Introduction

Through the issuance of this Request for Proposal (RFP), the Missouri Consolidated Health Care Plan (MCHCP), is soliciting proposals from qualified bidders that can provide both self-insured commercial Pharmacy Benefit Management (PBM) services for its active and non-Medicare retiree population and their dependents and self-insured Medicare Part D Employer Group Waiver Plan (EGWP) PBM services to its Medicare-eligible retirees and Medicare-eligible dependents of retirees. Any contract awarded from this RFP will be effective January 1, 2027.

MCHCP is, by Missouri statute, the purchaser of health insurance benefits for most State of Missouri employees, retirees and their dependents. It provides the same services on an elective basis for public entities. January, 2026, total membership exceeds 90,000 total lives (approximately 73,000 commercial lives; 17,000 EGWP lives).

MCHCP is seeking a PBM partner that will provide consultative services, in addition to administrative and reporting services. The PBM must meet with MCHCP on a regular basis to consult with MCHCP on the design of its pharmacy benefit, discuss areas in which the benefit can be enhanced or provide greater efficiency, resolve outstanding issues, keep MCHCP advised of prescription drug market trends and PBM legislation, and ensure the costs of the pharmacy benefits remain affordable.

MCHCP reserves the right to award any service in whole or in part, to one or more bidders, if submitted proposals suggest that doing so would be in MCHCP's best interest. MCHCP also reserves the right to issue multiple awards, no award, or cancel or alter the procurement at any time. In addition, MCHCP reserves the right to extend the proposed RFP period, if needed. Proposals containing the lowest cost will not necessarily be awarded as MCHCP recognizes that factors other than costs are important to the ultimate selection of the provider or providers of their benefit plan. Proposals provided in response to this RFP must comply with the submittal requirements set forth in the RFP, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein.

Please read the entire solicitation package and submit an offer in accordance with the instructions. All forms contained in the solicitation package must be completed in full and submitted along with the proposal submission, which combined, will constitute the offer. **This RFP and your response, including all subsequent documents or addendums, provided during this RFP process will become part of the contract terms and policy between the parties.**

MCHCP has retained Segal to assist in the evaluation of the financial proposals for completeness and responsiveness to the RFP and to review such proposals with them.

Background

MCHCP is governed by the provisions of Chapter 103 of the Revised Statutes of Missouri. Under the law, MCHCP is directed to procure health and prescription drug benefits for most State employees. The law also authorizes non-state public entities to participate in the plan. Rules and regulations governing the plan can be found by following this link http://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp. MCHCP is a separate, stand-alone state entity created by statute and organized under the direction of a 13-member Board of Trustees.

Currently MCHCP contracts with Express Scripts, Inc. to administer prescription drug benefits on a self-insured basis for Commercial and Medicare Employer Group Waiver Plan (EGWP) populations. The current contract has been effective since January 1, 2022, and expires on December 31, 2026.

MCHCP also contracts with UnitedHealthcare to provide MA only services, including prescription drug coverage for Medicare Part B. If an enrollee or dependent is Medicare-eligible due to age or disability at the time of the enrollee's retirement, the MA only and stand-alone Part D EGWP will become effective on the member's date of retirement for the Medicare-eligible member and any Medicare-eligible dependents. The Medicare-eligible retiree's other covered dependents who are not Medicare eligible will remain in MCHCP's commercial prescription drug plan.

MCHCP is seeking a PBM to administer a nationwide managed prescription drug plan (for commercial and EGWP populations) with the following attributes:

- Ability to administer commercial and EGWP prescription drug plans
- Access to a broad national network of retail pharmacies in both commercial and EGWP plans
- Efficient and effective mail order program
- Efficient and effective specialty drug program
- Real-time claims processing and reporting systems
- Competitive financial proposal (including effective discounts, rebates and extended rate guarantees)
- High quality account management
- Effective performance standards to assess and monitor performance
- Proactive and innovative responses to industry trends
- Ability to contract on an "administrative services only" basis, receiving its only income for this account from MCHCP administrative fees
- Claims adjudication
- Medicare Part D EGWP administrative assistance
- Data reporting (standard and ad-hoc reporting)
- Ability to integrate PBM services with other vendors (e.g., disease management, medical), if applicable
- Eligibility maintenance
- Patient and provider education
- Provider advocacy and assistance with claims issues
- Effective member communications
- Systematic prospective, concurrent, and retrospective drug utilization review
- Formulary management and 100% pass through of rebates sharing
- Clinical program management
- Distribution of ID Cards and pharmacy directories
- Medication Therapy Management, as applicable
- Availability of IT services, including online/real time availability to MCHCP and/or its designee(s)
- Pricing administration
- Member services, including quality and functionality of member website and mobile app
- Coordination with a third-party vendor administering the MA only benefit, as applicable

Purpose

MCHCP is soliciting competitive proposals to administer the MCHCP prescription drug plan of benefits that will allow MCHCP to use the PBM's lowest net cost formulary that replicates the current plan designs including the current clinical and utilization management programs (i.e., prior authorizations (PAs), quantity limits and step therapy programs). The proposed Part D EGWP should also replicate the current plan design and provide a lowest net cost prescription drug plan design within CMS guidelines. Bidders are required to provide pricing based upon their formularies that best meet the needs of MCHCP.

Transparent pricing at retail is required and must include 100% pass-through of all rebates (i.e., formulary rebates, manufacturer administration fees, price protection/inflation protection payments, and any other payments that are currently received or will be received in the future related to rebates). The PBM will pass through its contracted rates with participating pharmacies and all manufacturer revenue it receives from pharmaceutical manufacturers in excess of MCHCP's guaranteed rebate payments. The amount billed to MCHCP at retail pharmacies and specialty pharmacies will be equal to the amount paid by the PBM to the retail pharmacies and specialty pharmacies. The PBM's only profits are administrative fees and any clinical program fees MCHCP agrees to implement. Discounts and manufacturer payments achieved on MCHCP's behalf that exceed the financial guarantees are payable to MCHCP. Dispensing fees that are paid lower than the guaranteed amount are also passed through to MCHCP. The pricing arrangements will be evaluated based on the lowest net cost after member cost share, fees and rebates, including minimum guaranteed discounts, fees, and minimum rebates.

Bidders are encouraged to identify and offer features or enhancements that provide additional value without adding cost as well as any creative solutions that will achieve MCHCP’s goals. Of particular interest are programs that focus on lowest net cost and formulary strategies that focus on generics, biosimilars, and utilization management that manually verify data points such as diagnoses. MCHCP reserves the right to carve out specialty pharmacy and any other specialty services of the PBM.

Proposals will be reviewed and evaluated for completeness and responsiveness according to MCHCP's evaluation criteria. Based on the results of the evaluation, MCHCP will award the contract(s) to the most advantageous bidder(s), based on cost and the technical evaluation factors set forth in the RFP. Any contract awarded hereunder shall be subject to the approval of the Board of Trustees in accordance with applicable state laws and regulations. The MCHCP Board of Trustees has final responsibility for all MCHCP contracts.

Proposals will be considered complete only if the bidder responds to and meets all the requirements of this RFP. MCHCP will evaluate each proposal considering the following criteria:

- Overall net costs to MCHCP and its members
- Member and account service capabilities and ability to meet core client service requirements
- Clinical support to MCHCP
- Consultative support to MCHCP
- Strength of pharmacy network and formulary management programs
- PBM adherence to performance guarantees
- PBM account management and leadership structure

Contract Term

The initial agreement will be for the period of January 1, 2027, through December 31, 2027, with up to three additional one-year contracts renewable at the sole option of the MCHCP Board of Trustees.

Minimum Bidder Requirements.

Only bidders that meet the following minimum requirements will be considered. Bids from companies not meeting all the minimum requirements will not be considered by MCHCP for this contract.

- Licensing – The bidder must be licensed as necessary to do business in the State of Missouri to perform the duties described in this RFP and be in good standing with the office of the Missouri Secretary of State. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business.

- Size and Experience – The bidder must have been in the PBM business for a minimum of five years.

  The bidder must currently administer commercial prescription drug benefits to at least 500,000 covered lives and administer prescription drug benefits for at least two large employer groups with 50,000 covered lives or more. The bidder must be willing to disclose the names of the large employer clients if requested.

  The bidder or subcontractor must currently administer EGWP prescription drug benefits for at least 100,000 covered lives and administer EGWP prescription drug benefits to at least two large employer groups with 10,000 covered lives or more.

- Impact of Award – The bidder must certify that, if awarded a contract, the bidder would not increase its total annual claim payment volume by more than 25 percent with the addition of this business. MCHCP actual pharmacy claims (before rebates) were $373 million through November, 2025 and are estimated to exceed $405 million for the 2025 calendar year (commercial and EGWP). Pharmacy trend is estimated to be 12 percent for 2026 and 2027. The bidder must only use their book of business as of the proposal submission date and MCHCP's pharmacy expenses when calculating the percentage increase. Business not yet awarded may not be used in the calculation.

- Bankruptcy and Legal – The bidder must not have any bankruptcy filings within the last 5 years; and bidder's senior officers, board members, or directors must not have any felony convictions, and they must not have been excluded from Medicare.

- Contract Term – The bidder must agree to a one-year contract term with renewals for Years 2, 3 and 4.

- Employee Group Waiver Program (EGWP) – The bidder must have or have a subcontractor that has a 2026 contract in place with CMS and be approved to provide EGWP services similar in scope and size that is currently in place for MCHCP today. The bidder must be able to administer a commercial wrap for the EGWP program.

Assumptions and Considerations

Your proposal, including financial worksheets (Exhibit A-8 and Exhibit A-9) must be submitted using the Optavise online submission tool no later than **Monday, March 2, 2026, 5 p.m. CT (6 p.m. ET)**. Due to the limited timeframe for proposal analysis and program implementation, **no individual deadline extensions will be granted**.

