**FA 2 Attachment P-1: Plan Information**

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Complete each cell with the requested information. Items in the response column with the words **"Choose an Item"** contain a drop down list of options. Select a response from those options as applicable.

|  |  |  |  |
| --- | --- | --- | --- |
| **I.** | **GENERAL PLAN INFORMATION** | |  |
|  |  | **Response** | |
| 1. | Offeror's Legal Name | Click here to enter text. | |
| 2. | Plan Name | Click here to enter text. | |
| 3. | Address | Click here to enter text. | |
| 4. | City | Click here to enter text. | |
| 5. | State | Click here to enter text. | |
| 6. | Zip | Click here to enter text. | |
| 7. | Web Address | Click here to enter text. | |
| 8. | Operational Date | Click here to enter a date. | |
| 9. | Corporate Tax Status | Choose an item. | |
| 10. | Federal Employer Identification Number | Click here to enter text. | |
| 11. | Ownership/Controlling Interest | Click here to enter text. | |
| 12. | Commercial Group Membership | Click here to enter text. | |

**II. PHARMACY DELIVERY SYSTEMS**

**Participants' Access to Providers**

The State would like to determine the availability of pharmacy providers to its employee population. Prepare GeoAccess® GeoNetworks® report(s) for the Pharmacy network that you are proposing, using census data provided by The State and the parameters in the table below. Provide the reports using the following: 1. All retirees 2. All retirees in the Pharmacy Plan. Note that it is important that you follow the exact parameters. Report output is required for those with access and those without access, based upon the stipulated parameters. The report output should show the average distance to each Pharmacy. See the section entitled "**FA 2** **Attachment P-5: Access to Pharmacies**" for the required format of the output. In addition to the hard copy report, the data must be supplied in electronic format that has read/write capabilities. **Do not send the data in a read-only file.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Practice Specialty** |  | **Number of**  **Providers Available** | **Miles from**  **Employees Residence** |
| Retail Pharmacy | | 1 | 10 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Select Response** |
| 1 | Has the GeoAccess® GeoNetworks® reporting been completed using the requested parameters? | | | Choose an item. |
| 2. | Note the geo-mapping method used: | | | Choose an item. |
| 3. | What version of GeoAccess® GeoNetworks® was used to create the Accessibility Analysis? | | | Click here to enter text. |

**III. ADMINISTRATIVE AND OPERATIONAL ISSUES**

|  |  |  |
| --- | --- | --- |
| 1. | List the location(s) of your service centers (separately identify customer service, claims and mail order centers if in different locations) that would be servicing the State members for FA 2 and the corresponding geographic areas/regions covered by the respective location. Use the **"FA 2** **Attachment P-2: Explanations and Deviations"** worksheet if you need more space. | |
|  | **Service Center Location(s)** | **Geographic Region(s) Covered** |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Select Response** |
| 2. | Attach a copy of your standard report suite specific to FA 2, including a plan experience report, and performance metrics that would be provided to the State at the end of each quarter and the end of each fiscal year at no additional cost. At a minimum, your package should include those outlined in the Compliance Checklist. Label as **"FA 2** **Response Attachment P‑1: Management Reporting Package.”** | | | Choose an item. |

**IV. REFERENCES**

Complete the following tables with the requested reference information.

1. Please provide references for three clients (a minimum of 50,000 covered lives or your largest) for whom you currently provide similar prescription drug benefits administration services (EGWP). Please include at least one public sector client if that client meets the covered live criteria.

|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
| --- | --- | --- | --- | --- |
|  | Organization Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | # Members Enrolled | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Description of Services provided | Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. Please provide three of your terminated employer clients of similar size (a minimum of 50,000 covered lives or your largest) for whom you offered similar prescription drug benefits administration services (EGWP).

