to check the status of their MOP and specialty pharmaceutical prescription orders. The ARU initial menu shall also allow beneficiaries the option of being immediately transferred to a Customer Service Representative.

**C.5.15.1.5.** The contractor shall provide beneficiary services to all non-English speaking and hearing impaired beneficiaries.

**C.5.15.1.6.** The contractor's beneficiary service operation will be fully operational to support MOP, specialty pharmacy operations, and retail pharmacy services at the start of Option Period 1. The contractor's beneficiary service operation will be able to support beneficiary inquiries during the transition period beginning no later than 40 calendar days before the beginning of Option Period 1. The contractor shall be staffed to fully support retail pharmacy operations no later than 40 calendar days prior to the start of the delivery of retail pharmacy services.

**C.5.15.1.7.** The contractor shall provide a **Call Center Utilizers Report** in accordance with Section F.3.4.2.

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**C.5.15.1.8.** If the Social Security Number (SSN) is used on outgoing correspondence from the contractor to the beneficiary, the SSN shall be limited to the last four digits.

**C.5.15.2.** The contractor shall provide an Explanation of Benefits (EOB) to the beneficiary detailing the beneficiary's retail, mail order, and specialty prescription activity in accordance with the TOM, Chapters 8 and 23.

**C.5.16. Pharmacy Help Desk Service.** The contractor shall operate a pharmacy help desk that helps retail network pharmacies provide courteous, prompt, efficient retail pharmacy services to TRICARE beneficiaries in accordance with TRICARE Pharmacy Program requirements. The contractor's pharmacy help desk for retail network pharmacies will have hours of operation consistent with the network pharmacies' operating hours. The contractor will provide its TPharm network pharmacies a telephone number different from the beneficiary toll-free telephone number. Contractor staff will be dedicated predominantly to the TRICARE Pharmacy account. The contractor shall have adequate staff to fully support its retail network pharmacies at the start of the delivery of retail pharmacy services.

**C.5.17. Web Site.** The contractor shall provide a HIPAA-compliant web site that will provide a description of the TRICARE Pharmacy benefit and contractor contact information. This information shall include phone numbers, mailing, and email address(es).

**C.5.17.1.** This web site shall provide a link to the TMA pharmacy web site and Regional Managed Care Support Contractors' web sites.

**C.5.17.2.** The web site shall provide an email link to the contractor to allow beneficiaries or other interested parties to email inquiries or comments.

**C.5.17.3.** The web site shall allow TRICARE beneficiaries to manage their MOP account(s) to include ordering refills, pend prescriptions, and track their prescription status.

**C.5.17.4.** The web site shall allow TRICARE beneficiaries to check the status of member submitted claims filed for services provided through a retail pharmacy.

**C.5.17.5.** The web site shall provide the ability to locate TRICARE retail network pharmacies by zip code, and the ability to view and download prior authorization and medical necessity forms and criteria.

**C.5.17.6.** The web site shall allow TRICARE beneficiaries to download and print an Explanation of Benefits (EOB) detailing the beneficiary's retail, mail order, and specialty prescription activity in accordance with the TOM, Chapters 8 and 23, providing prescription activity for the preceding 12 months at a minimum.

**C.5.17.7.** The contractor's web site shall allow beneficiaries to register on-line to use the Mail Order Pharmacy and shall provide downloadable forms for MOP registration and prescription ordering.

**C.5.17.8.** The contractor shall provide a real-time web based formulary search tool available for public access to formulary information. This tool shall identify drug (generic or brand) availability by strength, formulation, co-payment, formulary status, quantity limits, formulary alternatives, and requirements for prior authorization. The tool shall also provide links to prior authorization and medical necessity forms. The contractor shall provide the information listed based on point of service and beneficiary category.

**C.5.17.9.** The contractor shall provide links to on-line drug and health information.

**C.5.18. Performance Standards.** Performance to standards in this section will be reported in actual percentages to the nearest tenth percent. (See Section H.2 for Performance Guarantees).

**C.5.18.1. Retail Pharmacy Network.** The contractor shall maintain a retail pharmacy network within the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the Northern Marianas Islands, H94002-08-C-0003

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American Samoa, and Guam sufficient to meet the following minimum beneficiary access standards on an overall basis, measured monthly:

(b)(4)

**C.5.18.2. Prescription Order and Prescription Claim Processing.**

**C.5.18.2.1.** MOP prescription processing and written notification of denied orders shall meet the following minimum requirements:

**C.5.18.2.1.1.** Prescriptions received not requiring clarification or intervention shall be mailed as follows, measured on a monthly basis –

- 95% within two calendar days of receipt
- 100% within four calendar days of receipt

**C.5.18.2.1.2.** Prescriptions received requiring clarification, intervention, or denial shall be mailed as follows, measured on a monthly basis –

- 95% within seven calendar days of receipt
- 100% within ten calendar days of receipt of the prescription

**C.5.18.2.1.3.** Prescriptions dispensed from the MOP shall be accurate 100% of the time, measured monthly.

**C.5.18.2.2.** Measured on a monthly basis, 100% of specialty pharmaceutical prescriptions dispensed from the MOP shall be processed to meet or exceed manufacturer recommended delivery practices and shall be delivered in a manner that will support the beneficiary maintaining the prescribed drug therapy regimen.

**C.5.18.2.3.** Retail Pharmacy claim processing.

**C.5.18.2.3.1.** 99% of electronic requests for approval to dispense shall be processed to completion in an average of five seconds of receipt, measured on a monthly basis.

**C.5.18.2.3.2.** 100% of electronic requests for approval to dispense shall be processed to completion within one working day of receipt, measured on a monthly basis.

**C.5.18.2.3.3.** 95% of paper claims shall be processed to completion within 10 working days of receipt, measured on a monthly basis.

**C.5.18.2.3.4.** 99% of paper claims shall be processed to completion within 20 working days of receipt, measured on a monthly basis.

**C.5.18.2.3.5.** 100% of paper claims shall be processed to completion within 30 working days of receipt, measured on a monthly basis.

**C.5.18.3. Prior Authorization Processing Standards**

**C.5.18.3.1.** Measured on a monthly basis, 95% of all Prior Authorization requests shall be completed and notification sent to the beneficiary within two working days of receipt of a properly completed Prior Authorization request.

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**C.5.18.3.2.** Measured on a monthly basis, 100% of all Prior Authorization requests shall be completed and notification sent to the beneficiary within five working days of receipt of a properly completed Prior Authorization request.

**C.5.18.3.3.** Measured quarterly, 99.5% of all prior authorizations completed during the preceding quarter shall be processed accurately and in accordance with the Government provided criteria.

**C.5.18.4. Medical Necessity Determination Standards**

**C.5.18.4.1.** Measured on a monthly basis, 95% of all Medical Necessity determination requests shall be completed and notification sent to the beneficiary within two working days of receipt of a properly completed Medical Necessity request.

**C.5.18.4.2.** Measured on a monthly basis, 100% of all Medical Necessity determination requests shall be completed and notification sent to the beneficiary within five working days of receipt of a properly completed Medical Necessity request.

**C.5.18.4.3.** Measured quarterly, 99.5% of all medical necessity determinations completed during the preceding quarter shall be processed accurately and in accordance with the Government provided criteria.

**C.5.18.5. Beneficiary service standards.** As measured on a monthly basis, the minimum performance shall be as follows:

<b>Service Category</b>	<b>Standard</b>
Telephone Answering (Initial answer)	100% within 20 seconds
Transfer to Beneficiary Service Rep after selection by caller	30 seconds Average Speed of Answer
Telephone Call Blockage rate	2% or less
Abandoned Call rate	3% or less
Telephone Calls Resolved	95% during the initial call, 100% within two business days
Priority Correspondence (Includes Electronic)	95% within 10 calendar days, 100% within 30 calendar days
Routine Correspondence (Includes Electronic)	85% within 15 calendar days, 100% within 30 calendar days

(Section C continued at next page)

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**C.5.18.6. Pharmacy Help Desk Standards.** As measured on a monthly basis, the minimum performance shall be as follows:

Service Category	Standard
Telephone Answering (Initial answer)	100% within 20 seconds
Transfer to Customer Service Rep after selection by caller	30 seconds Average Speed of Answer
Telephone Call Blockage rate	2% or less
Abandoned Call rate	3% or less

**C.5.18.7. Claim Payment Errors.** The absolute dollar value of the payment errors for the sampled TED records for the semi-annual claim review shall not exceed 0.5% for electronic retail pharmacy claims, 1% for mail order pharmacy claims, 2% for paper claims, and 0.5% for specialty pharmacy services. The error rate will be calculated separately for each of the four categories (for paper claims the error rate will be calculated from the combined audit result for both non-denied and denied claims) identified in Section H.3. The sample payment error rate will be defined as the total absolute payment error divided by the sample billed amount multiplied by 100. The rounding methodology specified in C.5.18 does not apply to the measurement of this standard, or to the application of the performance guarantee for this standard.

**C.5.18.8. Claim Occurrence Errors.** The TED occurrence error rate from sampled TEDs for the semi-annual claims review shall not exceed 3%. The error rate will be calculated separately for each of the four claim categories identified in Section H.3.1. The error rate will be calculated by dividing the total number of fields from the sampled TEDs into the total number of occurrence errors found from the sampled TEDs multiplied by 100.

**C.5.18.9. Member Choice Center (MCC)**

**C.5.18.9.1.** Measured monthly, the minimum Member Choice Center (MCC) telephone service standards shall be as follows:

Telephone Service Category	Standard
Telephone Answering (Initial answer)	100% within 20 seconds
Transfer to MCC	30 seconds Average Speed of Answer
Telephone Call Blockage rate	2% or less
Abandoned Call rate	3% or less

**C.5.18.9.2.** Conversions requested by the beneficiary under the requirements of Section C.5.8., 100% shall be completed within ten working days of the beneficiary making the request. The contractor will expire the conversion request if the conversion is not approved or denied within 10 working days.

**C.5.18.9.3.** The contractor shall continue conversion activity until either the conversion is completed, denied, or expired (10 work days has elapsed from the date of the beneficiary's request). The contractor shall notify the beneficiary that either the conversion has been successful, or that the conversion was unsuccessful with the explanation of why it was unsuccessful.

**C.5.18.9.4.** The contractor will only be paid for successful conversions; the contractor will not be paid for unsuccessful conversions. Successful conversions are defined as: 1) the successful transfer of a prescription from an MTF for filing by the MOP or 2) the successful transfer of a prescription from a retail pharmacy for filing by the MOP or 3) MCC receiving a new prescription from the beneficiary's provider for filling by the H94002-08-C-0003

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MOP. A prescription must be received within 40 days of beneficiary's initial conversion request to be considered as a successful conversion.

**C.5.19. Contract Phase-In.** Phase-in begins at contract award. Contract phase-in shall be completed in accordance with the TOM, Chapter 23, and the following:

**C.5.19.1.** The contractor shall complete all phase-in efforts in accordance with the Start-Up/Transition Plan, and be prepared to begin delivery of services in accordance with Schedule B of this contract. Phase-in efforts shall be completed prior to the applicable start work date of this contract and shall include:

**C.5.19.1.1.** Connectivity to PDTS, DEERS, TMA, and the DVA eligibility system.

**C.5.19.1.2.** Complete testing and certification that development is complete, and systems are functional for successful interaction with PDTS, DEERS, TEDs and the DVA eligibility system.

**C.5.19.1.3.** Successful completion of integration and benchmark testing for all systems (PDTS, DEERS, TEDS). Initial testing shall include all required financial transactions such as tracking transactions by fiscal year, voided, stale-dated or reissued checks, adjustment and cancellation TEDs, recording and reporting collections, and processing TEDs transactions that will maintain the clinical record, if required, while correcting financial data. Benchmark testing may be conducted in phases to coincide with the start date of differing aspects of the Pharmacy program (e.g., one test phase for mail order services, and a different phase for retail services).

**C.5.19.1.4.** The contractor shall establish Memoranda of Understanding (MOU) with TMA C&CS, the TRICARE Managed Care Support Contractors, other TRICARE contractors as necessary, the DVA, and DMDC. The MOU with the TRICARE Managed Care Support Contractors shall address necessary cooperation, exchange of information, and points of contact for such things as, program integrity issues, case management patients (including coordination of care for patients who are enrolled in the specialty pharmacy services), third-party liability, and claims jurisdiction issues.

**C.5.19.1.5.** The Contractor shall complete DIACAP testing and certification with, at a minimum, an Interim Authorization to Operate (IATO) issued not later than 30 dates prior to start of Option 1.

**C.5.19.2.** The incoming contractor shall arrange/attend meetings with Government and/or external agencies to establish all systems interfaces necessary to meet the requirements of this contract including PDTS, DEERS, TMA/TEDs, DVA eligibility system, and DIACAP certification.

**C.5.19.3.** The incoming contractor shall be responsible for processing claims for dates of service prior to the start work date of this contract. This includes initial submission claims, and any adjustments, corrections, or cancellations necessary for claims previously processed to completion by the outgoing contractor, including any corrections required to the associated TED record. The incoming contractor will begin processing these "run-off" claims on a date determined at the Transition meeting between the incoming and outgoing contractors and Government representatives.

**C.5.19.4.** The incoming contractor shall retain and use the TRICARE Encounter Provider record (TEPRV) provider numbers previously established by the outgoing contractor for all TED submissions (TSM, Chapter 2, Section 1.2.).

**C.5.20. Contract Phase-Out.** The contractor shall complete contract phase-out in accordance with the TOM, Chapter 23, and the following.

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**C.5.20.1.** Upon award of any subsequent contract, the incumbent TPharm contractor shall transition activities to the incoming contractor with minimal disruption of services to the beneficiaries. The incumbent TPharm contractor shall maintain sufficient qualified staff to meet all requirements of the contract, including beneficiary services and final processing of all pending claims including TED reporting requirements. Phase-out activities will be coordinated through the Contracting Officer. The outgoing incumbent contractor shall send a notice to all eligible beneficiaries who have used pharmacy services in the previous 12 months. The notice will provide the new contractor's information and points of contact (mailing addresses, email addresses, and phone numbers). The notice shall be sent not earlier than 95 days nor later than 90 calendar days prior to the expiration date of this contract. The Contracting Officer shall provide the new contractor's information and points of contact to the outgoing contractor at least 120 calendar days prior to the expiration date of this contract.

**(End of Section C)**

**SECTION D**  
**PACKAGING AND MARKING**

**D.1**

**PACKAGING AND MARKING**

D.1.1. Preservation, packaging, and marking for all prescription pharmaceuticals delivered hereunder shall be in accordance with applicable Federal and State laws.

D.1.2. All prescription pharmaceuticals delivered by the contractor's mail order pharmacy shall be adequately packaged and packed to ensure safe, undamaged delivery to beneficiary. Packaging must minimize pill breakage and protect pharmaceuticals from damage from environmental and handling conditions (i.e. temperature, humidity, light, pressure, impact) which can be reasonably anticipated during postal or commercial shipping processes.