The Board of Trustees has final responsibility for all MCHCP contracts. Responses to the RFP and all proposals will remain confidential until awarded by the MCHCP Board of Trustees or its designee or until all proposals are rejected.

Do not contact MCHCP directly regarding this RFP. Questions about the technical procedures for participating in this online RFP process should be addressed to Optavise. Any questions concerning the content of the RFP should be submitted via the messaging tool of Optavise.

Proposal Instructions

NOTE: READ THESE INSTRUCTIONS COMPLETELY PRIOR TO RESPONDING TO THE RFP

You must respond to all sections of this RFP to be considered. Bidders are strongly encouraged to read the entire RFP prior to the submission of a proposal. The bidder must comply with all stated requirements. Bidders are expected to provide complete and concise answers to all questions. Answers that do not respond to the questions as stated cannot be evaluated. Each question must be answered specifically and in detail. Reference should not be made to a prior response or to your contract, unless the question involved specifically provides such an option. Your responses to all questions must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your current capabilities.

1. Provide answers to all questions in your submission.
2. Provide an answer to each question even if the answer is "not applicable" or "unknown."
3. Answer the question as directly as possible.
    - If the question asks, "How many…", then provide a number.
    - If the question asks, "Do you…", then indicate Yes or No followed by an additional narrative explanation.
4. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader to your reference files.
5. Bidder is solely responsible for accuracy/validity of all answers.

If any information contained in the proposal is found to be falsified, the proposal will immediately be disqualified.

Proposals, including financials, must be valid until January 1, 2027. If a contract is awarded, prices shall remain firm for the specified contract period.

These instructions are to be read and followed by each bidder and failure to follow these instructions may result in rejection of a proposal offer for non-responsiveness or cancellation of contract if already awarded.

Any mention of "days" in this RFP will refer to calendar days unless noted otherwise.

Unless specifically stated, responses to the questionnaire are assumed to apply to both the commercial and EGWP populations.

A proposal may only be modified or withdrawn by signed, written notice which has been received by MCHCP prior to the official filing date and time specified.

Clarification of Requirements

It is assumed that bidders have read the entire RFP prior to the submission of a proposal and, unless otherwise noted by the bidder, a submission of a proposal and any applicable amendment(s) indicates that the bidder will meet all requirements stated herein.

The bidder is advised that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP as an RFP and any amendments and/or clarifications thereto. No other means of

communication, whether oral or written, shall be construed as a formal or official response or statement.

Schedule of Events

The timeline for the procurement is provided below. No pre-bid conference has been scheduled.

Activity	Timing
Online RFP Released	**Tuesday, January 27, 2026 8 a.m. CT (9 a.m. ET)**
Intent to Bid Document Due	**Tuesday, February 3, 2026 5 p.m. CT (6 p.m. ET)**
Limited Data Use Agreement Due	**Tuesday, February 3, 2026 5 p.m. CT (6 p.m. ET)**
Bidder Question Submission Deadline	**Tuesday, February 3, 2026 5 p.m. CT (6 p.m. ET)**
MCHCP Responses to Submitted Questions	**Friday, February 13, 2026 5 p.m. CT (6 p.m. ET)**
Online RFP Closes (all proposals due)	**Monday, March 2, 2026 5 p.m. CT (6 p.m. ET)**
Finalist Presentations/Site Visits (if necessary)	**April, 2026**
Final Vendor Selection	**Late May, 2026**
Program Effective Date	**January 1, 2027**

To avoid elimination from the RFP process, all proposals must be returned in the format and by the dates and time outlined in the Schedule of Events.

MCHCP reserves the right, at any time, to alter any deadlines or revise any part of the Schedule of Events above by notifying all bidders through the Optavise system.

Intent to Bid and Limited Data Use Agreement (LDUA)

The completed Exhibit A-1 Intent to Bid and Exhibit A-2 Limited Data Use Agreement (LDUA) forms must be submitted via the Optavise system by the date and time specified in the Schedule of Events above. These forms are available as Response Documents in Optavise. Submission of these forms does not bind participants to submit a proposal. If you are declining to bid, please officially decline on the Intent to Bid form in Optavise.

Upon receipt of the Intent to Bid and LDUA forms, Segal will verify if they have a current Global or Bid-Related NDA/Confidentiality Agreement on file. **No data will be issued without first having a signed NDA/Confidentiality Agreement in place between the bidder and Segal.** If there is no NDA/Confidentiality Agreement on file with Segal, a document will be issued to the interested bidder for signature. **Verbiage is non-negotiable.** Upon receipt of the newly signed NDA, or confirmation of an existing NDA, the data will be released to the bidder via secure workspace.

Questions

MCHCP will be using the online messaging module of the Optavise application for all official answers to questions from bidders, amendments to the RFP, exchange of information and notification of awards. It is the bidder's responsibility to notify MCHCP of any change in contact information of the bidder. During the bidding process you will be notified via the messaging module of the posting of any new bid related information.

All questions regarding specifications, requirements, competitive procurement process, etc., must be in writing and submitted through the online messaging module of the Optavise application by **Tuesday, February 3, 2026, 5 p.m. CT (6 p.m. ET)**. For step-by-step instructions, please refer to the *Downloads* section of the Optavise application and click on *User Guides*. Questions received after February 3, 2026, will be answered and posted through the messaging module as time permits, but there is no guarantee of a response to these questions.

Questions deemed universally applicable will be answered in writing and shared with all vendors who have indicated they are quoting. A summary of all questions and answers will be provided by **Friday, February 13, 2026**. MCHCP reserves the right to provide a combined answer to similar questions.

Bidders or their representatives may not contact other MCHCP employees or any member of the MCHCP Board of Trustees regarding this bidding opportunity or the contents of this RFP. If any such contact is discovered to have occurred, it may result in the immediate disqualification of the bidder from further consideration.

RFP Exceptions and Deviations

If your proposal is different in any way (more or less favorable) from that indicated in this RFP, clearly indicate where and explain the difference. All differences must be noted in Exhibit A-3 Proposed Bidder Modifications, available as a Response Document in Optavise. If you do not provide Exhibit A-3, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

Proposal Deadline

All proposal questionnaires, documents, and financial worksheets must be submitted no later than 5 p.m. CT (6 p.m. ET), Monday, March 2, 2026. Submissions received after that time will not be accepted.

Disclaimers

MCHCP will not be liable under any circumstances for any expenses incurred by any respondent in connection with the selection process.

The description of coverage and plan design contained in this RFP is solely intended to allow for the preparation and submission of proposals by respondents and does not constitute a promise or guarantee of benefits to any individual.

Confidentiality and Proprietary Materials

Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all proposals and related documents.

MCHCP is a governmental body under Missouri Sunshine Law (Chapter 610 RSMo). Section 610.011 requires that all provisions be "liberally construed and their exceptions strictly construed to promote" the public policy that records are open unless otherwise provided by law. Regardless of any claim by a bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Only information expressly permitted by the provisions of Missouri's Sunshine Law to be closed – strictly construed – will be redacted by MCHCP from any public request submitted to MCHCP after an award is made. Bidders should presume information provided to MCHCP in a proposal will be public following the award of the bid and made available upon request in accordance with the provisions of state law.

Access to Claim Files

To gain access to the claim history files, bidders must complete and sign Exhibit A-1 Intent to Bid and Exhibit A-2 Limited Data Use Agreement.

Upon receipt of the Intent to Bid form, Segal will verify if they have a current Global or Bid-Related NDA/Confidentiality Agreement on file. **No data will be issued without first having a signed NDA/Confidentiality Agreement in place between the bidder and Segal.** If there is no NDA/Confidentiality Agreement on file with Segal, a document will be issued to the interested bidder for signature. **Verbiage is non-negotiable.** Upon receipt of the newly signed NDA, or confirmation of an existing NDA, the data will be released to the bidder via secure workspace.

Exhibit A-8 and Exhibit A-9 Pricing Submission Worksheets

The financial worksheets (Exhibits A-8 and A-9) are available as Response Documents within the Optavise system. In addition to the pricing worksheets, bidders are required to complete the Financial Questionnaire.

Evaluation Process

Any apparent clerical error may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, MCHCP may contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

An award shall only be made to the bidder whose proposal complies with all mandatory specifications and requirements of the RFP. MCHCP reserves the right to evaluate all offers and based upon that evaluation to reject all offers.

MCHCP reserves the right to consider historic information and fact, whether gained from the bidder's proposal, question and answer conferences, references, or any other source, in the evaluation process. The bidder is cautioned that it is the bidder's sole responsibility to submit information related to the

evaluation categories and that MCHCP is under no obligation to solicit such information if it is not included with the bidder's proposal. Failure of the bidder to submit such information may cause an adverse impact on the evaluation of the bidder's proposal.

After determining that a proposal satisfies the requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal in relationship to the published evaluation criteria shall be made by using subjective judgment. The award of a contract resulting from this RFP shall be based on the lowest and best proposal received in accordance with the evaluation criteria stated below.