|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
| --- | --- | --- | --- | --- |
|  | Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | # Members Enrolled at Date of Termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Termination Date of Contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Reason for Termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**V. CONTACT INFORMATION**

|  |  |  |
| --- | --- | --- |
|  | **Primary contact of person authorized to execute this proposal** | |
|  | Name | Click here to enter text. |
|  | Title | Click here to enter text. |
|  | Address | Click here to enter text. |
|  | City | Click here to enter text. |
|  | State | Click here to enter text. |
|  | Zip Code | Click here to enter text. |
|  | Telephone # | Click here to enter text. |
|  | Cell Phone # | Click here to enter text. |
|  | E-mail Address | Click here to enter text. |

## FA 2 Attachment P-2: Explanations and Deviations

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** All deviations from the specifications of the Request for Proposal (RFP) must be clearly defined using this worksheet. Explanations must be numbered to correspond to the question number and section number to which it pertains. If additional space is required, submit a separate attachment labeled **“FA 2 Attachment P-2: Explanations and Deviations”** using the same table format. **Most importantly, keep all explanations brief.**  In the absence of any identified deviations, your organization will be bound to the terms of the RFP.

| **Section # / Question #** | **Indicate "Explanation" or "Deviation"** | **Offeror Response** |
| --- | --- | --- |
| Click here | Choose | Click here to enter text. |
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| Click here | Choose | Click here to enter text. |

Indicate if **“FA 2 Attachment P-2: Explanations and Deviations”** is provided: **Choose an item.**

## FA 2 Attachment P-3: Plan Designs

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**I. PLAN DESIGN CAPABILITIES**

Please indicate your ability to administer the following plan provisions.

| **CAPABILITIES** | | |
| --- | --- | --- |
| PD-1 | Please indicate whether or not the Offeror is able and willing to support and administer the following: |  |
|  | 1. Coinsurance at Retail | Choose |
|  | 1. Coinsurance at Mail | Choose |
|  | 1. Mixed copays at Retail (fixed dollar and percent) | Choose |
|  | 1. Mixed copays at Mail (fixed dollar and percent) | Choose |
|  | 1. 90 days supply at Retail | Choose |
|  | 1. Minimum/Maximum amounts with coinsurance | Choose |
|  | 1. Annual Out-Of-Pocket (OOP) maximums per person | Choose |
|  | 1. Annual Out-Of-Pocket (OOP) maximums per family/coverage unit | Choose |
|  | 1. Out-Of-Pocket (OOP) maximum per script | Choose |
|  | 1. Plan design integration with medical plan vendor(s) | Choose |
|  | 1. Coverage of OTC products | Choose |
|  | 1. First 2 fills free before cost sharing | Choose |
|  | 1. Copays specific to drug classes | Choose |
|  | 1. Copays based on previous drug trials (e.g., higher copay if claims history does not include trial of first-line/preferred drug/drug class) | Choose |
|  | 1. Copays based on place of service (e.g., incentives to use preferred retail pharmacies, specialty pharmacies, etc.) | Choose |
|  | 1. Copays dependent on participant's behavior (e.g., enrollment or stratification level in a disease management program). | Choose |
| PD-2 | Please indicate whether or not the Contractor is able and willing to customize refill-too-soon edits. | Choose |
| PD-3 | Please indicate whether or not the Contractor is able and willing to offer more than one formulary. *(Please note that the State is not requesting a proposal for more than one formulary at this time.)* | Choose |
| PD-4 | Please indicate whether or not the Contractor is able and willing to support and administer the proposed benefit plan designs for EGWP members, which is presented below in **Section II: Current Plan Design**. | Choose |
| PD-5 | Please indicate your acceptance that the State reserves the right to change without a contract modification any aspect of the plan design including, but not limited to, drugs to which Drug Utilization Review (DUR) is applied, the list of specialty medications in the Specialty Drug Management Program, new copayment structure, list of drugs eligible for the zero copay generics and prior authorization requirements. | Choose |
| PD-6 | Please indicate you acceptance that he State shall have the right to request changes to the terms of the EGWP Benefit from time to time by providing written notice to the Contractor. The Contractor shall implement any such requested changes, subject to the following conditions:   1. all changes to the EGWP Benefit must be consistent with the Medicare Drug Rules; 2. the EGWP Benefit, after implementation of such changes, must continue to meet the actuarial equivalence standards; 3. EGWP Benefit changes may be implemented only at times and in the manner permitted by the Medicare Drug Rules; and 4. any requested change that would increase the Contractor’s costs of administering the EGWP Benefit without an equivalent increase in reimbursement to Contractor from the State shall not be implemented unless and until the State and Contractor agree in writing upon a corresponding amendment to the reimbursement terms of this Modification. | Choose |