D.1.3. The reports, electronic media, and other products to be furnished by the contractor hereunder shall be adequately packaged and packed to ensure safe delivery at destination. All products must be clearly marked to identify the contents, the sender, and the individual/office to which they are being sent. Extra care shall be taken in packaging electronic media to protect against damage, and to ensure that the electronic media does not become separated from the routing markings. All reports and other products to be furnished are to be shipped via a method that provides for acknowledgment of receipt. The contractor shall retain such receipts. Shipments containing electronic media shall be marked as such and shall include the statement "Do Not X-Ray." The contractor shall include the contract number on all products to be furnished under the contract. The terms of this paragraph do not apply to contractor shipments to beneficiaries.

**(End of Section D)**

**SECTION E**  
**INSPECTION AND ACCEPTANCE**

**E.1**

**52.246-4 INSPECTION OF SERVICES--FIXED-PRICE (AUG 1996)**  
(Reference 46.304)

**E.2 MATERIAL INSPECTION**

**MATERIAL INSPECTION AND RECEIVING REPORT.** Within 15 calendar days after the end of each contract option quarter, the contractor shall submit a separate DD Form 250 Material Inspection and Receiving Report for each SLIN or CLIN paid based on submission of TEDs records (see G.8. through G.10), and covering the previous contract quarter, for Government Acceptance of Services.

**(End of Section E)**

**F.1**

**52.242-15 STOP-WORK ORDER (AUG 1989)**  
(Reference 42.1305)

**F.2 52.247-34 F.O.B. DESTINATION (NOV 1991)**  
(Reference 47.303-6)

**F.3 REPORTS**

As specified in the TOM, Chapter 14, Section 2, paragraph 2, and as identified below, the contractor shall provide the reports and data files required to monitor this contract. Reports will begin the first reporting period after the start of Option Period 1, unless otherwise noted.

**F.3.1. Daily Reports**

**F.3.1.1. Contractor Payment/Check Issue Reports (i.e., Check/Payment Register)**(Reference Section G.7.4) . The contractor shall provide electronic reports indicating payments issued for each cycle or approved release. All payments issued on the bank account must be reported including manual payments. The format is provided in Section J, Attachment 3. The occurrence of these reports is cycle dependent, but could occur as often as daily.

**F.3.2. Weekly Reports**

**F.3.2.1. Mail Order Pharmacy Prescription Order Report** (Reference section C.5.3) – The contractor shall report weekly, each Tuesday, for the preceding week, the number of prescription orders received including dispensed, pending, and rejected orders. The contractor shall make available additional detail level reporting upon request of the Government to resolve any discrepancies identified in the initial summary level report between the contractor and PDTS.

**F.3.2.2. Phase-in** (Reference Section C.5.19) – Weekly status report of phase-in activities. The report shall address those items identified in the phase-in plan as being key to the success of the transition. The first report shall be submitted the 20th calendar day after award and reporting shall continue through the 180th calendar day following the start of Option Period 1.

**F.3.2.3. Phase-out** (Reference Section C.5.20) – Weekly status reports of phase-out activities beginning the 30th calendar day following the award of the successor contract until notified by the Contracting Officer to discontinue the report.

**F.3.3. Monthly Reports**

**F.3.3.1. Pharmacy Change Report** (Reference Section C.5.2.1) – A monthly report identifying the name and location of all pharmacies that were added to or dropped from the network. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.2. Network Access Report** (Reference Section C.5.2.1 and C.5.18.1) – The Government shall provide a monthly ZIP code file listing all eligible beneficiaries. The contractor shall submit a monthly report generated on the 15th calendar day of the month. It shall be submitted to the Government by the 20th calendar day of each month. The report shall use Ingenix “GeoNetworks.”

The report shall include:

**F.3.3.2.1.** The total number of beneficiaries in urban areas and the number that live within 2 miles estimated driving distance of a retail network pharmacy.

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**F.3.3.2.2.** The total number of beneficiaries in suburban areas and the number that live within 5 miles estimated driving distance of a retail network pharmacy.

**F.3.3.2.3.** The total number of beneficiaries in rural areas and the number that live within 15 miles estimated driving distance of a retail network pharmacy.

**F.3.3.2.4.** The report shall also provide access data for U.S. Virgin Islands, the Northern Marianas Islands, American Samoa, and Guam. The report shall identify the number of eligible beneficiaries for each, and the number of network pharmacies for each location.

**F.3.3.3. Retail Pharmacy Claims Processing** (Reference Section C.5.2.4 and C.5.18.2.3)

**F.3.3.3.1.** Standard system availability report, including the average transaction processing time. The report shall be submitted by the 10<sup>th</sup> calendar day of each month.

**F.3.3.3.2.** Standard aging report for paper claims. The report shall be submitted by the 10<sup>th</sup> calendar day of each month.

**F.3.3.4. Denied/Appealed Paper Claims** (Reference Section C.5.2.4 and C.5.18.2.3) – Standard denied claims reports; report on appealed paper claims, to include reason for appeal and resolution. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.5. Mail Order Pharmacy Prescription Report** (Reference Section C.5.3) – The contractor shall provide a monthly report by the 10th calendar day of each month which lists the total number of prescriptions received at the MOP and the disposition of all prescriptions, i.e., prescriptions filled, returned to the beneficiary, and reason for return. This report shall also provide aging information for all prescriptions filled, all prescriptions returned, and pending prescription orders at end of the period, sorted by aging categories. Aging information shall be separated into two categories; (1) prescriptions not requiring clarification or intervention and, (2) prescriptions requiring clarification or intervention. Prescriptions filled, prescriptions returned, and pending prescription orders aging information shall be reported as follows:

1-2 Days    3-4 Days    5-7 Days    Daily Aging Over 7 Days

**F.3.3.6. Mail Order Pharmacy Replenishment Reconciliation Report** (Reference Section C.3.1 and C.5.3) – By the 10th calendar day of each month the contractor shall submit to the Contracting Officer, for the preceding month, a report (by unit quantity and current MCPF value) by pharmaceutical, by eleven digit NDC. The report shall account for all dispensed and returned product as reported on TED records for MOP prescriptions, all product ordered from the National Prime Vendor but not yet received, all product received from the National Prime Vendor to include Purchase Order number and date, date receipt acknowledgement was submitted to DSCP, and the un-replenished balance. The report shall also identify by NDC the unit quantity and extended MCPF value of any pharmaceuticals and supplies which have not been replenished for more than 35 days, identification and reason if the NDC is no longer dispensed and last date dispensed, and if applicable, the reason the NPV could not provide the pharmaceutical agent or supply. The report shall be submitted electronically in a format to be mutually agreed upon by the Government and the contractor at the post-award meeting.

**F.3.3.6.1. Mail Order Pharmacy Replenishment Reconciliation Summary Report** (Reference Section C.3.1 and C.5.3) – By the 10th calendar day of each month, the contractor shall submit to TMA Contract Resource Management, a summary version of the report in F.3.3.6 (with the same categories, but without listing specific pharmaceuticals).

**F.3.3.6.2. Mail Order Pharmacy Pended Prescription Report** (Reference Section C.5.3.4) – By the 10<sup>th</sup> calendar day of each month, the contractor shall deliver to the COR a report listing the total number of

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**DELIVERIES OR PERFORMANCE**

prescriptions pended, new prescriptions pended during the month, and the number of pended prescriptions dispensed during the month.

**F.3.3.7. Specialty Pharmacy Utilization Report** (Reference Section C.5.3.7) – To be tailored in accordance with the contractor’s proposal and mutually agreed to at the post-award meeting.

**F.3.3.8. Prior Authorization** (Reference Section C.5.7.1) – Standard reports, providing at a minimum, all Prior Authorization actions showing approvals and denials. Specific reasons for denials shall be provided. The report shall also show appeals and corresponding outcome, and reconsiderations and corresponding outcome. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.9. Medical Necessity** (Reference Section C.5.7.2) – Standard reports, providing at a minimum, all Medical Necessity Determination actions showing approvals and denials. Specific reasons for denials shall be provided. The report shall also show appeals and corresponding outcome, and reconsiderations and corresponding outcome. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.10. Quality Control** (Reference Section C.5.9. and C.5.18.2.1.3) – The contractor shall submit a monthly report to the COR listing dispensing errors for the Mail Order Pharmacy, including specialty pharmaceuticals. The report shall break down the error listing by type(s) of error for each dispensing facility. The report will clearly identify all dispensing errors, dispensing errors which are confirmed to have been shipped, and identify the status of all corrective actions. This report shall be submitted by the 10th calendar day of each month.

**F.3.3.11. Educational Update** (Reference Section C.5.12.2.6) – Monthly updates of pharmacy network changes, educational materials, or other items of interest to the beneficiaries. The update is to be submitted to TMA/C&CS. The first monthly update shall be delivered the 30th calendar day following the initial mailing of educational information to beneficiaries.

**F.3.3.12. Pharmacy Claims Data File** (Reference C.5.14.2) – Monthly data file containing all claims data for retail and mail order prescription services. The data shall be provided electronically in NCPDP Post Adjudication Standard format and shall be placed on a Government specified secure web site no later than 15 calendar days following the end of the month, with written notice to the COR.

**F.3.3.13. Beneficiary Services** (Reference Section C.5.15) – Standard customer service reports to include written, electronic, and telephonic contacts. The report shall provide performance metrics for all performance standards listed in Section C.5.18.5. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.14. Pharmacy Help Desk** (Reference Section C.5.16) – Standard reports routinely provided to its commercial clients. The report shall provide performance metrics for all performance standards listed in Section C.5.18.6. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.15. Member Choice Center (MCC)** (Reference Section C.5.8) – Standard customer service reports to include written, electronic, and telephonic contacts. The report shall provide performance metrics for all performance standards listed in Section C.5.18.9. The report shall be submitted by the 10th calendar day of each month.

**F.3.3.16. Pharmacy Claims Audit Report** (Reference C.5.14.5) – Monthly report of the contractor’s findings and any corrective action required for all on-site or desktop audits conducted under C.5.14. The report shall include both contractor initiated and Government directed audits. The report shall be submitted by the 15<sup>th</sup> calendar day each month.

**F.3.3.17. Bank Account Reconciliation Report** (Reference Section G.7.2.4). A Pharmacy Voucher/Bank Reconciliation Report for each bank account will be completed monthly and submitted to TMA/CRM within 30 days of the end of the month to reconcile TED records and payment related transactions. The format and instructions are provided in Section J, Attachments 4 and 4.01.

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**F.3.3.18. Accounts Receivable Reports** (Reference Section G.7.10). Two Accounts Receivable Summary Reports (one for TRICARE Only and one for Medicare Dual Eligible claims), along with Supplemental Reports showing the detail listings of debts supporting the summary reports, will be completed monthly for the status of claims-related recoupments as of the 25<sup>th</sup> of the month. Accounts Receivable Summary Reports shall be submitted to TMA/CRM for reporting purposes by the third federal work day following the 25<sup>th</sup> of the month. Supplemental Reports include detailed, aged listings of Written Off Debts, Debts Transferred to TMA and the Ending Receivables shall be submitted by the third federal work day following the 25<sup>th</sup> of the month. The formats are provided in Section J, Attachments 5.

**F.3.3.19. Bank Cleared Payment Reports** (Reference Section G.7) – The contractor shall require its bank to provide, via electronic transmission, a list of all payments clearing the account and a listing of all deposits (may be daily totals for deposits). Banks routinely report transactions to corporations and this file may be in the bank's format as long as the bank's format includes detailed transaction data to include individual transaction identification (either EFT transaction codes or check numbers) and dollar amount of payment. This report shall be filed monthly, with the first report submitted by the 30<sup>th</sup> calendar day of the month following the end of the first month of claims processing. Each subsequent report shall be submitted by the 30<sup>th</sup> calendar day of the month following the end of the month being reported.

**F.3.3.20. Bank Account Statement** (Reference Section G.7) - The contractor shall provide a monthly report/statement created by their bank that includes the following information:

- Beginning Balance in the account(s)
- Total payments for the month
- Total deposits for the month
- Total adjustments for the month (if applicable)
- Total of any other transactions for the month (if applicable)
- Ending Balance in the account(s)

#### **F.3.4. Quarterly Reports**

**F.3.4.1. Mail Order Pharmacy Utilizers** (Reference Section C.5.3.8) – Quarterly report listing all beneficiaries who have submitted a prescription order to the mail order pharmacy in the preceding contract quarter, including all filled and unfilled orders. The report shall be submitted within 10 calendar days of the end of each contract quarter. The report shall include beneficiary name, date of service, DEERS Patient ID number, date of birth, and telephone number.

**F.3.4.2. Call Center Utilizers** (Reference Section C.5.15.1.7) – Quarterly data file all beneficiaries who have contacted the beneficiary service center in the preceding contract quarter. The file shall include beneficiary name, date of contact, DEERS Patient ID number, date of birth, and telephone number. The file shall be placed on a Government specified secure web site no later than 15 calendar days following the end of the contract quarter, with written notice to the COR.

#### **F.3.5. Annual Reports**

**F.3.5.1. Recoupment Action Report** (Reference Section C.5.4) – An annual report of Recoupment Actions summarizing at a minimum, by Government-identified actions and by contractor-identified actions, the reasons for actions opened, age of open actions, amount of recoupment sought, actions closed, reason for closure, and amount of actual recoupment for actions closed. The report shall be submitted to TMA/OGC-AC within 30 calendar days of the end of each option period.

**F.3.5.2. Continuity of Operation Plan** (Reference Section C.5.10.6) – The contractor shall submit its Continuity of Operations Plan to the Contracting Officer within 90 calendar days following contract award. This plan shall be developed in accordance with the TSM, Chapter 1, Section 1.1.

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**F.3.5.3. Statement on Auditing Standards (SAS) No. 70** - Corporations are required to complete this report by the Sarbanes-Oxley Act of 2002 which is normally done after the end of the contractor's fiscal year. TMA, CRM requires a copy of this report. This report shall be submitted electronically on an annual basis. The first report shall be submitted within one month of the end of Option Period 1, with each subsequent report submitted within one month of the end of each following option period.

**F.3.6. MOU Requirements**

**F.3.6.1. MOU with TMA C&CS** (Reference Section C.5.12.3) – One time report to Contracting Officer, no later than 90 days after contract award, providing a summary and an executed copy of the contractor's MOU with TMA C&CS.

**F.3.6.2. Other MOUs as Required** (Reference Section C.5.19.1.4) – One time report to Contracting Officer, not later than 90 days after contract award, providing a summary and an executed copy of the contractors MOUs with Managed Care Support Contractors, other TRICARE contractors as necessary, and DMDC.

**F.3.7. Report of the Quantity of Unreplenished Pharmaceutical Agents and Supplies** (Reference Section G.11) – Within 120 calendar days of completion of each Option exercised under this contract, the contractor shall provide a report of the quantity of pharmaceutical agents and supplies by NDC that are no longer being dispensed and that have not been replenished. The report shall specify the pharmaceutical agent or supply, eleven digit NDC code, last date dispensed, the unreplenished unit quantity, current MCPF unit price and extended amount, price paid by the contractor per NDC, package size, the calculated contractor unit price, and the extended contractor paid amount.

**F.3.8. Contractor-Developed Prior Authorization Criteria** (Reference C.5.7.1.2) – The contractor shall submit its prior authorization criteria to the COR not less than 90 calendar days prior to the start of mail order and retail pharmacy services.