Evaluation Criteria

Several factors will be considered in the selection process. The primary factors include pricing (lowest net cost per member per month post rebates/fees/member cost share), pharmacy network access, formulary management and formulary disruption, contractual compliance, account management services, reporting capabilities, financial stability, performance guarantees, flexibility, references, clinical programs, and member service. **All bidders are required, at a minimum, to duplicate the plan features and levels of coverage presently offered by MCHCP unless otherwise noted within.**

Financial	
Pricing	500 points
Non Financial	
PBM Questionnaire Responses	500 points

The evaluation will be conducted in up to three phases:

- Phase I - Evaluation of Technical Proposal, which includes, but is not limited to, the following:
    - Response to RFP;
    - Analysis of Network Access and Disruption; and
    - Analysis of Formulary Disruption
- Phase II - Evaluation of Cost Proposal. Financial evaluations and point allocations will be determined through a comprehensive review of expected claims costs, administrative fees, and the strength of each vendor's financial guarantees. Guarantees will be assessed strictly on the proposed guarantee and the dollar value the vendor places at risk (i.e.-such as per-member-per-month commitments). This approach ensures an objective comparison across proposals and appropriately rewards vendors demonstrating meaningful financial accountability. The proposal with the lowest overall cost will receive the maximum points available within this category.
- Phase III - Finalist Evaluation. At any time during the finalist evaluation phase, MCHCP may, at MCHCP's discretion, contact a PBM to:
    - provide further or missing information or clarification of their proposal,
    - provide an oral presentation of their proposal,
    - interview the proposed key personnel, and/or
    - conduct an onsite visit of the PBM's facilities.

Reference checks may also be made during the finalist evaluation. However, there is no guarantee that MCHCP will look for information or clarification outside of the submitted written proposal. Therefore, it is important that the bidder ensures that all sections of the proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

Oral presentations may be required as part of the evaluation criteria. Additionally, MCHCP may ask for best and final offers. The evaluation team will make its final or conditional recommendation based on the above-described evaluation process. The final award decision will be made by the MCHCP Board of Trustees, upon recommendation by MCHCP staff.

MCHCP reserves the right to further clarify and/or negotiate with the PBM(s) on any matter submitted.

Finalist Selection

MCHCP will limit the number of finalists to the bidders receiving 85 percent (425 points) of the possible 500 non-financial points available or the top two bidders if less than two bidders receive 85 percent of the possible 500 non-financial points.

Pricing

Any cost and/or pricing data submitted or related to the bidder's proposal including any cost and/or pricing data related to contractual extension options shall be subject to evaluation if deemed by MCHCP to be in the best interests of members of MCHCP.

The contractor shall understand that pricing arrangements for subsequent years of this agreement will be negotiated but must be at or below the guaranteed pricing arrangements stated within this bid. All annual renewals are at the sole option of the MCHCP Board of Trustees.

In addition to completing and submitting Exhibits A-8 and A-9, bidders are required to complete all questions included in the Financial Questionnaire as instructed. Bidders should provide proposed fees and minimum guarantees separately for each year of the three-year renewal options so that MCHCP's pricing terms keep pace with expected market trends. Bidders are to provide a Transparent/pass through pricing arrangement with 100% pass through of all rebates and pharmaceutical manufacturer revenue.

If applicable, administrative fees and dispensing fees are requested on a per-claim paid basis unless specifically noted. Fees must be based on claims dispensed (not adjustments, errors, or redo's) and include, but not be limited to, the services described in Exhibit B – Scope of Work.

All services covered under the fee should be listed. However, some services may be offered as optional or ancillary and be covered by separate add-on fees. For example, separate fees for providing EOBs, COB, appeals, and subrogation or for providing duplicate ID cards can be offered and excluded from the base fees. These fees should be listed separately as an option.

Proposals, including financials, must be valid until January 1, 2027. If a contract is awarded, prices shall remain firm for the specified contract period.

Finalist Presentation

After an initial screening process, a technical question and answer conference, presentation, or interview may be conducted, if deemed necessary by MCHCP, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP also reserves the right to interview the proposed account management team. MCHCP may ask additional questions and/or conduct a site visit of the bidder's service center or other appropriate location.

Negotiation and Contract Award

The bidder is advised that under the provisions of this RFP, MCHCP reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply:

- Negotiations may be conducted in person, in writing, or by telephone.
- Negotiations will only be conducted with bidders who provide potentially acceptable proposals. MCHCP reserves the right to limit negotiations to those bidders which received the highest rankings during the initial evaluation phase. All bidders involved in the negotiation process will be invited to submit a best and final offer (BAFO).
- Terms, conditions, prices, methodology, or other features of the bidder's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.
- The mandatory requirements of this RFP shall not be negotiable and shall remain unchanged unless MCHCP determines that a change in such requirements is in the best interests of MCHCP and its members.
- Bidder understands that the terms of any negotiation are confidential until an award is made or all proposals are rejected.

Any award of a contract resulting from this RFP will be made only by written authorization from MCHCP.

Using Optavise

All decisions and evaluations will be determined from the proposals submitted electronically via the Optavise system.

The 2027 MCHCP Commercial PBM and Part D EGWP PBM RFP contains two broad categories of items that you will need to work on via the Optavise application:

1. Items Requiring a Response:

    a) Questionnaires (e.g., PBM Questionnaire) are online forms to collect your responses to our questions about your capabilities.

    b) Response Documents (e.g., Exhibit A-1 Intent to Bid) are attachment files (e.g., MS Word or Excel) that are posted to the Optavise website. They should be downloaded, completed by your organization, and then posted/uploaded back to the Optavise application. When you upload

your response, from the dropdown menu, identify each uploaded document as a Response document and associate it to the appropriate document by name. For step-by-step instructions, please refer to the "How to Download and Attach Files" User Guide located in the "Downloads" section on the application homepage.

2. Reference Files from Event Administrator:

    a) Documents (e.g., Exhibit B – Scope of Work) that you should download and read completely before submitting your RFP response.

These components can be found in the Optavise application under the 2027 MCHCP Commercial PBM and Part D EGWP PBM RFP on the Event Details page of the application.

Note that as you use the Optavise application to respond to this RFP, User Guides are accessible throughout the application by clicking on the help icon or from the *Downloads* area of the Optavise application homepage. For help with data entry and navigation throughout the application, you can contact the Optavise staff:

- Phone: 800-979-9351
- Email: systemsupport@optavise.com

Responding to Questionnaires

We have posted three forms for your response:

- PBM Questionnaire
- Financial Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to Optavise by **Monday, March 2, 2026, 5 p.m. CT (6 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains the items you and your team are required to access and respond to. For step-by-step instructions, please refer to the *How to Submit a Questionnaire* User Guide located in the *Downloads* section of the Optavise application homepage. You have the option to "respond online" or through two different off-line (or desktop) tools.

Completing Response Documents

The following documents must be completed, signed and uploaded to Optavise:

- Exhibit A-1 – Intent to Bid (due 5 p.m. CT, February 3, 2026)
- Exhibit A-2 – Limited Data Use Agreement (due 5 p.m. CT, February 3, 2026)
- Exhibit A-3 – Proposed Bidder Modifications (due 5 p.m. CT, March 2, 2026)
- Exhibit A-4 – Confirmation Document (due 5 p.m. CT, March 2 2026)
- Exhibit A-5 – Contractor Certification (due 5 p.m. CT, March 2, 2026)

The following exhibits must be reviewed and the bidder provide any suggested red-lined changes to the documents using Microsoft Word Track Changes functionality. Changes proposed may or may not be accepted by MCHCP.

- Exhibit A-6 – Sample Contract (due 5 p.m. CT, March 2, 2026)
- Exhibit A-7 – Business Associate Agreement (due 5 p.m. CT, March 2, 2026)

Completing Exhibits A-8 and A-9 Pricing Submission Worksheets

Financial worksheets (Exhibit A-8 MCHCP Commercial Pricing Proposal and Exhibit A-9 MCHCP EGWP Pricing Proposal) have been provided as Response Documents within the Optavise system. The spreadsheets contain worksheets to collect fee quotations based on the current benefit plan design. **Please be certain to complete all appropriate tabs within each workbook. These exhibits are due at 5 p.m. CT (6 p.m. ET), Monday, March 2, 2026, and must be uploaded to Optavise.**

Bidders are also required to complete and submit the Financial Questionnaire.

Proposals will be evaluated based on the value of the overall financial deal including the strength of the price point guarantees and the reconciliation process. Proposals with caveats and disclaimers will be adjusted in the financial analysis.

Notes Regarding PBM Pricing

Fee quotes should assume:

- Plan effective date: January 1, 2027
- Pricing must include all mandatory items required in this RFP. Optional items may be proposed and selected by MCHCP at its discretion.
- Submitted prices for 2027 shall be firm, while pricing arrangements for 2028, 2029, and 2030 shall be submitted as guaranteed “not to exceed” amounts. Proposed prices are subject to negotiation prior to the award of a contract by MCHCP.
- Annual renewals are solely at the option of MCHCP. Renewal pricing arrangements are due by May 15 of each year and are subject to negotiation.

RFP Checklist

Prior to the March 2, 2026, close date, please be sure you have completed and/or reviewed the following:

Type	***Document Name***
Questionnaire	PBM Questionnaire
Questionnaire	Financial Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Response	Exhibit A-1 Intent to Bid.docx **DUE: February 3, 2026**
Response	Exhibit A-2 Limited Data Use Agreement.docx **DUE: February 3, 2026**
Response	Exhibit A-3 Proposed Bidder Modifications.docx

Type	*Document Name*
Response	Exhibit A-4 Confirmation Document.docx
Response	Exhibit A-5 Contractor Certification.docx
Response	Exhibit A-6 Sample Contract.docx
Response	Exhibit A-7 Business Associate Agreement.docx
Response	Exhibit A-8 MCHCP Commercial Pricing Proposal.xlsx
Response	Exhibit A-9 MCHCP EGWP Pricing Proposal.xlsx
Reference	Introduction and Instructions – 2027 MCHCP Commercial PBM and Part D EGWP PBM RFP.pdf
Reference	Exhibit B – Scope of Work.docx
Reference	Exhibit C – General Provisions.docx
Reference	Attachment 1 – Drug Claims Functional Specification.xlsx
Reference	Attachment 2 – Enrollment file fields.docx
Reference	Attachment 3 – MCHCP Enrollment File.xlsx (available after receipt of completed and signed Exhibit A-2 Limited Data Use Agreement)

Contact Information

We understand that content and technical questions may arise. All questions regarding this document and the selection process must be submitted through the online messaging module of the Optavise application by **Tuesday, February 3, 2026, 5 p.m. CT (6 p.m. ET)**.