**II. CURRENT PLAN DESIGN**

|  |  |  |
| --- | --- | --- |
| **PLAN DESIGN Medicare Retirees** | | |
| **RETAIL AND MAIL ORDER PHARMACIES** | | |
| **Type of Drug** | **Up to 45 Day Supply (1 copay)** | **46 - 90 Day Supply (2 copays)** |
| Generics | $10 | $20 |
| Preferred Brands | $25 | $50 |
| Other Brands | $40 | $80 |
| **Out of Pocket Maximum** |  |  |
|  | **Medicare Retirees** | |
| Single only coverage | $1,500 | |
| Family coverage | $2,000 | |

***Notes for plan designs***

1. If a Brand Name drug is purchased when a Generic was available, the member pays the generic copayment plus the difference in costs between the Generic and Brand Name drug.
2. The State reserves the right to change co-payments in the plan design without a contract modification but by way of written notice to the Contractor.
3. Specialty drugs can be obtained at a retail pharmacy.
4. The member’s out-of-pocket expense is the minimum of Copay or U&C.

|  |
| --- |
| **CURRENT PROSPECTIVE DRUG UTILIZATION REVIEW PROGRAMS** |
| **Quantity Limits (or Managed Drug Limitations)** |
| Erectile Dysfunction  PPIs  Nasal Inhalers  Sedative/Hypnotics |
| **Step Therapy** |
| COX-2 Inhibitors (Celebrex®) |
| **Prior Authorizations** |
| Growth Hormones  Select ADHD/Narcolepsy, such as Adderall, Desoxyn, Dexedrine and Dextrostat  Tretinoin Products, such as Altinac, Avita, Retin-A, Tretinoin  Praluent, Repatha, and future approved PCSK9 drugs |

|  |  |
| --- | --- |
| **ZERO COPAY FOR GENERICS PROGRAM**  Copays reduced to $0 for the following generic drug classes (both retail and mail order pharmacies) | |
| **Drug Class** | **Generic Drugs (examples)** |
| HMG CpA Redictase Inhibitors (Statins) | simvastatin, pravastatin |
| Angiotensin Converting Enzyme Inhibitors (ACEIs) | lisinopril, lisinopril/HCTZ, enalapril, enalapril/HCTZ |
| PPIs | omeprazole |
| Inhaled Corticosteroids | budesonide |
| Selective Seritonin Reuptake Inhibitors (SSRIs) | fluoxetine, paroxetine, sertraline, citalopram |
| Contraception Methods | oral contraceptives, emergency oral contraceptives, diaphragm, levonorgestrel |
| Tobacco Cessation | bupropion |