**F.4. Period of Performance**

Base Period, Contract Phase-in: Date of Award through November 3, 2009

If exercised, Options 1, 2, 3, 4, and 5 will be:

- Option Period 1: November 4, 2009 through October 31, 2010
- Option Period 2: November 1, 2010 through October 31, 2011
- Option Period 3: November 1, 2011 through October 31, 2012
- Option Period 4: November 1, 2012 through October 31, 2013
- Option Period 5: November 1, 2013 through October 31, 2014

**F.5. Place(s) of Performance**

**Primary Place(s) of Performance**

The table below outlines contractor primary facilities serving TPharm:

(b)(4)
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(b)(4)

**Secondary Places of Performance**

The following facilities will serve in contractor continuity of operations plan:

(b)(4)

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**(End of Section F)**

**G.1**

**252.204-7006 BILLING INSTRUCTIONS (OCT 2005)**

When submitting a request for payment, the Contractor shall-

- (a) Identify the contract line item(s) on the payment request that reasonably reflect contract work performance; and
  - (b) Separately identify a payment amount for each contract line item included in the payment request.
- (End of Clause)]

**G.2 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS (MAR 2007)**

(a) "Definitions." As used in this clause--

(1) "Contract financing payment" and "invoice payment" have the meanings given in section 32.001 of the Federal Acquisition Regulation.

(2) Electronic form means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using one of the electronic forms provided for in paragraph (b) of this clause.

(3) "Payment request" means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.

(b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests using one of the following electronic forms:

(1) Wide Area WorkFlow-Receipt and Acceptance (WAWF-RA). Information regarding WAWF-RA is available on the Internet at <https://wawf.eb.mil>.

(2) Web Invoicing System (WInS). Information regarding WInS is available on the Internet at <https://ecweb.dfas.mil>.

(3) American National Standards Institute (ANSI) X.12 electronic data interchange (EDI) formats.

(i) Information regarding EDI formats is available on the Internet at <http://www.X12.org>.

(ii) EDI implementation guides are available on the Internet at <http://www.dod.mil/dfas/contractorpay/electroniccommerce.html>.

(4) Another electronic form authorized by the Contracting Officer.

(c) The Contractor may submit a payment request in non-electronic form only when--

(1) DoD is unable to receive a payment request in electronic form; or

(2) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer's determination with each request for payment.

(d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.

(e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payments requests.

(End of Clause)

**G.3 CONTRACT ADMINISTRATION**

The TRICARE Management Activity (TMA), Acquisition and Management Support Directorate, will perform contract administration, except as delegated to other Government agencies by the TMA Contracting Officer. The contractor will be provided a copy of all delegations of administration functions. The following individuals will be the Government points of contact during the performance of this contract.

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**G.3.1. Contracting Officer:** The TMA Contracting Officer is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government that may result in changes to the terms of this contract, including deviation from Section C. The Contracting Officer for administration of this contract is:

Contracting Officer  
TRICARE Management Activity  
Acquisition Management and Support  
16401 East Centretex Parkway  
Aurora, CO 80011-9066

**G.3.2. Contracting Officer's Representative:** The Contracting Officer will designate a Contracting Officer's Representative (COR) in writing. The contractor will be provided a copy of COR appointment. The written appointment will delineate the scope of authority of the COR. The COR has no authority to make any commitments or changes that affect any term or condition of the contract.

**G.3.3. Contractor Points of Contact Personnel :** The names and addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

Primary	Alternate
(b)(4)	

**G.3.4. Government Payment Office.**

Department of Defense  
TRICARE Management Activity  
ATTN: Contract Resource Management (CRM)  
16401 E. Centretex Parkway  
Aurora, CO 80011-9066

**G.4. ORDERING.**

**G.4.1. Ordering authority:** Only the TMA Contracting Officer has authority to issue task orders under the contract.

**G.4.2.** All task orders will be issued on SF30, modification of contract. Orders may be placed by facsimile transmission, mail, email, or courier.

**G.5. PAYMENT INSTRUCTIONS FOR MULTIPLE ACCOUNTING CLASSIFICATION CITATIONS.**

In accordance with DFARS PGI 204.7108 this subsection provides instructions to the paying office:

**G.5.1. Accounting and Appropriation Citations:** When obligated, accounting and appropriation citations will be identified in schedule B as informational subline items.

**G.5.2.** Each Contract Line Item Number (CLIN) is a separate contract type. Payments will be applied at the CLIN or Sub Line Item Number (SLIN) level. The paying office will assign payments to the accounting classification citation(s) based on the anticipated work performance under each CLIN as follows:

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**G.5.2.1.** Where there is a single line of accounting under a CLIN, the payment office will make payments with the funds established for that CLIN. If there is more than one line of accounting within a CLIN, the payment office will determine the appropriate line of accounting to use based on period of performance.

**G.6. OTHER INSTRUCTIONS TO PAYING OFFICE.**

**G.6.1.** The paying office will follow paying instructions included in any contract modification, including change order definitizations and performance incentive payment modifications.

**G.6.2.** The due date for making invoice payments to the contractor is specified in the Prompt Payment clause, FAR 52.232-25, included in this contract (i.e.: 30<sup>th</sup> day after receipt of proper invoice or acceptance, the later of) with the exception of two Administrative Fee CLINs. The 'Electronic Media Claims' & the 'Retail Prescription Administrative Fee, Department of Veterans Affairs (DVA) Beneficiaries' Administrative Fee CLINs shall be paid the 20<sup>th</sup> day after receipt of proper invoice or acceptance, the later of. For all line items the paying office will make invoice payments on or before the due date, but not earlier than 7 calendar days prior to the due date. For the Claims Processing CLINs the completion of the batch TRICARE Encounter Data (TED) submission (end date/time) is sent to TMA will be used to determine the date of receipt and the date the claim passes all TED edits shall be used to determine the date of acceptance. In the event that the payment office is informed of an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, or there are disagreements on the payment amounts, the payment office is not compelled to make payment by the above dates.

**G.6.3.** Revisions to payment instructions may be made as circumstances require. Revisions may be accomplished by correspondence between the contracting office and the paying office.

**G.7. RETAIL PHARMACY BENEFIT PAYMENTS.**

This section covers payments to network retail pharmacies, non-network retail pharmacies, State Medicaid agencies, clearinghouses, and beneficiaries.

**G.7.1. Retail Prescription Costs.**

**G.7.1.1.** The Government will bear the cost of retail prescriptions dispensed under this contract. The contractor acts as a Fiscal Intermediary for the Government to distribute, or pass-through, Government funds for certain pharmacy benefits.

**G.7.1.2.** The contractor shall establish and use a minimum of two separate bank accounts to reimburse claims in accordance with this section. One bank account will be used for transactions related to beneficiaries who are covered by TRICARE, but not Medicare (TRICARE-only Eligible). The second bank account will be used for transactions related to dual eligible beneficiaries who are eligible for coverage under both Medicare and TRICARE (Medicare-Dual Eligible). New bank accounts for both categories will be established for each Government fiscal year. If the contractor has a need for additional bank accounts, a request specifying the purpose of the additional accounts should be submitted to TMA/CRM for approval.

**G.7.1.3.** Contractors with more than one bank account shall ensure transactions are properly accounted for to prevent the commingling of funds. Failure to properly associate transactions with the correct pharmacy bank account could result in the over-execution of TMA/CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except deposits identified later as having been made to the wrong account. Any transactions reported under one bank account and identified later as belonging to a different bank account shall be reported immediately to TMA/CRM when identified. TMA/CRM will instruct the contractor as to what action to take.

**G.7.1.4.** Claim payments will be identified and paid for TRICARE-only eligible claims or Medicare-dual eligible claims from the appropriate bank accounts referenced above. For network pharmacies, payments will  
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be in accordance with the agreements that exist between the contractor and its network pharmacies, e.g., WAC plus/minus price adjustment, plus Dispensing Fee, minus the collected co-payment. Network pharmacy payments may be accumulated until the payment date is reached based on the payment agreements with the network pharmacies. For non-network pharmacy claims, the contractor shall reimburse the submitter of the claim, billed charges minus applicable co-payments and deductibles in accordance with the TRICARE Reimbursement Manual (TRM), Chapter 1. Upon processing a claim to completion, the contractor shall submit a TED record to TMA per TSM requirements.

**G.7.1.5.** Pharmacy benefit payments by the contractor on behalf of the Government will be facilitated by allowing the Contractor (through the Contractor's financial institution) to draw money from the designated Federal Reserve Bank (FRB). These draws may only be done for benefit payments that have previously been submitted on TEDs or as a non-TED, pharmacy voucher and approved for release by TMA/CRM and are clearing the contractor's financial institution on the day the draw is being accomplished. Advance payments are not allowed. No bank fees or other bank charges shall be paid from this account and no money should be drawn from the FRB for these charges. The contractor may not collect or hold pharmacy benefit funds, (i.e. draw funds from the FRB) before dissemination to the beneficiary or provider and the contractor shall return any collections to the government.

**G.7.1.6.** All payments for pharmacy claims processed by the contractor must be approved by the TMA/CRM Budget Office before the contractor may make payments to the beneficiary or provider. Unapproved draws and payments by the contractor will be immediately collected and subject the Contractor to penalties.

**G.7.1.7.** No manual invoices are required for routine TEDs-related benefit or administrative payments since TEDs are considered to be an invoice.

**G.7.2. Establishment of Bank Accounts for Retail Pharmacy Claims.**

**G.7.2.1.** The Department of the Treasury's Automated Standard Application for Payment System (ASAP), along with Fedwire provide a mechanism for disbursement of Government funds to the contractor for retail pharmacy payments. After authorization by TMA/CRM, these systems allow the contractor to draw cash directly from the FRB to cover payments as they clear the contractor's bank account. ASAP is used by the Treasury, the FRB, and TMA/CRM to verify the authorization to make draws and to track transactions made by the contractor's bank. Fedwire is used by the contractor's bank to actually draw funds from the FRB.

**G.7.2.2.** The contractor shall establish bank account(s) with a commercial bank that has Fedwire capability following Treasury requirements. The contractor shall submit bank information to TMA/CRM not later than 60 calendar days prior to the beginning of processing claims on a new account. The information shall include:

- Name of Bank
- Overnight mail address
- American Banking Association (ABA) routing number
- Taxpayer Identification Number (TIN) (must be the same TIN used for payment)
- Contractor's bank account number (if separate deposit and payment account numbers are used by the bank, provide both numbers).
- Individual point of contact at the bank and an alternate, including their phone numbers, fax numbers and e-mail addresses
- Individual point of contact at the contractor and an alternate, including their phone numbers, fax numbers and e-mail addresses

**G.7.2.3.** TMA/CRM will establish the bank account(s) on ASAP with the Treasury Department. TMA/CRM will notify the bank and the contractor once the bank account(s) have been established and provide codes or other information necessary for the bank to make draws against the FRB using Fedwire. Currently, ASAP has a requirement to identify a total dollar amount that may be drawn on the FRB. This dollar limit, established by TMA, only represents an administrative ceiling at the FRB, and does not constitute any authority to draw funds. Accounts will also have daily limits for the amount that can be drawn. The  
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Contractor will be notified of these limits by TMA/CRM. TMA/CRM will be able to increase these limits as needed.

**G.7.2.4.** Each bank account will be reconciled by the contractor on a monthly basis following the format and instructions in Section F.3.3.17.

**G.7.3. TED Record Submissions.**

**G.7.3.1. TED Voucher Transmission Requirements.**

**G.7.3.1.1.** TEDs shall be submitted per TSM requirements which include separate grouping by the Automated Standard Application for Payment (ASAP) System ID. TEDs will be rejected and must be resubmitted if not grouped correctly. Adjustments and cancellations may be included with initial submissions.

**G.7.3.1.2.** TED Batch/Vouchers shall be transmitted to TMA by 10 a.m. Eastern Time to be considered for that day's business. TED Batch/Vouchers received after 10:00 AM Eastern Time shall be considered received the next business day for payment and check release authorization purposes. Batch/Vouchers must pass all TED header edits as specified in the TSM. If all header edits are not passed, the Batch/Voucher will be rejected and returned to the contractor.

**G.7.3.1.3.** The contractor shall submit TED records to TMA on a daily basis (business days), following a ten-day hold for each retail Electronic Media Claim (EMC) transaction. The ten-day hold does not apply to paper claims, clearinghouse claims, State Medicaid agency claims, specialty pharmacy claims or mail order pharmacy claims, but the contractor may hold these claim types for one business day prior to submitting TED records. TMA will confirm that the voucher header is valid, and that it balances with the dollar amount of the related records.

**G.7.3.2. Voucher Integrity :** Voucher header and detail amounts transmitted by the contractor become "fixed" data elements in the finance and accounting system for purposes of control and integrity. Corrections or adjustments to reported (payment) amounts must be accomplished on separate voucher transmissions.

**G.7.3.3. Payment Suspension and TED Processing During Partial Funding Shortages.**

**G.7.3.3.1** Some of the funding TMA receives may be restricted in use to a specific federal agency, military department and/or to a particular health care program. Funding for these special purpose programs may run out before funding for other TMA programs. Therefore, the contractor shall have the ability to suspend claims payment and the associated submission of TED line item(s) to TMA based on values contained in the following TED record fields:

- Service Branch Classification Code (Sponsor), SBCC - As specified in the TRICARE Systems Manual (TSM), Chapter 2, Section 2.8.
- Enrollment/Health Plan Code (E/HPC) - As specified in the TSM, Chapter 2, Section 2.5.
- Special Processing Code (SP) - As specified in the TSM, Chapter 2, Section 2.8.
- Health Care Delivery Program Coverage Code - As specified in the TSM, Chapter 2, Addendum M.

**G.7.3.3.2.** The suspension of claims payment and their related TED records may be based on a single value (e.g. SBCC=A) or a combinations of values (e.g. SBCC=A & E/HPC=SR). Suspension of claims payments shall be implemented by the contractor within five workdays after receiving notification from the contracting officer. Any claims paid on or after the sixth workday, will be subject to immediate payment offset against any contractor invoices including TEDs related administrative payments. The contractor shall NOT, without prior contracting officer approval, initiate payment offset against any provider or beneficiary for payments made against suspended transactions and offset by TMA/CRM on contractor invoices.

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**G.7.3.3.3.** For all suspended transactions, the contractor shall hold the claim information until receiving instructions from the contracting officer to do otherwise. The contractor shall not reject the claims or return any information to the providers or beneficiaries unless instructed by the contracting officer. Once the contracting officer lifts the TED data submission restriction, the contractor may submit all withheld TED data on the next appropriate (batch/voucher) data submission. TMA/CRM will reimburse the contractor (without interest) for any invoice payment offsets done for TED suspended transaction that have not been recouped by the contractor.

**G.7.4. Authorization to Release Payment.**

**G.7.4.1.** The contractor shall not release pharmacy benefit payments without prior authorization from the TMA/CRM Budget Office. Authorization from TMA/CRM to release payments will be sent to the contractor via fax or e-mail NLT than 5:00 PM Eastern Time the day of receipt. Authorization will specify contract number, ASAP Account ID#, initial transmission received date, and total dollar amount of funds that may be released based on information contained in the Batch/Voucher header. Approval for funds release will be given provided the following criteria are met:

- Voucher submissions must pass all header edits as specified in TSM, Chapter 2, Section 2.3.
- TMA/CRM Budget Officer has confirmed that funding is available to cover payments.