For technical questions related to the use of Optavise, please contact the Optavise customer support team at systemsupport@optavise.com, or by calling the Customer Support Line at 800-979-9351.

EXHIBIT B
SCOPE OF WORK

The purpose of this Request for Proposal (RFP) for Pharmacy Benefit Services is to select a contractor that will enable Missouri Consolidated Health Care Plan (hereinafter referred to as MCHCP) to meet their pharmacy objectives by delivering on the following scope of services in a superior and cost-effective manner to all or a designated group of members covered by the plan.

B1. GENERAL REQUIREMENTS

B1.1 The contractor shall provide pharmacy benefit manager (PBM) services for a self-insured prescription drug program for members enrolled in MCHCP in accordance with the provisions and requirements of this document on behalf of MCHCP. The contractor understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and contractor expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. The contractor agrees that all subcontracts entered into by the contractor for the purpose of meeting the requirements of this contract are the responsibility of the contractor. MCHCP will hold the contractor responsible for assuring that subcontractors meet all the requirements of this contract and all amendments thereto. The contractor must provide complete information regarding each subcontractor used by the contractor to meet the requirements of this contract.

B1.2 The contractor is obligated to follow the performance standards as outlined in Section 18 of the PBM Questionnaire.

B1.3 The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, or a surety performance bond issued by an insurance carrier to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $5,000,000. The contract number and contract period must be specified on the performance security deposit or bond. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $5,000,000.

B1.4 The contractor acknowledges that MCHCP owns all claims-related data, including extracts, reports, and rebate details, and will provide this data upon MCHCP's request in a timely manner not to exceed 30 days from the date of the request.

B1.5 The contractor shall agree that eligible members are those employees, retirees and their dependents who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining eligibility.

B1.6 The contractor shall not regard a member as terminated until the contractor receives an official termination notice from MCHCP and MCHCP has communicated termination through the eligibility file or via PBM portal.

B1.7 The contractor must be aware of all rules and regulations contained in Chapter 22 of the Missouri Code of Regulations that apply to pharmacy benefits and be in compliance with all regulations as applicable at all times.

B2. PHARMACY NETWORK

B2.1 The contractor must provide and maintain a broad Missouri and national retail pharmacy network(s) for MCHCP members. The network must be available to members throughout the United States. The contractor shall notify MCHCP within five business days if the network geographic access changes from what was proposed by the contractor during the RFP process.

B2.2 The contractor shall maintain a network(s) that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay.

B2.3 The contractor shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the network(s) to meet the needs of the enrolled members. In addition to looking at the needs from an overall member population standpoint, the contractor shall ensure the network(s) is able to address the needs of those with special needs including but not limited to, visually or hearing impaired, limited English proficiency and low health literacy.

B2.4 The contractor must credential participating pharmacies consistent with the National Council for Prescription Drug Programs (NCPDP) standards to ensure the quality of the network(s).

B2.5 The contractor must contract with participating pharmacies, including negotiating pricing arrangements to optimize ingredient cost discounts while at the same time assuring adequate access to participating pharmacies. The contractor shall maintain a network that ensures reasonable access to both independent pharmacies and chain pharmacies.

B2.6 The contractor shall apply reimbursement methodologies or business practices that do not unfairly disadvantage independent pharmacies versus chain pharmacies, including but not limited to pricing, retrospective adjustments, and reimbursements.

B2.7 The contractor shall agree to provide written notice to MCHCP and then to affected members when a provider who fills a substantial number of scripts in the contractor's book of business within the previous 180 days leaves the network. The notice must be sent at least 30 days prior to the termination or non-renewal or as soon as possible after non-renewal or termination.

B2.8 The contractor must have the capability to process out-of-network claims for those members using non-participating pharmacies and/or for coordination of benefits.

B2.9 The contractor must provide a mail order pharmacy program that is fully integrated with the retail network(s) in terms of on-line real-time adjudication and Drug Utilization Review (DUR).

B2.10 The contractor(s) must provide a specialty pharmacy program. The contractor must maintain and agree to share an up-to-date and accurate specialty drug list with MCHCP at all times. However, the contractor may not require the use of its own or affiliated specialty pharmacy as a condition of contracting. MCHCP reserves the sole and exclusive right to determine which specialty pharmacy(ies) will be used for specialty medication dispensing and related services.

At any time during the term of the contract, MCHCP may carve out specialty pharmacy services and award to its choice of vendor. The contractor must fully support and integrate with MCHCP's chosen specialty pharmacy(ies).

B3. BENEFIT ADMINISTRATION

B3.1 The contractor must administer benefits as determined by MCHCP, in terms of covered drugs and member responsibility, in accordance with all applicable federal and state laws and regulations. MCHCP benefits and services are promulgated by rule in Title 22 of the Missouri Code of State Regulations.

B3.2 The contractor must administer a plan to commercial members (those MCHCP members not enrolled in the EGWP) and a separate CMS Part D Medicare Prescription Drug plan as an employer group waiver plan (EGWP) with wrap-around coverage that is substantially similar with the commercial plan to those enrolled in MCHCP's Medicare Advantage Plan, or maintain an active, legally binding agreement with an organization that holds a CMS-approved EGWP contract with substantially similar benefits as the commercial plan.

B3.3 The contractor must be able to administer a multi-tiered copayment structure, deductible/coinsurance structure, or any other benefit structure developed by MCHCP. MCHCP will consult with the contractor regarding the final benefit structure, but maintains authority on the final design.

B3.4 For mail order service, the contractor shall at a minimum track the dates the prescription or refill request was received, filled, and mailed. MCHCP requires that prescriptions requiring no intervention be shipped within two (2) business days of receipt. Prescriptions requiring intervention must be shipped within three (3) business days of receipt. For purposes of this provision, the mail service will be assumed to have a seven-day work week, excluding legal holidays.

B3.5 All mail order claims will be priced based on the original package size, defined as the quantity as originally purchased for the mail order facility before re-packaging in smaller quantities.

B3.6 The contractor must be able to implement changes to the program within 60 days of notification. This may include, but is not limited to, copayment changes, formulary changes, and/or changes in the prior authorization list. These changes are expected to be infrequent and many would likely be implemented at the beginning of a new plan year.

B3.7 The contractor agrees to conduct all grievances and internal appeals filed by MCHCP members, including but not limited to appeals under Patient Protection and Affordability Care Act, and appeals required by the Centers for Medicare and Medicaid (CMS), in accordance with applicable state and federal laws and regulations. The contractor agrees to participate in any review, appeal, fair hearing or litigation involving issues related to services provided under this Contract if, and to the extent, MCHCP deems necessary.

B3.8 The contractor must administer the EGWP on a self-insured basis, with pass-back to MCHCP of all third-party funding sources including CMS direct subsidies, pharmaceutical manufacturer discounts, federal reinsurance payments, Selected Drug subsidies, and CMS low income premium and cost sharing subsidies.

B3.9 The contractor must administer MCHCP pharmacy benefits, both Commercial and EGWP, on a carve-out basis.

B3.10 The contractor must administer the EGWP in accordance with all applicable laws and regulations. The contractor must also provide all necessary reporting and support on behalf of and approved by MCHCP to satisfy Medicare requirements.

B4. **IMPLEMENTATION**

B4.1 The contractor must coordinate all activity among MCHCP and their vendors in support of a successful onboarding experience (e.g., phone calls, emails, meeting agendas, and project lists.)

B4.2 The contractor must lead implementation calls and drive tasks to completion.

B4.3 The contractor must review and lead a thorough discussion of set-up documentation and available programs and edits.

B4.4 The contractor must agree to a final implementation schedule within thirty (30) days of the contract award. At a minimum, the timeline must include the required dates for the following activities:

- Training key staff
- Detailed benefit setup
- Secure file transfer setup
- Testing of eligibility file transfer
- Acceptable date for final eligibility file
- ID card production and distribution
- Testing file transmission to MCHCP's data warehouse vendor
- Communications schedule and member materials review
- Enrollment kit printing
- Finalization of formulary, prior authorization list, step therapy, quantity level limits, and other clinical programs, and
- Plan for transitioning mail order and specialty refills from incumbent.

B4.5 The contractor must have a customer service unit in place to answer member inquiries during open enrollment. Open enrollment is anticipated to be October 1-31, with coverage effective January 1, the following calendar year. At a minimum, the customer service unit must timely and accurately address network and benefit issues, including formulary content.

B4.6 Prior to January 1 of each plan year, the contractor shall implement any eligibility, plan design and benefit changes as directed by MCHCP and test all plan design and benefit elements. Any test results that fail to meet requirements will be corrected and retested prior to January 1. Test results will be shared with MCHCP.

B4.7 The contractor shall load all current prior authorizations, open mail order refills, specialty transfer files, claim history files, and accumulator files that exist for current members from the existing PBM at no charge to MCHCP if the files are provided by the former PBM in a reasonable format and contain valid data.

B4.8 The contractor must accept and load up to twelve months of historical claims data at no additional cost to MCHCP.

B4.9 The contractor shall grandfather MCHCP's current utilizers for 90 days following the contract effective date, with no impact on rebate guarantees during the grandfathering

period. In this instance, grandfathering indicates maintaining the current member cost share for each product whether it is at a $0 copay under the ACA or any of the member cost share tiers.

B5. CUSTOMER SERVICE

B5.1 The contractor must provide a high-quality customer service unit. PBM staff members must be fully trained in the MCHCP benefit design, and the contractor must have the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type. MCHCP may request copies of this performance report.