|  |  |
| --- | --- |
| **SPECIALTY DRUG MANAGEMENT PROGRAM** | |
| The Specialty Drug Management Program is a program that is designed to ensure the appropriate use of specialty drugs. Many specialty drugs are biotech medications that may have the following characteristics: expensive, limited access, complicated treatment regimens, compliance issues, special storage requirements and/or manufacturer reporting requirements. Specialty drugs in this program will be automatically reviewed for step therapy, prior authorization, and quantity or dosage limits. These specialty drugs will be limited to a maximum 30‐day supply per prescription fill. This list is subject to change without notice to accommodate new prescription medications and to reflect the most current medical literature.  ***Members only pay two copays for 90 days of specialty medication. Members will pay the 46 day-fill copay for the first two 30-day fills and receive the third 30-day fill with no member cost share (covered 100% by plan).*** | |
| **Disease** | **Specialty Drugs** |
| Rheumatoid Arthritis | Cimzia, Enbrel, Humira, Kineret, Orencia, Orthovisc, Remicade, Euflexxa, Hyalgan, Supartz, Synvisc |
| Multiple Sclerosis | Avonex, Betaseron, Copaxone, mitoxantrone, Novantrone, Rebif, Acthar HP, Tysabri |
| Blood Disorder | Aranesp, Arixtra, Epogen, Fragmin, Innohep, Lovenox, Nplate, Procrit, Leukine, Neulasta, Neupogen, Neumega, Proleukin, anti‐hemophiliac agents |
| Cancer | Afinitor, Gleevec, Iressa, Nexavar, Revlimid, Sprycel, Sutent, Tarcva, Tasigna, Temodar, Thalomid, Treanda, Tykerb, Xeloda, Zolinza, Eligard, Plenaxis, Trelstar, Vantas, Viadur, Zoladex, Thyrogen, Aloxi IV, Anzemet IV, Kytril IV, Zofran IV |
| Hepatitis C | Alferon N, Copegus, Infergen, Intron A, Pegasys, Peg‐Intron, Rebetol, ribasphere, ribavirin, Roferon‐A |
| Osteoporosis | Forteo, Reclast |

|  |
| --- |
| **EXCLUDED** |
| Anoretcis (any drug used for the purpose of weight loss) |
| DESI drugs (drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness) |
| Vitamins and minerals (except for prescription pre-natal vitamins) |
| Blood Glucose Meters |
| Pregnancy Termination Drugs (e.g., RU486, Mifeprex) |
| Aerochamber, Aerochamber with Mask and Nebulizer Masks |
| All Other Medical Supplies |
| Homeopathic Legend Products |
| Investigational Drugs |
| Non-ambulatory services |
| Worker's Compensation claims |

## FA 2 Attachment P-4: Participating Pharmacies

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please indicate the number of contracted pharmacies in your retail network for each of the counties listed below specific to FA 2.

**PHARMACY**

| **County/**  **Metro Area** | **Number of Pharmacies** | **% of Total Pharmacies** |
| --- | --- | --- |
| Allegany County | Click here | Click here |
| Anne Arundel County | Click here | Click here |
| Baltimore City | Click here | Click here |
| Baltimore County | Click here | Click here |
| Calvert County | Click here | Click here |
| Caroline County | Click here | Click here |
| Carroll County | Click here | Click here |
| Cecil County | Click here | Click here |
| Charles County | Click here | Click here |
| Dorchester County | Click here | Click here |
| Frederick County | Click here | Click here |
| Garrett County | Click here | Click here |
| Harford County | Click here | Click here |
| Howard County | Click here | Click here |
| Kent County | Click here | Click here |
| Montgomery County | Click here | Click here |
| Prince George’s County | Click here | Click here |
| Queen Anne's County | Click here | Click here |
| St. Mary's County | Click here | Click here |
| Somerset County | Click here | Click here |
| Talbot County | Click here | Click here |
| Washington County | Click here | Click here |
| Wicomico County | Click here | Click here |
| Worchester County | Click here | Click here |

## FA 2 Attachment P-5: Access to Pharmacies

**Instructions:** Provide access for the proposed network in two ways: 1) all Medicare retirees and spouses currently in the Pharmacy Plan and 2) all Medicare eligible retirees and spouses. Matches must be determined based on criteria outlined **“FA 2 Attachment P-1: Plan Information Section II Pharmacy Delivery Systems.”** The census data needed to perform this mapping is available for download upon execution of the Non-Disclosure Agreement (see RFP Section 1.37).