**G.7.4.2.** For payments made on a daily basis, a control number shall be included on the daily funding authorization which will authorize the contractor to mail/transmit payments to the pharmacies, beneficiaries, or other submitter of a claim.

**G.7.4.3.** For payments made for multiple days (e.g., network pharmacies), the contractor shall contact a TMA/CRM Fund Certification Officer to receive a payment authorization control number prior to mailing or transmission of payments. The contractor must provide to TMA/CRM Fund Certification Officer by e-mail or other agreed upon method, the total amount of payments by bank account and all TED voucher numbers being paid (TED voucher header totals by bank account and payment request totals by bank account must be equal to one another). If the payment request balances with TMA/CRM records, the Fund Certification Officer shall provide the contractor with payment authorization code(s) and amounts authorizing the release of payments.

**G.7.4.4.** Authorization to release payments does not constitute TMA's acceptance that all payments are valid and/or correct. Detailed records will be audited for financial compliance. All transactions in these bank accounts must be valid and justified. Any unreported/unauthorized disbursements identified by TMA will be subject to immediate payment offset against any payments being made to the contractor. All disputed amounts will remain in the possession of the Government until no longer in dispute

**G.7.5. Procedures for Benefit Payment Approval When the TED Record Processing System Is Not Available:** Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the contractor will send an email or fax with a listing of specific vouchers to TMA/CRM to request release of checks/EFT payments. This may be done daily. TMA/CRM will return to the contractor a signed release so the contractor can pay the providers and beneficiaries without delay. The contractor must not release payments until this approval is received. Upon notification by the Contracting Officer that the TED Record processing system is operating again, this process can be discontinued. The contractor requests will include the following Header information for each voucher (See TSML, Chapter 2, Section 2.2):

ELN	Element Name
0-001	Header Type Indicator
0-005	Contract Identifier
0-010	Contract Number

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ELN	Element Name
0-015	Batch/Voucher Identifier
0-020	Batch/Voucher Number
0-025	Batch/Voucher ASAP Account Number
0-030	Batch/Voucher Date YYYYDDD
0-035	Batch/Voucher Sequence Number
0-040	Batch/Voucher Resubmission Number
0-045	Total Number of Records
0-050	Total Amount Paid

**G.7.6. Release of Payments to Providers/Beneficiaries:** Benefit payments shall be released/mailed no later than two workdays after TMA/CRM has approved the release of payments. Check date shall be the same date as the Initial Transmission Date (derived by TMA and equal to the calendar date the Batch/Voucher was transmitted to TMA).

**G.7.7. Manual Payments to Providers/Beneficiaries for Retail Pharmacy Claims.**

**G.7.7.1.** Payments for retail prescription costs may only be made manually (not using TED records) with prior approval from the TMA/CRM. Manual payments will only be approved for exceptional and rare situations, such as agreements or settlements that are not specific to a particular claim.

**G.7.7.2.** If a manual payment is requested, the request shall include detailed information on the claims including the claim, documents supporting the claims, the calculation of how much is owed and a statement as to why the claim could not be handled through normal, automated processes.

**G.7.8. Draws on the Federal Reserve Bank by the Contractor.**

**G.7.8.1.** The contractor shall ensure that cash draw downs do not exceed the payments authorized, as they clear the bank on a given day, less deposits. The contractor shall ensure that any excess draws are immediately returned to the FRB. Interest and a penalty will be beginning the day after the overdraft and will continue until the overdraft amount is returned. Interest will accrue daily and is based on the Treasury Current Value of Funds Rate. The penalty will accrue daily and is based on the penalty rates in the Code of Federal Regulations, Title 31, Volume 1, PART 5, Subpart B Sec.5.5. TMA/CRM may initiate immediate payment offset against any payments to the contractor involved for the interest, penalties and/or the overdrawn amount.

**G.7.8.2.** The total amount of a cash draw down on the FRB is based on the daily total of benefit payments presented to the bank for payment. If estimates are needed due to timing of reports from check clearinghouses or the FRB, the draws shall be adjusted the next business day.

**G.7.8.3.** Computation of the amount of the draw must include any deposits of funds into the account. These deposits will reduce the amount of cash needed for the draw down on the day of the deposit.

**G.7.9. Voided, Staledated, or Returned Checks/EFTS.**

**G.7.9.1. Voided and Staledated Checks.**

**G.7.9.1.1.** For payments that are voided or staledated that are over \$10, a credit voucher through TEDs must be processed in accordance with the standards detailed in the TOM, Chapter 1, Section 3. If the check was

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issued as a manual voucher, the credit should be submitted as a similar manual voucher. The only exception to issuing a credit voucher would be staledates under \$10.00.

**G.7.9.1.2.** For voided/staledated payments of \$10.00 or less, the contractor may elect either to:

- Affect a credit voucher for the check using automated means, or
- Instead of making a voucher transaction, a memorandum record shall be prepared and included on a listing of transactions as submitted monthly in the Non-Financially Underwritten Funds Bank Account Reconciliation Report.

**G.7.9.2. Replacement Payments.**

**G.7.9.2.1.** Reissuance of payments will be made against the current fiscal year bank account.

**G.7.9.2.2.** Replacement payments may be issued upon request of the payee or authorized representative. If the check is not returned by the payee, the payee must provide a statement describing the loss or destruction of the check. Before a replacement check is issued, a stop payment order for the original check must have been issued and accepted by the bank.

**G.7.9.2.3.** If the claim history is not available to the contractor, the contractor shall submit a request for approval of check release to TMA/CRM within 10 workdays of the request by payee. Supporting documentation shall include the original check, the sponsor's SSN, a copy of the EOB, if available, or other documentation showing the computation and payment of the original check and the check or a copy or statement as described in G.7.9.2.2. above.

**G.7.9.2.4.** The contractor shall report the reissuance using the same procedure as was used to void/staledate the original.

**G.7.9.2.4.1.** If no credit voucher was made in the voiding/staledating of the check, no credit voucher is required for the reissue (i.e. if the contractor gets a returned check and immediately reissues from the same bank account, no TED or other voucher needs to be done). If the reissuance involves a check from a prior year, a TED or other voucher will need to be done to report the reissuance from the current year.

**G.7.9.2.4.2.** If the amount of a staledated/voided check to be reissued is \$10.00 or less, the contractor shall use the same procedure in the reissuance as was used for the staledating. If no credit voucher was made in the staledating of the check, no credit voucher is required for the reissue. The contractor shall reissue the payment and include the amount in the Pharmacy Bank Account Reconciliation Report.

**G.7.9.2.5.** Re-issuance of checks When Original Payee is deceased: Checks/EFTs issued by the contractor shall be made payable to the legal representative of the estate of the person concerned with an additional line stating "For the estate of \_\_\_\_." Checks shall not be payable to the "estate of" a decedent, nor to a deceased person. Checks shall be delivered to the named payee or mailed to the payee's address of record.

**G.7.10. Adjustments to Claim Payments.**

**G.7.10.1.** If an underpayment of a claim occurs, the contractor shall determine the amount of the underpayment, and pay any additional payment with the next group of payments issued from the current fiscal year bank accounts. Payments will be reported as an adjustment to the initial TED record, but in the current fiscal year, regardless of the fiscal year of the original payment.

**G.7.10.2.** If an overpayment of a claim occurs, the contractor shall follow recoupment procedures specified in the TOM, Chapter 10, to include offsetting overpayments against future payments. Collections, whether cash or offset, shall be shown as separate credit transactions as an adjustment to the initial TED record. Debts

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established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report in accordance with Section F.3.3.18.

**G.7.11. Financial Editing of Detail Claims Data for Pharmacy Claims.**

**G.7.11.1.** The TED system allows for the categorization of claim errors based on the type or classification error failed during the edit process. TMA will use the edits specified in the TSM, Chapter 2, Section 8.1, Financial Edits, to determine the propriety of payments. TED records that fail the Financial Edits specified in the TSM, Chapter 2, Section 8.1 will be “flagged” by TMA as inadequate payment information.

**G.7.11.2.** The contractor shall correct the claims flagged by TMA within 90 calendar days. If not corrected in 90 calendar days, TMA will send a demand letter requiring resolution or reimbursement for all claims identified through TEDs as edit failures. The contractor shall respond within 30 calendar days as to why the claim(s) in question cannot be corrected.

**G.7.11.3.** If resolution cannot be reached between TMA and the contractor, the total amount of improper payments still in dispute will be collected by TMA.

**G.7.11.4.** The contractor shall take no recourse against TRICARE beneficiaries or providers under the situations described in this paragraph without prior TMA approval.

**G.7.12. Federal Fiscal Year End Processing of Pharmacy Bank Accounts.**

**G.7.12.1.** The contractor shall establish a separate bank account for each new Government fiscal year. All payments issued for benefit payments and all refunds received shall be processed against the new account effective the first day of the new fiscal year. The contractor shall also transfer all recoupment installment payments to the new account from the previous year’s account.

**G.7.12.2.** Cash draw downs against the prior fiscal year’s bank account may continue, if required, until all payments from the prior year have either cleared or have been canceled, but no longer than the end of February of the following year or five months after the last payments have been issued on an account (in the case of a contract closeout).

**G.7.12.3.** Bank accounts shall be closed no later than the end of February, following the fiscal year end, or one month after the last payment on an account has been cashed, staledated, or been voided. A final bank account reconciliation shall be made within 30 calendar days following the last authorized transactions. All transactions that were not previously approved by TMA/CRM shall be explained with supporting documentation on the final bank reconciliation report (Section F.3.3.17.). TMA reserves the right to not accept these transactions.

**G.7.12.4.** Any outstanding balance in the account shall be reimbursed to TMA no later than the required submission date of the final bank account reconciliation. This balance may be subject to interest if it includes overdrawn amounts that were required to be submitted at an earlier date.

**G.7.13. Federal Fiscal Year End Processing of TEDs.**

**G.7.13.1.** All TED data must be received no later than 10:00 AM ET, (8:00 AM MT; 7:00 AM PT) on September 28. Any Batch/Voucher received after 10:00 AM ET will be rejected by TMA and must be resubmitted by the contractor using next fiscal year Batch/Voucher CLIN/ASAP Account Numbers. The contractor should not submit batch/vouchers with dates of September 29 and September 30. Any payment processed after September 28<sup>th</sup>, must use the next fiscal year Batch/Voucher CLIN/ASAP Account Numbers and must utilize the new fiscal year check stock, as applicable. The contractor shall not submit Batch/Vouchers to TMA between September 28 10:00 AM Eastern Time and October 1, 12:01 AM Eastern Time. Transmission Files (TD Files) sent on September 28<sup>th</sup> cannot exceed 300,000 records.

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**G.7.13.2.** All payments not included in the contractor's final fiscal year data submission on September 28 must have a Batch/Voucher Date on or after October 1. Contractors will be able to test their new fiscal year's transactions in benchmark starting September 1. Like production, benchmark data must be received at TMA by 10AM ET on September 28. Between 10 AM Eastern Time on September 28 and 12:01AM Eastern Time on October 1 no benchmark data can be transmitted to TMA.

**G.8. RETAIL PHARMACY – TEDs RELATED CLAIMS PROCESSING FEE CLINs.**

**G.8.1 Retail Prescription Administrative Fees**

**G.8.1.1.** Invoice and payment procedures for CLINs X004, X005 and X006 (Retail Prescription Administrative Fees) are the same for paper and electronic claims, with the exception of the payment due date calculation (see G.6.2). Submission of a TED record to TMA is considered submittal of an invoice.

**G.8.1.2.** Claim Quantity: The contractor is paid the unit price for each TED record that passes all TED edits as specified in the TSM and validated by the TMA TED record edit system.

**G.8.1.3.** Unit Price (Claims Processing Fee) and Performance Period: The contractor is paid the claims processing unit price identified in Section B for the contract period in which the contractor originally submits the claim. The Batch/Voucher date in the voucher header is used to determine the contract period and applicable unit price.

**G.8.2. Prior Authorization or Medical Necessity Fees.**

**G.8.2.1.** For Prior Authorization or Medical Necessity reviews, the contractor will be paid the appropriate administrative fee under CLIN X007 (Prior Authorizations) or X008 (Medical Necessity Determinations) for all reviews completed.

**G.8.2.2.** Payment for PAs/MNs will be based on submission of a separate TED record. Processes described in G.7.3. TED Record Submissions, G.7.11. Financial Editing of Detail Claims Data for Pharmacy Claims, and G.7.13. Federal Fiscal Year End Processing of TEDs, apply to PA/MN TEDs.

**G.8.3. ADMINISTRATIVE CLIN PAYMENT ELIGIBILITY**

**G.8.3.1. Eligible Administrative CLIN Records:** If the TED record is eligible to receive an Administrative CLIN payment (all retail claims are eligible to receive an administrative CLIN payment), then the TED record (Including Type of Submission 'C' - complete cancellation to TED record data) shall be submitted by the contractor to TMA using a Header Type Indicator of '6' or '9' (even if the TED record has already received an Administrative CLIN payment).

**G.8.3.2. Ineligible Administrative CLIN Records:** If the contractor determines the TED record submitted is not eligible to receive an Administrative CLIN payment OR the contractor wants to refund an administrative CLIN payment to TMA, then the contractor shall submit the TED record to the TRICARE Management Activity (TMA) using a Header Type Indicator of '0' or '5'. No Administrative CLIN payments can occur on any TED record grouped in a Batch/Voucher with Header Type Indicator of '0' or '5'. Only no-pay and credits can be processed under these header types.

**G.8.4. Procedures for Administrative Fee Payments When the Ted Record Processing System Is Not Available:** Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the contractor may submit invoices outside of the TED system to the Contracting Officer. The invoice shall list the number of claims processed by CLIN. This may be submitted daily or grouped by no more than five days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

**G.9. MAIL ORDER AND SPECIALTY PHARMACY BENEFIT.**  
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This section covers the reporting requirements/replenishment for dispensing Mail Order Pharmacy prescriptions.

**G.9.1. Drug Replenishment:** The Government will bear the cost of prescriptions dispensed at the MOP under this contract by providing drug replenishment through Defense Supply Center, Philadelphia (DSCP) and the National Prime Vendor (NPV) per Section C.3.

**G.9.2. TED Record Submissions:** The contractor generates TED records for each prescription filled per TSM requirements. TEDs are reported on separate headers for TRICARE only and TRICARE Medicare Dual Eligible. No manual invoices are required for TEDs-related benefit or administrative payments. Processes described in G.7.3. TED Record Submissions, G.7.11. Financial Editing of Detail Claims Data for Pharmacy Claims, and G.7.13. Federal Fiscal Year End Processing of TED, also apply to mail order and specialty pharmacy.