B5.2 By December 20, 2026, the contractor must provide welcome packages to all members that will be effective on January 1, 2027. For members effective after January 1, 2027, the contractor must provide welcome packages prior to the effective date of coverage, or within 15 working days of receipt by the contractor of the enrollment or status change notice from MCHCP, whichever date is latest. A welcome package includes, at a minimum, the member ID card and general information about the benefit. The welcome package contents must be approved by MCHCP prior to distribution.

B5.3 Upon a member's request, the contractor shall issue and mail a membership identification card within two business days of the request. The contractor shall re-card the entire population should a benefit change or other change in operation result in the identification card in the member's possession becoming obsolete.

B5.4 The contractor shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified customer service personnel, including at least one registered pharmacist. Live customer service personnel must be available 24 hours a day, seven days a week.

B5.5 The contractor must have a customized active, current website for MCHCP members that is updated regularly. MCHCP members must be able to access this site to obtain current listings of network providers, print ID cards, review benefits and plan design, review explanation of benefits, check status of deductibles, maximums or limits, obtain a history of pharmacy claims, perform price comparison of drugs between pharmacies, map provider locations, complete satisfaction surveys and other information. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will contact the contractor immediately. The contractor must correct inaccuracies within 10 days of being notified by MCHCP or when the contractor discovers the inaccuracy.

B5.6 The contractor must be able to support single sign-on from MCHCP's Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML).

B5.7 The contractor must conduct a member satisfaction survey annually using a statistical random sample of MCHCP members representative of the population. The timeframe for conducting and reporting the survey shall be mutually agreed upon by the contractor and MCHCP. A separate survey must be conducted for the Commercial and EGWP populations.

B5.8 The contractor must provide an EGWP communication timeline that aligns with CMS requirements. Member communications must be customized, and that customization must meet CMS requirements for EGWP.

B6. ACCOUNT MANAGEMENT

B6.1 MCHCP requires the contractor to meet with MCHCP staff and/or Board of Trustees at least quarterly to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as to propose new ideas that may benefit MCHCP and its members. These meetings will take place at the MCHCP office or virtually if in-person meetings are not possible.

B6.1.1 The contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified to reduce costs and/or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members affected.

B6.1.2 The contractor must also present benchmark data by using the PBM's entire book of business, a large subset of comparable clients to MCHCP, or some other industry norm.

B6.1.3 The data must be separated between Commercial and EGWP populations. The commercial population must be separated between active employees and retirees.

B6.2 The contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include but is not limited to a dedicated account executive, a customer service manager, a registered pharmacist, and a management information system representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

B6.2.1 Be able to devote the time needed to the account, including being available for frequent telephone and regular consultation with MCHCP. Dedicated account team members may service other accounts but must consistently be available

to MCHCP. Offerors who are not committed to account service will not receive serious consideration.

B6.2.2 Be extremely responsive.

B6.2.3 Be comprised of individuals with specialized knowledge of the contractor's networks, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, and relations with third parties.

B6.2.4 Be thoroughly familiar with all the contractor's functions that relate directly or indirectly to the MCHCP account.

B6.2.5 Be able to effectively advance the interest of MCHCP through the contractor's corporate structure.

B7. COORDINATION WITH BUSINESS ASSOCIATES

B7.1 The contractor shall coordinate, cooperate, and electronically exchange information with MCHCP's identified business associates as necessary to implement benefit design. Necessary information can include, but is not limited to, deductible and out-of-pocket accumulators, participation in care management, or referral for disease management. Frequency of electronically exchanged information can be daily.

B7.2 The contractor shall work with MCHCP's contracted high-deductible health plan (HDHP) administrator (currently Anthem Blue Cross Blue Shield) to coordinate deductible and out-of-pocket accumulations. This requires the contractor to send a daily file to MCHCP's contracted HDHP administrator, and to accept a daily file from the contracted HDHP administrator, for the purpose of adjudicating and applying claims to a member's deductible and out-of-pocket maximum in real time.

B7.3 Contractor will work with MCHCP's Medicare Advantage (MA) plan to coordinate benefits for MCHCP's Medicare eligible members.

B8. REPORTING

B8.1 The contractor shall agree to:

B8.1.1 Provide monthly claims and utilization data to MCHCP and/or MCHCP's decision support system vendor (currently Merative) in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;

B8.1.2 Provide data in an electronic format and within a timeframe specified by MCHCP;

B8.1.3 Place no restraints on use of the data provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and

B8.1.4 This obligation continues for a period of one year following contract termination.

B8.1.5 MCHCP reserves the right to retain a third-party contractor (currently Merative) to receive the data from the contractor and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to, all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of the contractor's duties under this contract, including the provision of data as specified without constraint on its use.

B8.1.6 The contractor shall agree to pay applicable fees associated with data format changes due to contractor-initiated or regulatory compliance requirements.

B8.2 The contractor must provide an online reporting utility that allows MCHCP to run reports and download report results in a manipulatable format (Microsoft Excel, for example).

B8.3 The contractor must provide monthly appeals reporting. MCHCP and the contractor will negotiate format and content upon contract award. Additionally, the contractor shall copy MCHCP on adverse benefit determination (ABD) letters issued by the contractor.

B8.4 The contractor must provide quarterly rebate reporting at the NDC-9 level. The rebate reporting should include rebate amounts expected and rebate amounts received. The rebate amounts received should reconcile to the quarterly rebate payments. Quarterly reports are due within ninety (90) days following the end of the calendar quarter.

B8.5 The contractor must provide supporting documentation for all invoiced fees with each invoice.

B8.6 At the request of MCHCP, the contractor shall submit standard reports to MCHCP on a monthly, quarterly, and/or annual basis. MCHCP and the contractor will negotiate the format, content and timing upon contract award.

B8.7 At the request of MCHCP, the contractor shall submit additional ad hoc reports on information and data readily available to the contractor. If any reports are substantially different from the reports agreed upon, fair and equitable compensation will be negotiated with the contractor.

B9. PAYMENT

B9.1 The contractor shall not bill more frequently than once every two weeks from a centralized billing system for all network pharmacies and mail order pharmacies. The invoice shall be submitted electronically in an Excel-compatible format. The invoice shall clearly designate and describe all components of the billing and shall separate the billed activity between claims and administration. Furthermore, the invoice should clearly delineate the activity between MCHCP's commercial and EGWP pharmacy claims and the administration fees associated with each program separately and individually. Commercial activity should further be separately designated between active and retiree transactions.

B9.2 MCHCP will initiate payment to the contractor within ten business days of receipt of the invoice. Payment will be made via Automated Clearing House (ACH) to the financial institution designated by the contractor.

B9.3 The contractor must agree that MCHCP must not be responsible for any amounts owed by members to the contractor. Collecting such amounts must be the sole responsibility of the contractor.

B9.4 The contractor must agree to pay to MCHCP any financial recoveries from audits contractor has performed on any contracted pharmacies within 30 days of receipt by the contractor.

B10. INFORMATION TECHNOLOGY AND ELIGIBILITY FILE

B10.1 The contractor shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply this information in an electronic format, and the contractor must process such information within 24 hours of receipt. The contractor must provide a technical contact that will provide support to MCHCP Information Technology Department for EDI issues.

B10.1.1 The contractor and MCHCP will provide each other a recommended data mapping for the 834 transaction set to MCHCP after the contract is awarded.

B10.1.2 After processing each file, the contractor will provide a report that lists any errors and exceptions that occurred during processing in a delimited file format (CSV). The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

B10.1.3 The contractor shall provide access to view data on their system to ensure the file MCHCP sends is correctly updating the contractor's system.

B10.1.4 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B10.1.5 The contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a delimited file format (CSV) or a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records and shall be provided to MCHCP no later than the second Thursday of each month.

B10.2 The contractor must work with MCHCP to develop a schedule for testing of the electronic eligibility file. The expectation is that testing is completed 60 days prior to the effective date of the contract. The contractor must accept a final eligibility file no later than 30 days prior to the contract effective date.

B10.3 The contractor shall agree to provide at no cost to MCHCP, direct on-line, real time access to the contractor's system for the purpose of updating eligibility and member enrollment verification on an as-needed basis. The contractor must provide training on the system at MCHCP's office no later than December 1, 2026.

B10.4 All electronic protected health information (ePHI) must be encrypted in transit using TLS 1.3 (or TLS 1.2 at minimum) with FIPS-approved cipher suites and strong certificate management. For file operations and data at rest, encryption shall use symmetric keys of at least AES-256, asymmetric keys of at least RSA 2048 bits (4096 bits preferred), elliptic curve keys of at least 256 bits (e.g., NIST P-256), and hash functions of SHA-256 or stronger for integrity and digital signatures. Cryptographic operations key management shall adhere to NIST SP 800-57 guidelines, including secure generation, storage, rotation, and destruction.

B11. CLINICAL MANAGEMENT

B11.1 The contractor shall integrate and coordinate the following types of services to utilize health care resources and achieve optimum patient outcome in the most cost-effective manner: utilization management including prior authorization and concurrent, retrospective, and prospective drug utilization review; step therapy; quantity level limits; pharmacy and therapeutics committee review of formulary; and other clinical components of pharmacy management. These services must be performed in a matter to be consistent with Chapter 22, Missouri State Regulations.

B11.2 The contractor must provide a formulary consisting of the most cost-effective drugs within various therapeutic or pharmacological classes of drugs. MCHCP reserves the right to approve the final list of drugs included on the formulary and any changes throughout the contract period.

B11.3 The contractor must notify MCHCP ninety (90) days prior to any formulary changes and notify any member who is impacted by the formulary change at least sixty (60) days prior to the change.

B11.4 The contractor must notify MCHCP by June 1 of any anticipated drug exclusions or movement of medications to/from the non-specialty and specialty preferred drug list planned for the following calendar year, and MCHCP may reject the annual formulary suggested change with no changes to the stated financials during the lifetime of the contract. Any proposed changes may only improve the rebate guarantees. The contractor must provide the names of the medications and the impact to MCHCP of the drug exclusions by August 1st of each year.

B11.5 The contractor must agree that the contractor's organization must never switch for a medication with a lower ingredient cost to a higher ingredient cost regardless of rebate impact without MCHCP's approval.

B11.6 The contractor shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to ensure ongoing efficacy. The contractor may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. The contractor shall make available its clinical review criteria upon request.

B11.7 The contractor shall provide physician-to-pharmacist and pharmacist-to-pharmacist communications.

B11.8 Utilization management services shall be conducted by appropriately licensed personnel with expertise in the services being reviewed.

B11.9 The contractor shall obtain all information required to make a utilization review decision, including pertinent clinical information. The contractor shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

B11.10 The contractor shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

B11.11 The contractor must provide management of patients with specialty disease states (e.g., Hemophilia, Rheumatoid Arthritis).

B11.12 The contractor will provide a prior authorization process that requires documentation of disease severity, other treatments tried, and test results to validate diagnosis. Prior authorization programs shall be used as a clinical management strategy and not a strategy to increase rebates. The contractor shall not utilize attestations when reviewing prior authorizations. The contractor shall utilize pharmacists when completing prior

authorization reviews, and prior authorization criteria will be provided to MCHCP and/or its consultants upon request.

B12. QUALITY ASSURANCE PROGRAM

B12.1 The contractor must provide a quality assurance program and be prepared to demonstrate the quality assurance program it would utilize for MCHCP during the bidding process. The program must contain, at a minimum, the following attributes:

B12.1.1 Each prescription reviewed by a licensed pharmacist;

B12.1.2 Tracking abusive providers and members;

B12.1.3 Using methods that meet or exceed industry standards, auditing the internal dispensing and utilization procedures of participating pharmacies; and

B12.1.4 Employ a system that meets or exceeds industry standards (for a large governmental sector) for preventing, detecting, and reporting both actual and patterns of fraud and abuse. In addition, the contractor must report its results to MCHCP at least quarterly.

B13. GENERAL SERVICE REQUIREMENTS

B13.1 The contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by the contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to such items as plan wide newsletters if they do not contain information on eligibility, enrollment, rates, etc., which MCHCP must review.

B13.2 The contractor shall refer all questions received from members regarding eligibility or premiums to MCHCP.

B14. CLAIM PAYMENTS

B14.1 The contractor shall process claims utilizing the contracted discount arrangements negotiated with participating providers.

B14.2 The contractor shall process 99.5% of all retail and mail scripts without monetary errors.

B14.3 The contractor shall agree that if a claims payment platform change occurs throughout the course of the contract, MCHCP reserves the right to delay implementation of the new system for MCHCP members until a commitment can be made by the contractor that transition will be without significant issues. This may include requiring the

contractor to put substantial fees at risk and/or agree to an implementation audit related to these services to ensure a smooth transition.

B14.4 The contractor must be able to coordinate benefits in accordance with MCHCP regulations.

B15. **COST MITIGATION**

B15.1 The contractor will offer cost-management strategies to control costs in order to decrease MCHCP's pharmacy trend. All strategies will be approved by MCHCP prior to implementation.

B15.2 The contractor will work with MCHCP to recommend cost containment strategies and provide estimated savings for each initiative.

B16. **CONTRACT RENEWAL**

B16.1 Renewal pricing is due by May 15 of each year.

B16.2 On an annual basis, MCHCP may review the financial terms of the Contract against comparable financial offerings available in the marketplace. Such review may be conducted by MCHCP's actuary and would consider the total value of the pricing terms (discounts, dispensing fees, administrative fees, rebates) to create an aggregate benchmark. Contractor will have ten (10) business days to offer a comparable or better financial arrangement following such request from MCHCP or its actuary. Upon agreement of the market check pricing by the parties, within ten (10) business days, the contractor will prepare and submit revised renewal pricing to be effective January 1 of the next succeeding contract year, beginning January 1, 2028, if applicable. The contractor understands and agrees that MCHCP will not have access to the details of other PBM financial arrangements utilized by its actuary to conduct this market check and, therefore, will not be able or required to provide contractor such details at any time.

B17. **CONTRACT TERMINATION**

B17.1 At contract termination, MCHCP requires the contractor to continue to perform the duties listed below for the stated time period following termination. No additional compensation other than terms and conditions agreed to in the contract will be given for continuation of these activities.

B17.1.1 Paper processing for out-of-network claims that were incurred while the contract was in place for two years following contract termination

B17.1.2 Monthly claim file submissions to MCHCP's data vendor (currently Merative) for one year following contract termination

B17.1.3 Processing all prescriptions received in the mail order facility prior to contract termination using existing time frames stated in Section B3.4.

B17.1.4 Send at least the most current 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for MCHCP members to the next/successor PBM at no charge if MCHCP terminates the contract with or without cause at any point of the contractual term.

B17.1.5 Maintain, and require its subcontractors to maintain, supporting financial information and documents that are adequate to ensure that claims are made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of contractor invoices. Such documents will be maintained and retained by the contractor or its subcontractors for a period of ten (10) years after the date of submission of the final billing or until the resolution of all audit questions, whichever is longer. The contractor agrees to timely repay any undisputed audit exceptions taken by MCHCP in any audit of the contract.

B17.1.6 Unless MCHCP specifies in writing a shorter period of time, the contractor agrees to preserve and make available all books, documents, papers, records and other evidence involving transactions related to this contract for a period of ten (10) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds ten (10) years. The contractor agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the ten (10) year post-contract period. Delivery of and access to the records shall be at no cost to MCHCP.

B18. **PERFORMANCE STANDARDS**

B18.1 Performance standards are outlined in Section 18 of the PBM Questionnaire. The contractor shall agree that any liquidated damages assessed by MCHCP shall be in addition to any other equitable remedies allowed by the contract or awarded by a court of law including injunctive relief. The contractor shall agree that any liquidated damages assessed by MCHCP shall not be regarded as a waiver of any requirements contained in this contract or any provision therein, nor as a waiver by MCHCP of any other remedy available in law or in equity.

B18.2 Unless otherwise specified, all performance guarantees are to be measured quarterly, reconciled quarterly and any applicable penalties paid annually. MCHCP reserves the right to audit performance standards for compliance.

B18.3 All performance guarantees must be finalized before a contract is awarded.

B19. **MCHCP REQUIREMENTS AND SERVICES** – MCHCP will provide the following administrative services to assist the contractor:

B19.1 Certification of eligibility;

B19.2 Enrollments (new, change, and terminations) in an electronic format;

B19.3 Maintenance of individual eligibility and membership data; and

B19.4 Payment of monies due the contractor.

EXHIBIT C
GENERAL PROVISIONS

C1. TERMINOLOGY AND DEFINITIONS

Whenever the following words and expressions appear in this Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply. The definitions below apply to all questions, grids and other requests in this RFP. Unless noted otherwise, these definitions will be included as part of MCHCP's contract should you be selected as the contractor. Confirm your agreement with the definitions below, and succinctly explain any deviations in Exhibit A-3 Bidder's Proposed Modifications to the RFP.

C1.1 **Administration Fee** means the agreed upon amount that will be paid to the Contractor by MCHCP for administration of the pharmacy benefit Plan.

C1.2 **Amendment** means a written, official modification to an RFP or to a contract.

C1.3 **Average Wholesale Price or AWP** means the "average wholesale price" for the actual package size of the legend drug dispensed as set forth in the most current pricing list in Medi-Span's® Prescription Pricing Guide (with supplements). Contractor must use a single nationally recognized reporting service of pharmaceutical prices for MCHCP and such source will be mutually agreed upon by Contractor and MCHCP. Contractor must use the manufacturer's full actual 11-digit National Drug Code (NDC) to determine AWP for the actual package size on the date the drug is dispensed for all legend drugs dispensed through retail pharmacies, mail service pharmacies and specialty pharmacies. Repackaging which has the effect of inflating AWP is explicitly prohibited. "Price shopping", meaning the Contractor's use of multiple AWP reporting services in order to select the most advantageous AWP price as a means to inflate discount calculations, is prohibited**.**

The parties understand there are extra-market industry, legal, government, and regulatory activities which may lead to changes relating to, or elimination of, the AWP pricing index that could alter the pricing intent under the Agreement. If the pricing source changes the methodology for calculating AWP or replaces AWP, or if, as a result of such change Contractor utilizes another recognized pricing benchmark other than AWP (e.g., to Wholesale Acquisition Cost), then participating pharmacy, and mail service pharmacy rates, rebates, and guarantees, as applicable, will be modified as reasonably and equitably necessary to maintain the pricing intent under the Agreement. Contractor shall provide MCHCP with at least ninety (90) days' notice of the change (or if such notice is not practicable, as much notice as is reasonable under the circumstances), and written illustration of the financial impact of the pricing source or index change (e.g., specific drug examples). If MCHCP disputes the illustration or the financial impact of the pricing source, the parties agree to cooperate in good faith to resolve such disputes.

C1.4 **Authorized Generic** means prescription drugs that are produced by brand companies and marketed as generics under private label.

C1.5 **Bidder** means a person or organization who submitted an offer in response to this RFP.

C1.6 **Biosimilar Drug** or **Biosimilars** means a drug that is approved by the Food and Drug Administration as a "biosimilar" product, as such term is defined at 42 U.S.C. §262(i)(2), pursuant to the provisions of 42 U.S.C. §262(k), or pursuant to any successor legislative provision relating to expedited approval of biological products which are highly similar to a reference biological product.

C1.7 **Brand Name Drug** means a legend drug or OTC with a proprietary name assigned to it by the manufacturer and distributor and so indicated by Medi-span® (or mutually agreed upon nationally recognized publication if unavailable). Brand Drugs include Single-Source Brand Drugs and non-MAC Multi-Source Brand Drugs.