**G.10. MAIL ORDER PHARMACY – TEDs RELATED CLAIMS PROCESSING FEE.**

**G.10.1 – Mail Order and Specialty Pharmacy Services Administrative Fees:** Payment of administrative/dispensing fees will be made on CLINs X001(Mail Order and Specialty Pharmacy Services Administrative Fees). Payment will be based on the CLIN unit price multiplied by the number of eligible records with that CLIN. The contractor shall be paid one administrative fee per TED record indicator number. The government will offset administrative/dispensing fee payments based on the calculated co-payment amounts (i.e. what was required to be collected by the contractor from the beneficiary) to determine the net amount due the contractor or government. Administrative/dispensing fee payments shall be reported on the disbursing document showing the amounts paid by CLIN, co-payment offsets shall be separately reported on the disbursing document citing '9999CP' in the CLIN field (NOTE '9999CP' is not a CLIN but is used by TMA, CRM to report co-payment amounts). Co-payment offsets shall be calculated on a Net 30 basis and based on the same due date calculation used for administrative/dispensing fee payments. The government shall pay any amount due to the contractor in accordance with the Prompt Payment Act, after acceptance of the TED record. Process described in G.7.3 TED Record Submissions, G.7.11. Financial Editing of Detail Claims Data for Pharmacy Claims, and G.7.13. Federal Fiscal Year End Processing of TED, also apply to Mail Order and Specialty Pharmacy Services Administrative Fees.

**G.10.2. Prior Authorization or Medical Necessity Fees:** Payment for PAs/MNs will be based on submission of a separate TED record and paid under CLIN X007 (Prior Authorizations) or X008 (Medical Necessity Determinations) (see G.8.2 above).

**G.10.3. ADMINISTRATIVE CLIN PAYMENT ELIGIBILITY**

**G.10.3.1. Eligible Administrative CLIN Records:** If the TED record is eligible to receive an Administrative CLIN payment (all mail order claims are eligible to receive an administrative CLIN payment, with the exception of Type of Submission 'C' - complete cancellation to TED record data), then the TED record shall be submitted by the contractor to TMA using a Header Type Indicator of '6' or '9' (even if the TED record has already received an Administrative CLIN payment).

**G.10.3.2. Ineligible Administrative CLIN Records:** For a TED record submitted with a Type of Submission 'C' that would normally be eligible to receive an Administrative CLIN payment but is being cancelled OR if the contractor determines the TED record submitted is not eligible to receive an Administrative CLIN payment OR the contractor wants to refund an administrative CLIN payment to TMA, then the contractor shall submit the TED record to the TRICARE Management Activity (TMA) using a Header Type Indicator of '0' or '5'. No Administrative CLIN payments can occur on any TED record grouped in a Batch/Voucher with Header Type Indicator of '0' or '5'. Only no-pay and credits can be processed under these header types.

**G.10.4. Procedures for Administrative Fee Payments when the TED Record Processing System Is Not Available:** Upon notification by the Contracting Officer that the TED Record processing system is not  
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operating normally, the contractor may submit invoices outside of the TED system to the Contracting Officer. The invoice shall list the number of claims processed by CLIN. This may be submitted daily or grouped by no more than five days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

**G.11. MAIL ORDER PHARMACY - UN-REPLENISHED MOP PHARMACEUTICAL AGENTS AND SUPPLIES.**

**G.11.1.** Interim Settlement of Unreplenished MOP Pharmaceutical Agents and Supplies will be made on CLINs X003 (Un-Replenished MOP Pharmaceutical Agents & Supplies).

**G.11.1.1.** The contractor may submit a public voucher requesting reimbursement for pharmaceuticals that cannot be replenished through the NPV. The Government shall reimburse the contractor for the actual cost of MOP dispensed pharmaceutical agents and supplies that are not expected to be replenished through the NPV. The contractor shall attach the report at Section F.3.7 to support the request for reimbursement of dispensed pharmaceutical agents and supplies.

**G.11.1.2.** Interim cost reimbursement vouchers (i.e. SF1034) (electronic) for unreplenished pharmaceutical agents and supplies may be submitted by the contractor no more frequently than each option quarter, to include the Option Period Settlement at G.11.2., unless otherwise authorized by the Contracting Officer.

**G.11.2.** Option Period Settlement of Unreplenished MOP Pharmaceutical Agents and Supplies will be made on CLINs X003 (Un-Replenished MOP Pharmaceutical Agents & Supplies).

**G.11.2.1.** Ending unreplenished balances for MOP pharmaceutical agents and supplies will be carried forward to the next option period exercised, if any. After government approval of the MOP multi-source generic baseline, the contractor will be reimbursed actual cost for unreplenished partial packages of pharmaceuticals no longer dispensed.

**G.11.2.2.** Following the last option period exercised under this contract containing MOP requirements, the Government will reimburse the contractor actual cost for all MOP pharmaceutical agents and supplies that have not been replenished by the NPV. All reimbursements will be based on the report at Section F.3.7, in a form mutually agreed to by the Government and the contractor. Billing will be submitted on cost reimbursement vouchers (i.e. SF1034) (electronic).

**G.12. OTHER ADMINISTRATIVE PAYMENTS ON CONTRACT.**

**G.12.1. Phase-In:** The contractor will invoice interim payments for retail and mail order at the beginning of benchmark testing in three equal installments up to 50% of the Phase-In amount associated with each CLIN. The contractor will invoice the remaining 40% on November 4, 2009. The final invoice will be invoiced one month after the start of performance. The contractor will invoice 100% of the (b)(4) for VA services on 1 April 2010 after the VA go-live date. The Government reserves the right to suspend interim payments and/or withhold payment on any invoice in the event the contractor has not completed all implementation and transition requirements mutually agreed upon and associated with the CLIN. Upon completion of all transition and implementation requirements, the Government shall issue payment to the contractor for the final invoice. The interim payment schedule is as follows:

Retail	Mail	VA
(b)(4)		

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**G.12.2. Defense Information Assurance Certification and Accreditation Process (DIACAP)**

**G.12.2.1 Base Period:** Payment for CLIN 0002 (Defense Information Assurance Certification and Accreditation Process (DIACAP) will be made based on the submission (electronic) and acceptance of contractor invoice. The Contractor may invoice for interim payment of 50% of the CLIN amount upon obtaining DIACAP Interim Authority to Operate. The Contractor may submit a final invoice (electronic) DD250 for the balance following obtaining DIACAP Authority to Operate.

**G.12.2.2. Option Periods:** Payment for CLINs X009 (Defense Information Assurance Certification and Accreditation Process (DIACAP) shall be made no more frequently than monthly based upon submission (electronic) and acceptance of DD Form 250.

**G.12.3. Mail Order Support Center:** Payment for transactions completed under CLIN X002 (Mail Order Support Center) will be made based on the monthly submission (electronic) of a DD250, with supporting documentation to include a breakdown by sub-CLIN of each transaction completed and the name of the beneficiary for whom the transaction was completed. The contractor shall not include, and will not be paid for, transactions it could not or did not complete within the time standards specified under C.5.18.9.

**G.12.4. Beneficiary Mailings:** Payments for CLINs X010 (Beneficiary Mailings) will be made based on the submission (electronic) and acceptance of a quarterly DD250. Only one DD250 shall be submitted each quarter. The DD250 will be supported by a letter which certifies the number of units that were mailed during the quarter.

**G.12.5. Award Fee Pool:** Payment for CLINs X0011 (Award Fee Pool) will be made based on the submission (electronic) and acceptance of DD250, with supporting documentation of the Award Fee Determination made by the Government in accordance with Section H.4.

**G.12.6. Retail Network Cost Control Incentive Fee:** Payment of any amount earned under CLINs X012 (Retail Network Cost Control Incentive Fee) will be paid not more frequently than once per Option Period based on submission (electronic) and acceptance of a DD250, with supporting documentation of the computation described in Section H.1.

**G.12.7. Phase-Out:** Payment for CLINs X013 (Phase Out) activities will be made only once during the contract, based upon submission (electronic) of a completed and accepted DD Form 250.

**G.13. Postaward Meetings**

**G.13.1.** The Contractor shall attend any Postaward Orientation Conference (not separately priced) convened by the Contracting Officer in accordance with Federal Acquisition Regulation Subpart 42.5.

**G.13.2.** The Government and the contractor shall meet at least quarterly during each option period for a Program Management Review (PMR) (not separately priced) to discuss management and operational issues, to include but not limited to, the items detailed in the contract Surveillance Plan at Section J, Attachment 2 .

**(Section G continues at next page with G.99 Accounting and Appropriation Data)**

**G.99. Accounting and Appropriation Data**

(b)(4)

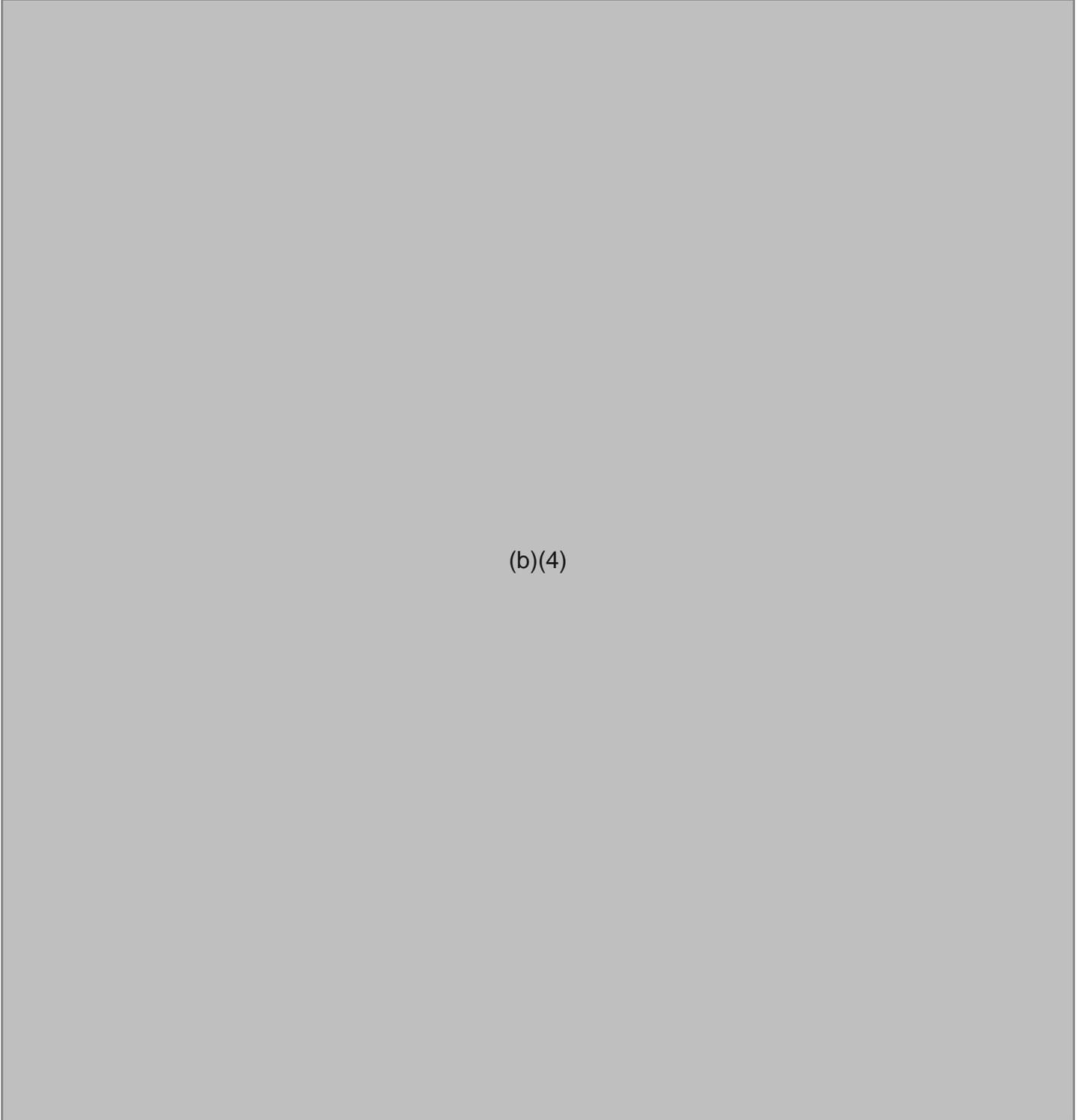
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H.1

**FINANCIAL INCENTIVES FOR ACTUAL RETAIL NETWORK REIMBURSEMENT COSTS**

**H.1.1.** The following table, Retail Network Reimbursement Table H-1, contains the “Guaranteed Average Price Adjustment Percentage” and “Guaranteed Average Dispensing Fee” proposed and guaranteed by the contractor for prescriptions for brand, generic, and specialty drug categories for each respective option period.



(b)(4)

**H.1.2.** Subject to paragraph H.1.5. below, the contractor may earn an incentive fee if the total actual retail network reimbursement cost in a contract option period **is less than** the “Total Expected Government Cost for H94002-08-C-0003

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Reimbursement of Retail Network Pharmacy Costs” that would have resulted from applying the Guaranteed Average Price Adjustment Percentage and the Guaranteed Average Dispensing Fee per prescription to the prescriptions filled in the retail network during the contract option period. The Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs will be calculated by first applying the WAC price published by First DataBank (FDB) that is in effect at the time the prescription transaction is processed, then adjusting the WAC price by applying the applicable “Guaranteed Average Price Adjustment Percentage” at table H-1, and finally, adding the applicable “Guaranteed Average Dispensing Fee” at table H-1 for each retail network prescription processed during the period. Prescriptions for which no WAC price published by First DataBank (FDB) is available at the time the prescription transaction is processed will be excluded from the calculation. The incentive will equal 5% of the difference between the total actual retail network reimbursement cost and Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs, up to a maximum of \$5 million per option period. For example, if in any option period the contractor’s Guaranteed Average Price Adjustment Percentage and the Guaranteed Average Dispensing Fee per prescription result in a Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs of \$5 billion, and the actual cost to the Government was \$4.95 billion, the contractor would be eligible for an incentive payment of \$2.5 million (5% of the savings of \$50 million).

**H.1.3.** The Government will assess a Negative Incentive if the total actual retail network reimbursement cost in a contract option period **exceeds** the Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs that would have resulted from applying the Guaranteed Average Price Adjustment Percentage and the Guaranteed Average Dispensing Fee per prescription to the prescriptions filled in the retail network during the contract option period. The difference between the actual costs and the Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs will be deducted from future payments to the contractor. For example, if in any option period the contractor’s Guaranteed Average Price Adjustment Percentage and the Guaranteed Average Dispensing Fee per prescription result in a Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs of \$5 billion, and the actual cost to the Government was \$5.01 billion, the contractor would be assessed a negative incentive amount of \$10 million.

**H.1.4.** The Government’s Pharmacy Data Transaction Service (PDTS) will accumulate reimbursement data from all retail network pharmacy transactions. PDTS will be the sole determining source for calculating the total actual retail network reimbursement cost, calculating the Total Expected Government Cost for Reimbursement of Retail Network Pharmacy Costs, and calculating the amounts of any incentive due the contractor in accordance with H.1.2. or any negative incentive owed to the Government in accordance with H.1.3.

**H.1.5.** To earn the incentive fee payment referenced in paragraph H.1.2. above, the contractor must meet or exceed all retail network access standards (See C.5.18.1) during a minimum of eleven months in each of option periods 2, 3, 4, and 5; a minimum of eight months in option period 1; and a minimum of three months in option period 6. The contractor must also maintain its retail network with a minimum of 90% of the number of pharmacies it originally proposed throughout each option period. Veterans Affairs, Public Health Service, and Indian Health Service pharmacies will not be included in the retail network access calculations.

**H.1.6.** Coordination of benefits claims, DVA claims, Medicaid claims, Public Health Service claims, Indian Health Service claims, non-network claims, and prescriptions for supplies and compounded medications will not be included in the calculation for the incentive fee payment referenced in H.1.2. above.

## **H.2. PERFORMANCE GUARANTEES**

**H.2.1.** The performance guarantees described in this provision are the contractor’s guarantee that the contractor’s performance will not be less than the performance standards described. The rights of the Government and remedies described in the Performance Guarantee provision are in accordance with, and in addition to all other rights and remedies of the Government. Specifically, the Government reserves its rights and remedies set forth in the Inspection of Services clauses (FAR 52.246-4) and the Default clause (FAR 52.249-8).

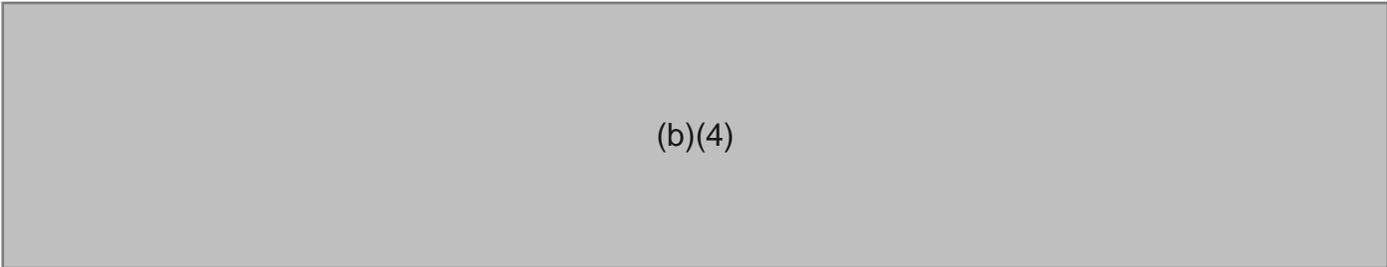
**H94002-08-C-0003**

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**H.2.2.** The contractor guarantees that performance will meet or exceed the standards in this Section H.2, and as stated in Section C. For each occurrence the contractor fails to meet each guaranteed standard, the Government will withhold from the contractor the amount listed in the schedule below. Performance guarantee withholds will continue until the contractor’s performance improves to meet or exceed the standard. Performance will be measured as specified below. The contractor will be notified of withholds accumulated and assessed on a quarterly basis. For the purposes of this Section H.2, the term “performance standard” is defined as the contract standards that are restated in this Section H.2. For purposes of determining if the stated performance standard has been met, the Government will utilize the rounding methodology detailed in Section C.5.18. If it is determined that the performance standard was not met, then the performance guarantee withhold will be applied against the actual level of performance. Each standard will be guaranteed, measured, and assessed applicable withhold separately, and in addition to, other standards.

**H.2.2.1. Retail Network Pharmacy Access (C.5.18.1)**

**Standards:** The contractor shall maintain a retail pharmacy network within the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the Northern Marianas Islands, American Samoa, and Guam sufficient to meet the following minimum beneficiary access standards on an overall basis, measured monthly:



(b)(4)

**Withhold:** If the contractor fails to meet any access standard, the performance guarantee withhold(s) in accordance with the tables below will be applied as follows, for each standard and each month the minimum access standard(s) is not met. Monthly Administrative Price (MAP) refers to the sum of CLINs for processing retail network pharmacy claims (EMC and paper) for the reporting month. For example, if during the reporting month, the sum of CLINs X004 and X005 equals \$5 million, and retail network access was 87.9% for urban areas, a performance guarantee withhold of 0.4% would be applied. The performance withhold guarantee would equal \$20,000 for the urban standard (i.e., 0.4% X \$5 million).

**URBAN AREAS:**

Actual Access Performance	Applicable Withhold
Less than 91.0% and more than or equal to 89.0%,	0.2% of the MAP
Less than 89.0% and more than or equal to 87.0%	0.4% of the MAP
Less than 87.0% and more than or equal to 85.0%	0.6% of the MAP
Less than 85.0% and more than or equal to 83.0%	0.8% of the MAP
Less than 83%.0	1.0% of the MAP

**SUBURBAN AND RURAL AREAS:**

Actual Access Performance	Applicable Withhold
Less than 95.0% and more than or equal to 93.0%,	0.2% of the MAP
Less than 93.0% and more than or equal to 91.0%	0.4% of the MAP

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Less than 91.0% and more than or equal to 89.0%	0.6% of the MAP
Less than 89.0% and more than or equal to 87.0%	0.8% of the MAP
Less than 87%.0	1.0% of the MAP

**Compliance** with these standards will be determined based on the contractor’s monthly Retail Network Access Report (F.3.3.2).

**H.2.2.2. Mail Order Pharmacy Prescription Processing (C.5.18.2.1.)**

**Standards:** MOP prescription processing and written notification of denied orders shall meet the following minimum requirements:

<b>Mail Order Pharmacy Prescription Processing Standards</b>
Measured monthly, not less than 95% of prescriptions received not requiring clarification or intervention shall be mailed within two calendar days of receipt.
Measured monthly, 100% of received prescriptions that do not require clarification or intervention shall be mailed within four calendar days of receipt.
Measured monthly, 95% of prescriptions received requiring clarification, intervention, or denials shall be mailed within seven calendar days of receipt.
Measured monthly, 100% of specialty pharmaceutical prescriptions dispensed from the MOP shall be processed to meet or exceed manufacturer recommended delivery practices and shall be delivered in a manner that will support the beneficiary maintaining the prescribed drug therapy regimen.

**Withhold:** If the contractor fails to meet any MOP prescription processing standard, the Government will withhold a performance guarantee amount of \$5.00 per prescription not meeting the standard. For example, if only 91.7% of all CLIN X001 prescriptions not requiring clarification or intervention processed during the month are mailed within two calendar days, a performance guarantee will be assessed on 3.3% of all CLIN X001 prescriptions not requiring clarification or intervention processed that month. The 3.3% represents the difference between the actual performance of 91.7% and the standard of 95%. For example, if 3.3% equates to 15,000 prescriptions, the performance guarantee withhold will be \$75,000.00 (i.e., 15,000 prescriptions X \$5.00 per prescription).

**Compliance** with these standards will be determined based on the contractor’s monthly prescription status reports (F.3.3.5).

**H.2.2.3. Paper Claims Processing (C.5.18.2.3.)**

**Standards:** The contractor shall process paper claims for prescriptions in a manner to meet the following minimum processing standards on an overall basis, measured monthly. Compliance with these standards will be determined based on the contractor’s monthly claims status reports (F.3.3.3.2.), and TED data:

<b>Paper Claims Processing Standards</b>
Measured monthly, not less than 95% of paper claims shall be processed to completion within ten working days of receipt
Measured monthly, 99% of paper claims shall be processed to completion within 20 working days of receipt

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Measured monthly, 100% of paper claims shall be processed to completion within 30 working days of receipt

**Withhold:** If the contractor fails to meet any of the paper claims processing standards, the Government will withhold a performance guarantee amount of \$1.00 per paper claim not meeting the standard. For example, if only 92.1% of paper claims are processed within ten working days, a performance guarantee withhold will be assessed equal to 2.9% of the paper claims processed that month. The 2.9% represents the difference between the actual performance of 92.1% and the standard of 95%. For example, if 2.9% equates to 1,050 paper claims, the performance guarantee withhold will be \$1,050 (i.e., 1,050 paper claims X \$1.00 per claim).

**Compliance** with these standards will be determined based on the contractor's monthly claims status reports (F.3.3.3.2.), and TED data.

**H.2.2.4. Prior Authorization and Medical Necessity Processing (C.5.18.3. & C5.18.4)**

**Standards:** The contractor shall process prior authorizations and medical necessity requests and send beneficiary notification in a manner to meet the following minimum processing standards on an overall basis, measured monthly:

<b>Prior Authorization and Medical Necessity Processing Standards</b>
Measure monthly, not less than 95% of all Prior Authorization (PA) requests shall be completed and notification sent to the beneficiary within two working days of receipt of a properly completed Prior Authorization request.
Measured monthly, 100% of all Prior Authorization requests shall be completed and notification sent to the beneficiary within five working days of receipt of a properly completed Prior Authorization request.
Measured monthly, not less than 95% of all Medical Necessity (MN) requests shall be completed and notification sent to the beneficiary within two working days of receipt of a properly completed MN request
Measured monthly, 100% of all Medical Necessity requests shall be completed and notification sent to the beneficiary within five working days of receipt of a properly completed Medical Necessity request

**Withhold:** If the contractor fails to meet any of the prior authorization or medical necessity processing standards, the Government will withhold a performance guarantee amount of \$1.00 per day for all PA and/or MN requests not processed within the applicable standard. For example, if only 90.1% of PAs are completed and mailed within two working days, a performance guarantee withhold will be assessed on 4.9% of the PAs received that month. The 4.9% represents the difference between the actual performance of 90.1% and the standard of 95%. If 4.9% equates to 285 PA requests, and on average they were 1.6 days late, the performance guarantee withhold will be \$456 (i.e., 285 X 1.6 X \$1.00).

**Compliance** with these standards will be determined based on the contractor's monthly prior authorization status report (F.3.3.8.) and medical necessity status report (F.3.3.9).

**H.2.2.5. Prior Authorization and Medical Necessity Accuracy (C.5.18.3.3 & C.5.18.3.4)**

**Standards:** The contractor shall process prior authorizations and medical necessity requests and send beneficiary notification in a manner to meet the following minimum accuracy standards, measured quarterly:

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<b>Prior Authorization and Medical Necessity Accuracy Standards</b>
Measured quarterly, 99.5% of all prior authorizations completed during the quarter shall be processed accurately.
Measured quarterly, 99.5% of all Medical Necessity (MN) determinations completed during the preceding quarter shall be processed accurately and in accordance with the Government provided criteria.

**Withhold:** If the contractor fails to meet either standard, based on the results of the Government’s quarterly audit (See Section J, Attachment 2), the Government will withhold a performance guarantee amount equal to the total administrative fee for all PA and/or MNs processed during the quarter times the rate of inaccurate processing. For example, if the total administrative fee for prior authorizations during the quarter was \$400,000 and the Government’s quarterly audit indicates that 2.5% of sampled prior authorizations were inaccurately processed, the Government will assess a performance guarantee withhold of \$10,000 (i.e., \$400,000 X 2.5%).

**H.2.2.6. Telephone Service – Transfer Time (C.5.18.5, C5.18.6. and C.5.18.9)**

**Standard:** Measured on a monthly basis, all calls received for Beneficiary Services, Pharmacy Help Desk, and Mail Order Support Center shall be transferred to an appropriate Service Representative in a manner to meet the following minimum call transfer standards.

<b>Telephone Service – Call Transfer Standards</b>
Measured on a monthly basis, all Beneficiary Services calls received shall be transferred to a Beneficiary Service Representative (BSR) with an Average Speed of Answer (ASA) of not more than 30 seconds after the caller has selected the option to speak to a BSR
Measured on a monthly basis, all Pharmacy Help Desk calls received shall be transferred to a Customer Service Representative (CSR) with an Average Speed of Answer (ASA) of not more than 30 seconds after the caller has selected the option to speak to a CSR
Measured on a monthly basis, all calls received by the Mail Order Customer Support Center shall be transferred to a Mail Order Customer Support Center Representative (MOSCR) after selection by caller with an Average Speed of Answer (ASA) of not more than 30 seconds after the caller has selected the option to speak to a MOSCR

**Withhold:** If the contractor fails to meet any of the telephone call transfer standards, the Government will withhold a performance guarantee amount of \$10,000 for each second in which the contractor exceeds the standard. For example, if the average speed of answer for Beneficiary Services calls for a given month is 32 seconds, a performance guarantee withhold of \$20,000 will be assessed (i.e., 2 seconds x \$10,000 per second). ASA is the total amount of time (in seconds) to answer all calls received during the month, divided by the total number of calls received during the month. The ASA will be rounded to the nearest whole second for purposes of calculating the performance guarantee.

**Compliance** with these standards will be determined based on the contractor’s monthly report of Beneficiary Services (F.3.3.13.), monthly report of Pharmacy Help Desk Services (F.3.3.14.), and contractor’s monthly report of Mail Order Support Center (F.3.3.15.).

**H.2.2.7. Telephone Service - Blocked Calls and Abandoned Calls (C.5.18.5, C5.18.6. and C.5.18.9).**

**Standard:** Measured on a monthly basis, all calls received for Beneficiary Services, Pharmacy Help Desk, and Mail Order Support Center shall be transferred to a appropriate Service Representative in a manner to meet the following minimum call transfer standards.

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<b>Telephone Service – - Blocked Call and Abandoned Call Standards</b>
Measured on a monthly basis, not less than 98% of all Beneficiary Service calls shall be received without the caller encountering a busy signal.
Measured on a monthly basis, not more than 3% of all Beneficiary Service calls will be abandoned by the callers
Measured on a monthly basis, not less than 98% of all Pharmacy Help Desk calls shall be received without the caller encountering a busy signal
Measured on a monthly basis, not more than 3% of all Pharmacy Help Desk calls will be abandoned by the callers
Measured on a monthly basis, not less than 98% of all Mail Order Support Center calls shall be received without the caller encountering a busy signal
Measured on a monthly basis, not more than 3% of all Mail Order Support Center calls will be abandoned by the callers

**Withhold:** , If the contractor fails to meet any of the Blocked Calls or Abandoned Calls standards, the Government will withhold a performance guarantee amount of \$0.50 per blocked or abandoned call in excess of the standard. For example, if 96.1% of calls are received without the caller encountering a busy signal, then a performance guarantee equal to 1.9% of the calls (1.9% represents the differences between the actual number of blocked calls and the standard of 98%) will be assessed. If 1.9% equates to 400 calls, the performance guarantee withhold will be \$200.00 (i.e. 400 X \$0.50).

**Compliance** with these standards will be determined based on the contractor’s monthly report of Beneficiary Services (F.3.3.13.), monthly report of Pharmacy Help Desk Services (F.3.3.14.), and contractor’s monthly report of Mail Order Support Center (F.3.3.15.).

**H.2.2.8. Member Choice Center (MCC) (C.5.18.9)**

**Standards:** The contractor shall process Mail Order Support Center services in accordance with the following:

<b>Member Choice Center Standards</b>
Of those transactions requested by the beneficiary under the requirements of Section C.5.8., 100% shall be completed within ten working days of the beneficiary making the request, measured monthly.

**Withhold:** If the contractor fails to meet the Member Choice Center standard, the Government will withhold a performance guarantee amount of \$1.00 per day for all transactions requested not processed within the standard. For example, if only 95.5% of requested transactions are completed within ten working days, a performance guarantee withhold will be assessed on 4.5% of the transactions requested during the period. The 4.5% represents the difference between the actual performance of 95.5% and the standard of 100%. If 4.5% equates to 320 transaction requests, and on average they were 2.6 days late, the performance guarantee withhold will be \$832 (i.e., 320 X 2.6 X \$1.00).