C1.8 **Breach** shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

C1.9 **Compound** means a prescription that meets the following criteria: two or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed or measured then prepared according to the Prescriber's order and the pharmacist's art.

C1.10 **Coinsurance** is the shared portion of payment between the plan and the member where each pays a percentage of pharmaceutical expenses.

C1.11 **Commercial Wrap** means the self-insured, commercial wrap-around coverage for members supplemented by the Employer Group Waiver Program.

C1.12 **Contract** means a legal and binding agreement between two or more competent parties, in consideration for the procurement of services as described in this RFP.

C1.13 **Contractor** means a person or organization who is a successful bidder as a result of an RFP and/or who enters into a contract or any subcontract of a successful bidder.

C1.14 **Copayment** is the fixed dollar payment for specific pharmaceutical services that the covered individual must pay.

C1.15 **Covered Drug(s)** means those prescription drugs, supplies, Specialty Drugs and other items that are covered under the Plan, each as indicated on the Set-Up Forms.

C1.16 **Dispensing Fee** means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Drug to a Member.

C1.17 **Disruption Analysis** means a review of where Members are obtaining their prescriptions under the current program, followed by a review to determine if any of them will no longer have the same access under the new Contract. It also includes the identification of any Members so affected, along with proposed remediation.

C1.18 **Employee** means any person employed in a benefit-eligible position by the State of Missouri or a participating member agency, or a person eligible for coverage by a state-sponsored retirement system or by a retirement system sponsored by a participating member agency.

C1.19 **Formulary or Preferred Drug List** means the list of FDA-approved prescription drugs and supplies developed by the Contractor's Pharmacy and Therapeutics Committee and/or customized by MCHCP, and which is selected and/or adopted by MCHCP. Routine additions and/or deletions to the Formulary are hereby adopted by MCHCP, subject to MCHCP's discretion to elect not to implement any such additions or deletion through the Set-Up Form process.

C1.20 **Generic Drug** means a legend drug or OTC that is identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medi-Span© (or mutually agreed upon nationally recognized publication if unavailable). Generic Drugs include all products involved in patent litigation, Single-Source Generic Drugs, Multi-Source Generic Drugs, Multi-Source Brand Name drugs subject to MAC, House Generics, DAW 0 claims, DAW 9 claims, Authorized Generics and Generic drugs that may only be available in a limited supply.

C1.21 **House Generic** means those Brand Drugs submitted with DAW 5 code in place of their generic equivalent(s) and for which, therefore, pharmacies are reimbursed at Generic Drug rates, including MAC, as applicable, for these drugs (*e.g.*, Amoxil v. amoxicillin).

C1.22 **Limited Distribution** means limited distribution and exclusive distribution Specialty Drugs which are only available through no more than two pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.

C1.23 **MAC** means the maximum allowable unit cost of a drug and establishes an upper limit reimbursement price for certain drugs dispensed without regard to the specific manufacturer whose drug is dispensed, and which drugs are identified on a "MAC List".

C1.24 **MAC List** means the list of drugs designated from lists established by PBM for which reimbursement to a pharmacy shall be paid according to the MAC price established by PBM for such list.

C1.25 **May** means that a certain feature, component, or action is permissible, but not required.

C1.26 **Medicare member** means an MCHCP member who is eligible for Medicare.

C1.27 **Member** means any person who is a participant in Missouri Consolidated Health Care Plan (MCHCP).

C1.28 **Must** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a proposal being considered non-responsive.

C1.29 **Multi-Source** means a legend drug or OTC that is manufactured by more than one labeler.

C1.30 **Non-duplication Coordination of Benefits (COB)** means the coordination method utilized by MCHCP and further defined at 22 CSR 10-2.070. A complete description can be found at http://s1.sos.mo.gov/cmsimages/adrules/csr/current/22csr/22c10-2.pdf.

C1.31 **Off-shore** means outside of the United States.

C1.32 **Participant** means eligible members identified for a program.

C1.33 **Participating Pharmacy** means a contracted retail, mail, or specialty network pharmacy (or Pharmacy Provider) which has agreed to provide pharmaceutical services to all MCHCP members and to be reimbursed at an agreed upon rate by PBM.

C1.34 **Pass through Pricing** means that the full value of all retail pharmacy discounts and dispensing fees (including specialty drugs) negotiated between Contractor and the pharmacies shall accrue to MCHCP at the point of sale and that MCHCP will not be obligated to reimburse Contractor for an amount greater than such contracted rates.

C1.35 **PHI** shall mean Protected Health Information, as defined in 45 C.F.R. 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, MCHCP by contractor pursuant to performance of services under the contract.

C1.36 **Pricing Pages** apply to the form(s) on which the bidder must state the price(s) applicable for the services required in the RFP. The pricing pages must be completed and uploaded by the bidder prior to the specified proposal filing date and time.

C1.37 **Privacy Regulations** shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

C1.38 **Proposal Filing Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of proposals by Optavise system.

C1.39 **Provider** means a licensed health care practitioner, hospital or care giver who by law and by contract may receive reimbursement for services rendered.

C1.40 **Rebate(s)** mean compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access. Rebates must also include revenue received by the Group Purchasing Organization (GPO) in connection with the Plans' utilization. All manufacturer-derived revenue, regardless of how categorized by the PBM, is encompassed by the definition of "Rebates".

C1.41 **Request for Proposal (RFP)** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.

C1.42 **Respondent** means any party responding in any way to this RFP.

C1.43 **Retiree** means a person who is not an employee and is receiving or is entitled to receive a retirement benefit from the State of Missouri or a retirement system of a participating member agency of the plan.

C1.44 **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature, which govern the operations of all agencies of the State of Missouri. Chapter 103 of the statutes is the primary chapter governing the operations of MCHCP.

C1.45 **Set-Up Form** means any standard Contractor document or form, which when completed and signed by MCHCP, will describe the essential benefit elements and coverage rules adopted by MCHCP for its plan.

C1.46 **Shall** has the same meaning as the word must.

C1.47 **Should** means that certain feature, component and/or action is desirable but not mandatory.

C1.48 **Single-Source** means a legend drug manufactured by one labeler.

C1.49 **Single-Source Generic Drug** means a new Generic Drug introduction manufactured by one labeler during the exclusivity period, not to exceed six (6) months.

C1.50 **Specialty Drugs** means a Drug or Product that is dispensed to a member for any NDC that is contained on the PBM's provided Specialty Drug List. If a Drug, Product, or NDC is not listed on the Specialty Drug List, it will not be considered a Specialty Drug. Additionally, New to Market status does not exempt a Drug, Product, NDC, or Claim from being a Specialty Drug. If the PBM considers a Drug, Product, NDC, or Claim as a Specialty Drug based on indicators on the formulary and is New to Market, it will be included in all Specialty Drug pricing guarantees, Specialty Drug adjudication, and Specialty Drug reconciliation.

C1.51 **Subscriber** means eligible members, excluding spouses and dependents.

C1.52 **Transparency** means the full disclosure by the Contractor as to all of its sources of revenue that enables the Plan Sponsor (and its agents), to have complete and full access to all information necessary to determine and verify that the Contractor has met all terms of this Contract and satisfied all Pass-Through Pricing requirements.

C1.53 **Usual and Customary Price** (**U&C)** means the retail price charged by a Participating Pharmacy for a Covered Drug in a cash transaction on the date the drug is dispensed as reported to Contractor by the Participating Pharmacy.

The following definitions shall apply to EGWP only, and do not replace definitions for commercial population benefits:

C1.54 **Copayment** or **Copay** means that portion of the charge for each Covered Product dispensed to an EGWP Enrollee that is the responsibility of such EGWP Enrollee (e.g., copayment, coinsurance, cost sharing, and/or deductibles under initial coverage limits and up to annual out-of-pocket thresholds) as provided under the EGWP Benefit.

C1.55 **Enrollee Submitted Claim** means (a) a claim submitted by an Enrollee for Covered Drugs dispensed by a pharmacy other than a Participating Pharmacy, (b) a claim submitted by an Enrollee for a vaccination, or (c) a claim for Covered Drugs filled at a Participating Pharmacy for which the Enrollee paid the entire cost of the Covered Product.

C1.56 **EGWP Benefit** means the prescription drug benefit to be administered by Contractor under the Agreement.

C1.57 **EGWP Enrollee** means each Part D Eligible Retiree who is enrolled in the EGWP Benefit in accordance with the terms of the Agreement.

C1.58 **EGWP Plus** means a prescription drug benefit plan design that provides coverage beyond the standard Part D benefit, and is defined by CMS as other health or prescription drug coverage.

C1.59 **Late Enrollment Penalty** or **LEP** means the financial penalty incurred under the Medicare Drug Rules by Medicare Part D beneficiaries who have had a continued gap in creditable coverage of sixty-three (63) days or more after the end of the beneficiary's initial election period, adjusted from time to time by CMS.

C1.60 **Medicare Formulary** means the list of prescription drugs and supplies developed, implemented and maintained in accordance with the Medicare Drug Rules for the EGWP Benefit.

C1.61 **Medicare Rebate Program** means Contractor's or its Affiliate's manufacturer rebate program under which Contractor or its Affiliate contracts with pharmaceutical manufacturers for Rebates payable on selected Covered Drugs that are reimbursed, in whole or in part, through Medicare Part D, as such program may change from time to time.

C1.62 **Part D** or **Medicare Part D** means the Voluntary Prescription Drug Benefit Program set forth in Part D of the Act.

C1.63 **Part D Eligible Retiree** means an individual who is (a) eligible for Part D in accordance with the Medicare Drug Rules, (b) not enrolled in a Part D plan (other than the EGWP Benefit), and (c) eligible to participate in MCHCP's Current Benefit.