**Compliance** with this standard will be determined based on the contractor’s monthly report of Member Choice Center (F.3.3.15.).

**H.2.2.9. Correspondence Processing (C.5.18.5).**

**Standards:** The contractor shall process priority and routine correspondence in a manner to meet the following minimum processing standards:

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<b>Correspondence Processing Standards</b>
Measured on a monthly basis, not less than 95% of priority correspondence will be processed to completion within ten calendar days
Measured on a monthly basis, not less than 85% of routine correspondence will be processed to completion within 15 calendar days

**Withhold:** If the contractor fails to meet either standard, the Government will withhold a performance guarantee amount of \$1.00 per piece of correspondence that is processed below the standard. For example, if 92.4% of such correspondence is processed within the standard, then a performance guarantee withhold will be applied to 2.6% of priority correspondence processed that month (2.6% represents the difference between the actual performance of 2.6% and the standard of 95%). If 2.6% equates to 100 pieces of correspondence, the performance guarantee withhold will be \$100.00 (i.e., 100 X \$1.00).

**Compliance:** Correspondence performance will be determined based on the contractor's monthly report of Beneficiary Services (F.3.3.13.)

**H.2.2.10. TED Edit Accuracy (TOM Chapter 1).**

**Standard:** Measured on a monthly basis, the accuracy rate for TED edits shall be not less than:

95 % after six months of performance during the first option period and

99 % after nine months and thereafter during the entire term of the contract

**Withhold:** If the contractor fails to meet the standard and falls below either of the two standards of 95 % after six months or 99 % after nine months, a performance guarantee amount of \$1.00 for each TED record not meeting the standard will be withheld. For example, if only 93.3% of all TEDs pass edits after six months, then a performance guarantee amount will be applied 1.7% of all TEDs submitted during the period (1.7% equals the difference between the contractor's actual performance and the standard in this example). If 1.7% equates to 153,000 TEDs, the performance guarantee withhold amount will be \$153,000.00 (i.e., 153,000 X times \$1.00). The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

**H.2.2.11. Claim Payment Error Rate (Section C.5.18.7) (Measured on a Semi-Annual Basis)**

**Standard:** The absolute value of the payment errors for the sampled TED records for the semi-annual claim review shall not exceed 0.5% for electronic retail pharmacy claims, 1% for mail order pharmacy claims, 2% for paper claims, and 0.5% for specialty pharmacy services claims. The error rate will be calculated separately for each of the four categories (for paper claims, the error rate will be calculated from the combined audit result for both non-denied and denied claims) identified in Section H.3. The sample payment error rate will be defined as the total absolute payment error divided by the sample billed amount multiplied by 100.

**Withhold:** If the contractor fails to meet the payment error rate standards, the performance guarantee amount will be the overpayment dollar amount from the audit sample projected to the universe from which the sample was drawn. Underpayment error amounts will not be used to offset the overpayment dollar amount. The performance guarantee shall be separately assessed for each of the four categories identified in Section H.3.

**H.3. CLAIM REVIEW SAMPLING AND ERROR DETERMINATIONS.**

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**H.3.1.** Sample means will be used as point estimates of payment and occurrence errors. There will be four separate payment and occurrence samples as follows: 1) Electronic Retail Pharmacy Claims; 2) Paper Retail Pharmacy Claims ; 3) Mail Order Pharmacy Claims; and 4) Specialty Pharmacy Services Claims . The Paper Retail Pharmacy Claim sample will also include a separate sample of denied claims. The payment samples and occurrence samples shall be drawn on a semi-annual basis from TEDs records which pass all TMA edits. Payment samples shall be drawn from all records with Government payments or billed amounts greater than zero and less than \$20,000, although the Government may choose to exclude certain claims strata from the sampling frame. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts or billed amounts of over \$20,000. Payment samples shall be stratified at multiple levels, either by payment amount, billed amount or by other claims-based parameters. Records to be sampled for both the occurrence and payment audits will be “net” records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in batches/ vouchers which fail TRICARE edits or which are otherwise not valid for processing as submitted by the contractor will be excluded from the sampling frame. Audit results from the payment sample will be used to determine if a Performance Guarantee for Claims Payment Error Rate as stipulated in Sections C.5.18.7 and H.2.2.11 will be applicable.

The design of the non-denied payment and the occurrence samples will utilize a ninety percent (90%) confidence level, while the denied payment sample for paper retail pharmacy claims uses an eighty percent (80%) confidence level. Precision estimates are one percent (1%) for the non-denied payment sample, two percent (2%) for the denied payment sample (paper retail pharmacy claims only), and one and one-half percent (1.5%) for the occurrence samples.

The non-denied payment sample will be drawn from all TED records with government payments greater than \$0 to \$20,000. In addition, all TED records with a government payment amount of \$20,000 and over will be reviewed. The denied payment sample will be drawn from all TED records with billed amounts greater than \$0 to \$20,000. In addition, all TED records with billed amounts of \$20,000 and over will be reviewed.

All payment samples will be stratified at multiple levels within the greater than \$0 to \$20,000 range. Samples will be drawn on a semi-annual basis from TEDs that pass all TMA edits. TED records to be sampled will be “net” records (i.e., at the time the sample is drawn, any changes available for an initial TED submission, such as adjustments or a cancellation, constitutes a net record). TEDs in batches or vouchers which fail TRICARE edits or which are otherwise unable to be processed as submitted by the Contractor will be excluded from the sampling frame.

**H.3.2. Required Contractor Documentation.**

**H.3.2.1.** Upon receipt of the TEDs Record Indicator (TRI) listing from TMA or designated review contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. The Contractor shall submit via registered mail, certified mail, or similarly guaranteed delivery service one legible copy of each submitted claim form (for paper claims), a screen print for electronic retail pharmacy claims and a copy of the prescription for mail order prescription claims along with the following required documents. All documentation must be received at TMA or designated review contractor within forty-five (45) calendar days from the date of the TMA or designated review contractor letter transmitting the ICN listing.

**H.3.2.1.1.** Claim related correspondence when attached to the claim or related to the adjudication action, (e.g., development records, pharmacy receipts).

**H.3.2.1.2.** Other claim-related documentation, such as medical necessity or prior authorization records (screen prints acceptable), other health insurance documents, negotiated/discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements, and 4) negotiated rate and such other documents as are required to support the action taken on the claim.

**H.3.2.1.3.** A copy of the Explanation of Benefit (EOB) (or payment summary) for each claim selected.  
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**H.3.2.2.** Payment and/or occurrence errors will be assessed if the Contractor does not provide the above claim-related documents or if the documents provided are not legible. The Contractor has the option of submitting original documents in these cases where the copy is not legible. TMA or designated review contractor will return original documents upon completion of the review process.

**H.3.2.3.** Additional data regarding any unique claim adjudication guidelines used to process claims shall be furnished by the contractor as necessary.

**H.3.3. Payment Error Determinations (Section C.5.18.7.)**

**H.3.3.1.** Payment errors are based only on the claim information available and those processing actions which occur prior to the date the review sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the review sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to indicate the action taken and the date the action was completed is submitted. Actions and determinations occurring subsequent to the date the review sample is pulled or actions and determinations which occur after the date the review sample is pulled will not be considered in the review regardless of whether resolution of a payment error exists. Adjustment transactions are not allowed on total claim denials. Therefore, subsequent reprocessing actions to a denied claim which occurs prior to the date the review sample is pulled will be considered during the review.

**H.3.3.2.** Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount, but sent to the wrong payee, denial of a payable claim, misapplication of the cost-share/co-pay/deductible, payment of a non-covered drug, etc. Following are the applicable payment errors:

<b>Payment Error Code</b>	<b>Payment Error</b>
01K	Authorization/Pre-Authorization Error
02K	Unsupported Benefit Determination
03K	Billed Amount Incorrect
04K	Cost-Share/Deductible/Catastrophic Cap Error
06K	Development Required
07K	Duplicate Claim/Services Paid
08K	Eligibility Determination - Patient
09K	Eligibility Determination – Provider/Pharmacy
11K	Medical Necessity/Review Not Evident
13K	OHI/TPL Government Pay Miscalculated
14K	OHI Payment Omitted
15K	Payee Wrong – Sponsor/Patient
16K	Payee Wrong – Provider/Pharmacy
18K	Pricing Incorrect
20K	Signature Error

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Payment Error Code	Payment Error
21K	Timely Filing Error
23K	Contract Jurisdiction Error
24K	Benefit Determination Wrong
25K	Claim Not Provided
26K	Claim Not Auditable
99K	Other

**H.3.3.3.** The TED record will be the data source to determine if payment errors have occurred.

**H.3.3.4.** All incorrectly coded financial fields on a TED record are considered to be occurrence errors regardless of whether associated payment errors exist.

**H.3.3.5.** If a claim is selected for review and the Contractor cannot produce the claim or the claim provided is not auditable, a 100% payment error based upon the total amount billed will be assessed.

**H.3.4. TED Occurrence Error Determinations.** (Section C.5.18.8)

**H.3.4.1.** The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample multiplied by 100.

**H.3.4.2.** Occurrence error determinations are based on the claim information available and those processing actions taken which occur prior to the date the review sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the review sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to indicate the action taken and the date the action was completed is submitted. Actions and determinations occurring subsequent to the date the review sample is pulled or actions and determinations which occur after the date the review sample is pulled will not be considered in the review regardless of whether resolution of an occurrence error exists.

**H.3.4.3.** Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including fields in financial fields, shall be counted as occurrence errors. The following are occurrence error categories and codes. All TED record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the TED record.

Error Categories	Errors Condition Specific to Data Field
A	Incorrect Claim Information
B	Incorrect Patient/Sponsor Information
C	Incorrect Provider Information
G	Incorrect Financial Information
I	Incorrect Non-Institutional Claims/ Provider/ Utilization Information

**H.3.4.4.** Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. Following is a listing of these error conditions and the associated number of occurrence errors that will be assessed when each condition is identified:

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<b>Error Code</b>	<b>Error Condition</b>	<b>Number of Errors</b>
08J	Incorrect Record Type	5 errors
10J	Claim Not Provided for Review	2 errors
11J	Claim Not Auditable	2 errors
12J	Unsupported TED Transaction	2 errors

**H.3.5. Error Determination Rebuttals.**

**H.3.5.1.** Contractor rebuttals of review error findings must be submitted to TMA or designated review contractor within 45 calendar days of the date of the review transmittal letters. Rebuttals not postmarked within 45 calendar days of the review letter will be excluded from further consideration. Rebuttal responses from TMA or the designated review contractor are final. The only exception to this will be if the contractor submits new documentation (including an explanation of claim circumstances) during the initial rebuttal response which results in a new or additional errors being assessed. Contractor rebuttals to new errors assessed by TMA or the designated review contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated review contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 45 to the Julian calendar date of the TMA or designated review contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.

**H.4. AWARD FEE.**

The award fee will be administered semi-annually during each contract option period in accordance with the award fee plan. The award fee pool is shown in Section B and any awarded portions disbursed semi-annually in accordance with the TPharm Award Fee Plan (see Section J, Attachment 11). Unearned portions of the award fee pool are not available for any subsequent award.

**H.5. ALLOWABLE PHARMACEUTICAL COSTS**

FAR clause 52.216-7 - Allowable Cost and Payment (Dec. 2002) is applicable to CLINs X003 “Un-Replenished MOP Pharmaceutical Agents & Supplies” only. Submission of an invoice with a detailed description of each item(s) being reimbursed is considered an acceptable invoice or voucher required in accordance with FAR 52.216-7(a)(1). This clause does not substitute any portion of, nor make changes to the FAR 52.216-7 clause included in this contract.

**H.6. CONTRACT TYPE**

This is a hybrid contract, with primarily fixed price per unit contract line items (CLINs) awarded as Indefinite Delivery/Requirements type contract items pursuant to FAR 16.503, Firm-Fixed-Priced CLINs awarded as Firm-Fixed-Price contract items pursuant to FAR 16.202, and cost-reimbursable CLINs awarded as cost type contract items pursuant to FAR 16.302. The contract also contains provisions for Award Fee, Performance Guarantees, and Retail Network Pharmaceutical Cost Guarantees/Incentives. (See Section B.1 for contract type by CLIN).

**(End of Section H)**

SECTION I  
CONTRACT CLAUSES

**I.1**

**52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)**

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es):

<http://www.arnet.gov/>; <http://farsite.hill.af.mil/>; or <http://www.acq.osd.mil/dpap/dars/dfars/index.htm>  
(End of Clause)

**I.2 252.201-7000 CONTRACTING OFFICER'S REPRESENTATIVE (DEC 1991)**

(Reference 201.602-70)

**I.3 52.202-1 DEFINITIONS (JUL 2004)**

(Reference 2.201)

**I.4 52.203-3 GRATUITIES (APR 1984)**

(Reference 3.202)

**I.5 52.203-5 COVENANT AGAINST CONTINGENT FEES (APR 1984)**

(Reference 3.404)

**I.6 52.203-6 RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT (SEP 2006)**

(Reference 3.503-2)

**I.7 52.203-7 ANTI-KICKBACK PROCEDURES (JUL 1995)**

(Reference 3.502-3)

**I.8 52.203-8 CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)**

(Reference 3.104-9)

**I.9 52.203-10 PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)**

(Reference 3.104-9)

**I.10 52.203-12 LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (SEP 2007)**

(Reference 3.808)

**I.11 52.203-13 CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (DEC 2007)**

(Reference 3.1004)

**I.12 52.203-14 DISPLAY OF HOTLINE POSTER(S) (DEC 2007)**

(Reference 3.1004)

**I.13 252.203-7001 PROHIBITION ON PERSONS CONVICTED OF FRAUD OR OTHER DEFENSE-CONTRACT-RELATED FELONIES (DEC 2004)**

(Reference 203.570-3)

**I.14 252.203-7002 DISPLAY OF DOD HOTLINE POSTER (DEC 1991)**

(Reference 203.7002)

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**I.15 52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON RECYCLED PAPER (AUG 2000)**

(Reference 4.303)

**I.16 52.204-7 CENTRAL CONTRACTOR REGISTRATION (APR 2008)**

(Reference 4.1104)

**I.17 52.204-9 PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (SEP 2007)**

(Reference 4.1303)

**I.18 252.204-7000 DISCLOSURE OF INFORMATION (DEC 1991)**

(Reference 204.404-70)

**I.19 252.204-7001 COMMERCIAL AND GOVERNMENT ENTITY (CAGE) CODE REPORTING (AUG 1999)**

(Reference 204.7207)

**I.20 252.204-7003 CONTROL OF GOVERNMENT PERSONNEL WORK PRODUCT (APR 1992)**

(Reference 204.404-70)

**I.21 252.204-7004 ALTERNATE A, CENTRAL CONTRACTOR REGISTRATION (SEP 2007)**

(Reference 204.1104)

**I.22 252.205-7000 PROVISION OF INFORMATION TO COOPERATIVE AGREEMENT HOLDERS (DEC 1991)**

(Reference 205.470)

**I.23 52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (SEP 2006)**

(Reference 9.409)