C1.64 **True Out-of-Pocket Costs** or **TrOOP** means costs incurred by an EGWP Enrollee or by another person on behalf of an EGWP Enrollee, such as a deductible or other cost-sharing amount, with respect to Covered Drugs, as further defined in the Medicare Drug Rules.

C1.65 **Vaccine Claim** means (i) a Medicare Part D covered vaccine claim for reimbursement submitted by a Participating Pharmacy, mail order Pharmacy, Contractor specialty pharmacy, physician, or

other entity and (ii) a Medicare Part B covered vaccine claim submitted by a Participating Pharmacy. Vaccine Claim is a Prescription Drug Claim for purposes of this Agreement.

C2. GENERAL BIDDING PROVISIONS

C2.1 It shall be the bidder's responsibility to ask questions, request changes or clarification, or otherwise advise MCHCP if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from bidders regarding specifications, requirements, competitive procurement process, etc., must be directed to MCHCP via the messaging tool on the Optavise web site, as indicated on the last page of the *Introduction and Instructions* document of the RFP. Such communication must be received no later than Tuesday, February 3, 2026, 5 p.m. CT (6 p.m. ET).

Every attempt shall be made to ensure that the bidder receives an adequate and prompt response. However, to maintain a fair and equitable procurement process, all bidders will be advised, via the issuance of an amendment or other official notification to the RFP, of any relevant or pertinent information related to the procurement. Therefore, bidders are advised that unless specified elsewhere in the RFP, any questions received by MCHCP after the date noted above might not be answered.

It is the responsibility of the bidder to identify and explain any part of their response that does not conform to the requested services described in this document. Without documentation provided by the bidder, it is assumed by MCHCP that the bidder can provide all services as described in this document.

C2.2 Bidders are cautioned that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

C2.3 MCHCP monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among bidders, price-fixing by bidders, or any other anticompetitive conduct by bidders, which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.

C3. PREPARATION OF PROPOSALS

C3.1 Bidders must examine the entire RFP carefully. Failure to do so shall be at the bidder's risk.

C3.2 Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.

C3.3 Unless otherwise specifically stated in the RFP, any manufacturer's names, trade names, brand names, and/or information listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. Proposals that do not comply with the requirements and specifications are subject to rejection without clarification.

C3.4 Unless specifically stated, responses to the questionnaire are assumed to apply to both the Commercial and EGWP populations.

C4. DISCLOSURE OF MATERIAL EVENTS

C4.1 The bidder agrees that from the date of the bidder's response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to MCHCP:

C4.1.1 Any material adverse change to the financial status or condition of the bidder;

C4.1.2 Any merger, sale or other material change of ownership of the bidder;

C4.1.3 Any conflict of interest or potential conflict of interest between the bidder's engagement with MCHCP and the work, services or products that the bidder is providing or proposes to provide to any current or prospective customer; and

C4.1.4 (1) Any material investigation of the bidder by a federal or state agency or self-regulatory organization; (2) Any material complaint against the bidder filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming the bidder before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming the bidder as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against the bidder by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against the bidder as a result of any material criminal or civil action in which the bidder was a party; or (7) Any other matter material to the services rendered by the bidder pursuant to this RFP.

C4.1.4.1 For the purposes of this paragraph, "material" means of a nature, or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this RFP. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, the bidder is obligated to make its best faith efforts to disclose only those relevant matters which come to the attention of or should have been known by the bidder's personnel involved in the engagement covered by this RFP and/or which come to the attention of or should have been known by any individual or office of the bidder designated by the bidder to monitor and report such matters.

C4.2 Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to either reject the proposal or continue evaluating the proposal.

C5. COMPLIANCE WITH APPLICABLE FEDERAL LAWS

C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable Care Act (PPACA), as amended.

C5.2 Any bidder offering to provide services must be able to sign a Business Associate Agreement (BAA) (see Exhibit A-7) due to the provisions of HIPAA. Any requested changes shall be noted and returned with the RFP**. The changes are accepted only upon MCHCP signing a revised BAA after contract award.**

C5.3 Upon awarding of the contract by the Board, the BAA shall be signed by both parties within five (5) working days of the request to sign, or the award of the contract may be rescinded.

Attachment 1

Drug Claims Functional Specifications for File Layout - Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Health Insights Field	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length									
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Yes	Yes	Adjustment Type values will be identified in the Data Dictionary.
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated	Yes		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount	Yes		Format 9(8)v99 (2 - digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.	Yes		
6	Claim Type Code	38	39	2	Character	Client-specific code for the type of claim	Yes	Yes	Claim Type Codes will be identified in the Data Dictionary.
7	Co-Insurance	40	49	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
8	Copayment	50	59	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
9	Date of Birth	60	69	10	Date	The birth date of the person.			MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
10	Date of Service	70	79	10	Date	The date of service for the drug claim.	Yes		MM/DD/CCYY format
11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	Yes		MM/DD/CCYY format This is the check date.
12	Days Supply	90	93	4	Numeric	The number of days of drug therapy covered by the prescription.	Yes		
13	Deductible	94	103	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
14	Dispensing Fee	104	113	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
15	Family ID/Employee SSN	114	122	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	Yes		The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
16	Formulary Indicator	123	123	1	Character	An indicator that the prescription drug is included in the formulary.	Yes		"Y" or "N"
17	Gender Code	124	124	1	Character	The member's gender code.	Yes		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
18	Ingredient Cost	125	134	10	Numeric	The charge or cost associated with the pharmaceutical product.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
19	Metric Quantity Dispensed	135	145	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.	Yes		Format 9(8)v99 (3 - digit, implied decimal)
20	NDC Number Code	146	156	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Yes		Please leave out the dashes.
21	Net Payment	157	166	10	Numeric	The actual check amount for the record	Yes		Format 9(8)v99 (2 - digit, implied decimal)
22	Network Paid Indicator	167	167	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.	Yes		Y or "N"
23	Network Provider Indicator	168	168	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.	Yes		Y or "N"
24	Ordering Provider ID	169	181	13	Character	The ID number of the provider who prescribed the drug.	Yes		It is preferred that this is the same identifiers used in medical claims. Typically, this is the physician's NPI or the DEA#. If these are not available, the Federal Tax ID (TIN) is acceptable.
25	Ordering Provider Name	182	211	30	Character	The Name of the provider who referred the patient or ordered the test or procedure.	Yes		

Attachment 1
Drug Claims Functional Specifications for File Layout - Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Health Insights Field	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length									
26	Ordering Provider Zip Code	212	216	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.	Yes		
27	PCP Responsibility Indicator	217	217	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	Yes		
28	Provider ID	218	230	13	Character	The identifier for the provider of service.	Yes		This should be the NCPDP (National Council for Prescription Drug Programs) number. (Note: The pharmacy NPI is collected in field #36 in this layout.)
29	Rx Dispensed as Written Code	231	231	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.	Yes		
30	Rx Mail or Retail Code	232	232	1	Character	The Merative standard code indicating the purchase place of the prescription.	Yes		M for Mail, "R" for Retail
31	Rx Payment Tier	233	233	1	Character	Client-specific description for the payment tier of the drug claim.	Yes		Data Supplier will help Merative understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary
32	Rx Refill Number	234	237	4	Numeric	A number indicating the original prescription or the refill number.	Yes		This is the refill number, not the number of refills remaining.
33	Sales Tax	238	247	10	Numeric	The amount of sales tax applied to the cost of the prescription.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
34	Third Party Amount	248	257	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Yes		Format 9(8)v99 (2 - digit, implied decimal)
35	Discount	258	267	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
36	Provider NPI Number	268	277	10	Character	The National Provider Identifier for the pharmacy.			
37	Funding Type Code	278	278	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement	Yes		"S" = Self-funded "F" = Fully-funded
38	Account Structure	279	286	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	TBD	TBD	Additional fields may be added to the layout if there is more than one component of the account structure.
39	HRA Amount	287	296	10	Numeric	The amount paid from the HRA to pay the provider.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
40	HSA Amount	297	306	10	Numeric	The financial amount of the healthcare savings account for consumer-driven health plans	Yes		Format 9(8)v99 (2 - digit, implied decimal)
41	Compound Code	307	307	1	Character	Client-specific code for the compound of the drug.	Yes	Yes	Compound Codes will be identified in the Data Dictionary. Note that the NCPDP values include: '0' – Not Specified '1' – Not a Compound '2' – Compound
42	Excess Copayment Amount	308	317	10	Numeric	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
43	Tax Amount	318	327	10	Numeric	The amount charged by some states per drug claim.	Yes		Format 9(8)v99 (2 - digit, implied decimal)
44	CUSTOM FIELD # (if applicable)	328	328	1	TBD	Additional Rows/Fields to be added as Custom Fields are identified.	TBD	TBD	TBD
45	Filler	329	399	71	Character	Reserved for future use			Fill with blanks
46	Record Type	400	400	1	Character	Record type identifier			Hard Code to "D"

Attachment 2
Drug Claims Functional Specifications for File Layout - Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Fixed-Record Length							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	399	355	Character	Reserved for future use	Fill with Blanks
6	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'T'

ATTACHMENT 2
ENROLLMENT FILE FIELDS

Field Name	Description
Unique ID	Number assigned by MCHCP
Relation	Identifies if member is subscriber, spouse, or child 1 – subscriber 2 – spouse 3 – child
Status	Identifies status of member ACT – Active Employee RTN – Retired Employee CBR – COBRA Participant DSB – Participant on Long Term Disability SVR – Survivor VES – Vested Participant
Zip	5-Digit Zip Code
YOB	Year of Birth (yyyy)
Gender	M – Male F – Female
Commercial-EGWP	C – Commercial Plan E – EGWP Plan