**I.24 252.209-7001 DISCLOSURE OF OWNERSHIP OR CONTROL BY THE GOVERNMENT OF A TERRORIST COUNTRY (OCT 2006)**

(Reference 209.104-70)

**I.25 252.209-7002 DISCLOSURE OF OWNERSHIP OR CONTROL BY A FOREIGN GOVERNMENT (JUN 2005)**

(Reference 209.104-70)

**I.26 252.209-7004 SUBCONTRACTING WITH FIRMS THAT ARE OWNED OR CONTROLLED BY THE GOVERNMENT OF A TERRORIST COUNTRY (DEC 2006)**

(Reference 209.409)

**I.27 52.211-15 DEFENSE PRIORITY AND ALLOCATION REQUIREMENTS (APR 2008)**

(Reference 11.604)

**I.28 52.215-2 AUDIT AND RECORDS--NEGOTIATION (JUN 1999)**

(Reference 15.209)

**I.29 52.215-8 ORDER OF PRECEDENCE--UNIFORM CONTRACT FORMAT (OCT 1997)**

(Reference 15.209)

**I.30 52.215-11 PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA--MODIFICATIONS (OCT 1997)**

(Reference 15.408)

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**I.31 52.215-13 SUBCONTRACTOR COST OR PRICING DATA--MODIFICATIONS (OCT 1997)**  
(Reference 15.408)

**I.32 52.215-14 INTEGRITY OF UNIT PRICES (OCT 1997)**  
(Reference 15.408)

**I.33 52.215-18 REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (JUL 2005)**  
(Reference 15.408)

**I.354 52.215-19 NOTIFICATION OF OWNERSHIP CHANGES (OCT 1997)**  
(Reference 15.408)

**I.35 52.215-20 REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA (OCT 1997)**  
(Reference 15.408)

**I.376 52.215-21 REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA--MODIFICATIONS (OCT 1997)**  
(Reference 15.408)

**I.37 252.215-7000 PRICING ADJUSTMENTS (DEC 1991)**  
(Reference 215.408)

**I.38 52.216-7 ALLOWABLE COST AND PAYMENT (DEC 2002)**  
(Reference 16.307)

**I.39 52.216-18 ORDERING (OCT 1995)**  
(Reference 16.506)

**I.40 52.216-21 REQUIREMENTS (OCT 1995)**  
(Reference 16.506)

**I.41 52.216-22 INDEFINITE QUANTITY (OCT 1995)**  
(Reference 16.506)

**I.42 52.217-8 OPTION TO EXTEND SERVICES (NOV 1999)**  
(Reference 17.208)

**I.43 52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 2000)**  
(Reference 17.208)

**I.44 52.219-8 UTILIZATION OF SMALL BUSINESS CONCERNS (MAY 2004)**  
(Reference 19.708)

**I.45 52.219-9 SMALL BUSINESS SUBCONTRACTING PLAN (APR 2008)**  
(Reference 19.708)

SECTION I  
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**I.46 52.219-10 INCENTIVE SUBCONTRACTING PROGRAM (OCT 2001)**

(a) Of the total dollars it plans to spend under subcontracts, the Contractor has committed itself in its subcontracting plan to try to award certain percentages to small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, respectively.

(b) If the Contractor exceeds its subcontracting goals for small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, and women-owned small business concerns in performing this contract, it will receive (b)(4) percent of the dollars in excess of each goal in the plan, unless the Contracting Officer determines that the excess was not due to the Contractor's efforts (e.g., a subcontractor cost overrun caused the actual subcontract amount to exceed that estimated in the subcontracting plan, or the award of subcontracts that had been planned but had not been disclosed in the subcontracting plan during contract negotiations). Determinations made under this paragraph are unilateral decisions made solely at the discretion of the Government.

(c) If this is a cost-plus-fixed-fee contract, the sum of the fixed fee and the incentive fee earned under this contract may not exceed the limitations in 15.404-4 of the Federal Acquisition Regulation.

(End of Clause)

**I.47 52.219-16 LIQUIDATED DAMAGES--SUBCONTRACTING PLAN (JAN 1999)**

(Reference 19.708)

**I.48 252.219-7003 SMALL BUSINESS SUBCONTRACTING PLAN (DOD CONTRACTS) (APR 2007)**

(Reference 219.708)

**I.49 52.222-1 NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997)**

(Reference 22.103-5)

**I.50 52.222-3 CONVICT LABOR (JUN 2003)**

(Reference 22.202)

**I.51 52.222-21 PROHIBITION OF SEGREGATED FACILITIES (FEB 1999)**

(Reference 22.810)

**I.23 52.222-26 EQUAL OPPORTUNITY (MAR 2007)**

(Reference 22.810)

**I.53 52.222-35 EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS. [SEP 2006]**

(Reference 22.1310)

**I.54 52.222-36 AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (JUN 1998)**

(Reference 22.1408)

**I.55 52.222-37 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (SEP 2006)**

(Reference 22.1310)

**I.56 52.222-39 NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC 2004)**

(Reference 22.1605)

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**I.57 52.222-41 SERVICE CONTRACT ACT OF 1965 (NOV 2007)**

(Reference 22.1006)

**I.58 52.222-42 STATEMENT OF EQUIVALENT RATES FOR FEDERAL HIRES (MAY 1989)**

(Reference 22.1006)

**I.59 52.222-43 FAIR LABOR STANDARDS ACT AND SERVICE CONTRACT ACT--PRICE ADJUSTMENT (MULTIPLE YEAR AND OPTION CONTRACTS) (NOV 2006)**

(Reference 22.1006)

**I.60 52.222-50 COMBATING TRAFFICKING IN PERSONS (AUG 2007)**

(Reference 22.1705)

**I.61 52.223-6 DRUG-FREE WORKPLACE (MAY 2001)**

(Reference 23.505)

**I.62 52.223-14 TOXIC CHEMICAL RELEASE REPORTING (AUG 2003)**

(Reference 23.906)

**I.63 52.224-1 PRIVACY ACT NOTIFICATION (APR 1984)**

(Reference 24.104)

**I.654 52.224-2 PRIVACY ACT (APR 1984)**

(Reference 24.104)

**I.65 52.225-13 RESTRICTIONS ON CERTAIN FOREIGN PURCHASES (FEB 2006)**

(Reference 25.1103)

**I.66 252.225-7031 SECONDARY ARAB BOYCOTT OF ISRAEL (JUN 2005)**

(Reference 225.7605)

**I.67 252.226-7001 UTILIZATION OF INDIAN ORGANIZATIONS, INDIAN-OWNED ECONOMIC ENTERPRISES, AND NATIVE HAWAIIAN SMALL BUSINESS CONCERNS (SEP 2004)**

(Reference 226.104)

**I.68 52.227-1 AUTHORIZATION AND CONSENT (DEC 2007)**

(Reference 27.201-2)

**I.69 52.227-14 RIGHTS IN DATA--GENERAL (DEC 2007)**

(Reference 27.409)

**I.70 52.227-17 RIGHTS IN DATA--SPECIAL WORKS (DEC 2007)**

(Reference 27.409)

**I.71 52.229-3 FEDERAL, STATE, AND LOCAL TAXES (APR 2003)**

(Reference 29.401-3)

**I.72 52.230-2 COST ACCOUNTING STANDARDS (APR 1998)**

(Reference 30.201-4)

**I.73 52.230-6 ADMINISTRATION OF COST ACCOUNTING STANDARDS (MAR 2008)**

(Reference 30.201-4)

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**I.74 252.231-7000 SUPPLEMENTAL COST PRINCIPLES (DEC 1991)**

(Reference 231.100-70)

**I.75 52.232-1 PAYMENTS (APR 1984)**

(Reference 32.111)

**I.76 52.232-8 DISCOUNTS FOR PROMPT PAYMENT (FEB 2002)**

(Reference 32.111)

**I.77 52.232-11 EXTRAS (APR 1984)**

(Reference 32.111)

**I.78 52.232-17 INTEREST (JUN 1996)**

(Reference 32.617)

**I.79 52.232-18 AVAILABILITY OF FUNDS (APR 1984)**

(Reference 32.705-1)

**I.80 52.232-19 AVAILABILITY OF FUNDS FOR THE NEXT FISCAL YEAR (APR 1984)**

(Reference 32.705-1)

**I.81 52.232-22 LIMITATION OF FUNDS (APR 1984)**

(Reference 32.705-2)

**I.82 52.232-23 ASSIGNMENT OF CLAIMS (JAN 1986)**

(Reference 32.806)

**I.83 52.232-25 PROMPT PAYMENT (OCT 2003)**

(Reference 32.908)

**I.84 52.232-33 PAYMENT BY ELECTRONIC FUNDS TRANSFER--CENTRAL CONTRACTOR  
REGISTRATION (OCT 2003)**

(Reference 32.1110)

**I.85 52.232-37 MULTIPLE PAYMENT ARRANGEMENTS (MAY 1999)**

(Reference 32.1110)

**I.86 252.232-7010 LEVIES ON CONTRACT PAYMENTS (DEC 2006)**

(Reference 232.7102)

**I.87 52.233-1 I DISPUTES (JUL 2002)--ALTERNATE I (DEC 1991)**

(Reference 33.215)

**I.88 52.233-3 PROTEST AFTER AWARD (AUG 1996)**

(Reference 33.106)

**I.89 52.233-4 APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004)**

(Reference 33.215)

**I.90 52.237-3 CONTINUITY OF SERVICES (JAN 1991)**

(Reference 37.110)

**I.91 52.237-7 INDEMNIFICATION AND MEDICAL LIABILITY INSURANCE (JAN 1997)**

(Reference 37.403)

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**I.92 52.239-1 PRIVACY OR SECURITY SAFEGUARDS (AUG 1996)**

(Reference 39.107)

**I.93 52.242-13 BANKRUPTCY (JUL 1995)**

(Reference 42.903)

**I.94 52.243-1 I CHANGES--FIXED-PRICE (AUG 1987)--ALTERNATE I (APR 1984)**

(Reference 43.205)

**I.965 52.243-2 I CHANGES--COST-REIMBURSEMENT (AUG 1987)--ALTERNATE I (APR 1984)**

(Reference 43.205)

**I.96 52.243-6 CHANGE ORDER ACCOUNTING (APR 1984)**

(Reference 43.205)

**I.97 52.243-7 NOTIFICATION OF CHANGES (APR 1984)**

(Reference 43.107)

**I.98 52.243-7001 PRICING OF CONTRACT MODIFICATIONS (DEC 1991)**

(Reference 243.205-70)

**I.99 52.243-7002 REQUESTS FOR EQUITABLE ADJUSTMENT (MAR 1998)**

(Reference 243.205-71)

**I.100 52.244-2 SUBCONTRACTS (JUN 2007)**

(Reference 44.204)

**I.101 52.244-5 COMPETITION IN SUBCONTRACTING (DEC 1996)**

(Reference 44.204)

**I.102 52.244-6 SUBCONTRACTS FOR COMMERCIAL ITEMS (MAR 2007)**

(Reference 44.403)

**I.103 52.246-25 LIMITATION OF LIABILITY--SERVICES (FEB 1997)**

(Reference 46.805)

**I.104 52.248-1 VALUE ENGINEERING (FEB 2000)**

(Reference 48.201)

**I.105 52.249-2 TERMINATION FOR CONVENIENCE OF THE GOVERNMENT (FIXED-PRICE)  
(MAY 2004)**

(Reference 49.502)

**I.106 52.249-6 TERMINATION (COST-REIMBURSEMENT) (MAY 2004)**

(Reference 49.503)

**I.107 52.249-8 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE) (APR 1984)**

(Reference 49.504)

**I.108 52.253-1 COMPUTER GENERATED FORMS (JAN 1991)**

(Reference 53.111)

**SECTION I  
CONTRACT CLAUSES**

**I.109 52.211-9000 AVAILABILITY OF DOCUMENTS (AUGUST 2004)**

AVAILABILITY OF DOCUMENTS (AUGUST 2004) All pertinent documents and attachments which do not accompany the solicitation but are incorporated by reference may be obtained upon written request to, or examined in, the Acquisition Management and Support Directorate, Aurora, Colorado. Telephone: (303) 676-3775 Facsimile: (303) 676-3554

(End of Provision)

**I.110 52.211-9001 AVAILABILITY OF REGULATIONS (AUGUST 2004)**

AVAILABILITY OF REGULATIONS (AUGUST 2004) The Federal Acquisition Regulation (FAR) may be purchased from the Superintendent of Documents, Government Printing Office (GPO), Washington, DC 20402 or viewed on the World Wide Web at <http://www.arnet.gov/far/>. The Defense Federal Acquisition Regulations Supplement (DFARS) may be viewed at <http://www.acq.osd.mil/dpap/dfars/index.htm>. The TRICARE Acquisition Manual (TAM) may be viewed at <http://www.tricare.osd.mil/contracting/acquisitionpolicy/index.cfm?apfx=tam>.

(End of Provision)

**I.111 52.219-9000 SUBMISSION OF SUBCONTRACTING PLAN (JANUARY 2001)**

SUBMISSION OF SUBCONTRACTING PLAN (JANUARY 2001) (a) This provision is not applicable to small business concerns. (b) The offeror shall submit a subcontracting plan which meets the requirements of FAR 19.704(a). The subcontracting plan shall be submitted with the offeror's business proposal.

(End of Clause)

**I.112 52.222-49 SERVICE CONTRACT ACT--PLACE OF PERFORMANCE UNKNOWN (MAY 1989)**

(a) This contract is subject to the Service Contract Act, and the place of performance was unknown when the solicitation was issued. In addition to places or areas identified in wage determinations, if any, attached to the solicitation, wage determinations have also been requested for the following: "NONE" The Contracting Officer will request wage determinations for additional places or areas of performance if asked to do so in writing by "not later than 20 calendar days after Solicitation "Date Issued" (see SF-33, Block 5). "

(b) Offerors who intend to perform in a place or area of performance for which a wage determination has not been attached or requested may nevertheless submit bids or proposals. However, a wage determination shall be requested and incorporated in the resultant contract retroactive to the date of contract award, and there shall be no adjustment in the contract price.

(End of Clause)

**(End of Section I)**

**SECTION J  
LIST OF ATTACHMENTS**

**J.1  
ATTACHMENTS / DESCRIPTIONS**

**Section J Attachments**

<b>Attch#</b>	<b>Description</b>
<b>1</b>	TPharm PDTS Interface Control Document (ICD) dated 12 March 2008
<b>2</b>	TPharm Surveillance Plan dated October 31, 2007
<b>3</b>	Payment/Check Issue Report Format
<b>4</b>	Bank Account Reconciliation Report Format
<b>4.01</b>	Bank Account Reconciliation Report Instructions
<b>5</b>	Accounts Receivable Report Formats
<b>6</b>	Service Contract Act Wage Determinations At Award
<b>7</b>	Subcontract Plan dated May 30, 2008
<b>8</b>	Service Contract Act Wage Determinations Incorporated Retroactively for Wage Determinations: WD 05-2123, WD 05-2361, WD 05-2083, 05-2097, 05-2115, 05-2273, 05-2367, 05-2449, and 05-2447

**(End of Section J)**