Complete A and B below and provide the GeoAccess® GeoNetworks® report and label as **FA 2** **Response Attachment P-5: GeoAccess® GeoNetworks® Report** in the following report format.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Zip Code** | **Average Distance to Pharmacies** | **Total Number of Employees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
| **SAMPLE FORMAT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

1. Provide subtotals for all Medicare retirees and spouses currently in the Pharmacy Plan by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area** | **Average Distance to Pharmacies** | **Total Number of**  **Medicare Retirees and Spouses** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Allegany County | Click here | 1193 | Click here | Click here | Click here | Click here |
| Anne Arundel County | Click here | 3389 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 4765 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 6776 | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 334 | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 324 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1567 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 416 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 252 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 557 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 797 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 323 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 1 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1354 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 364 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1100 | Click here | Click here | Click here | Click here |
| Prince George’s County | Click here | 1287 | Click here | Click here | Click here | Click here |
| Queen Anne’s County | Click here | 486 | Click here | Click here | Click here | Click here |
| St. Mary’s County | Click here | 401 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 417 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 451 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1393 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1278 | Click here | Click here | Click here | Click here |
| Worchester County | Click here | 498 | Click here | Click here | Click here | Click here |

1. Provide subtotals for all Medicare retirees and spouses by County of residence and by region of residence as shown in the table below:

| **Metropolitan/ Geographic Area** | **Average Distance to Pharmacies** | **Total Number of**  **Medicare Retirees and Spouses** | **Employees Matched** | | **Employees Not Matched** | |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Percent** | **Number** | **Percent** |
| Allegany County | Click here | 1518 | Click here | Click here | Click here | Click here |
| Anne Arundel County | Click here | 4288 | Click here | Click here | Click here | Click here |
| Baltimore City | Click here | 6000 | Click here | Click here | Click here | Click here |
| Baltimore County | Click here | 8640 | Click here | Click here | Click here | Click here |
| Calvert County | Click here | 417 | Click here | Click here | Click here | Click here |
| Caroline County | Click here | 411 | Click here | Click here | Click here | Click here |
| Carroll County | Click here | 1923 | Click here | Click here | Click here | Click here |
| Cecil County | Click here | 535 | Click here | Click here | Click here | Click here |
| Charles County | Click here | 329 | Click here | Click here | Click here | Click here |
| Dorchester County | Click here | 679 | Click here | Click here | Click here | Click here |
| Frederick County | Click here | 973 | Click here | Click here | Click here | Click here |
| Garrett County | Click here | 390 | Click here | Click here | Click here | Click here |
| Harford County | Click here | 3 | Click here | Click here | Click here | Click here |
| Howard County | Click here | 1674 | Click here | Click here | Click here | Click here |
| Kent County | Click here | 445 | Click here | Click here | Click here | Click here |
| Montgomery County | Click here | 1354 | Click here | Click here | Click here | Click here |
| Prince George’s County | Click here | 1643 | Click here | Click here | Click here | Click here |
| Queen Anne’s County | Click here | 613 | Click here | Click here | Click here | Click here |
| St. Mary’s County | Click here | 497 | Click here | Click here | Click here | Click here |
| Somerset County | Click here | 548 | Click here | Click here | Click here | Click here |
| Talbot County | Click here | 565 | Click here | Click here | Click here | Click here |
| Washington County | Click here | 1777 | Click here | Click here | Click here | Click here |
| Wicomico County | Click here | 1578 | Click here | Click here | Click here | Click here |
| Worchester County | Click here | 639 | Click here | Click here | Click here | Click here |

## FA 2 Attachment P-6: Compliance Checklist

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**​Instructions:** Complete each item with the requested information.  Items in the response column with the words**"Choose”** contain a drop down list of options. Select a response from those options as applicable.

**NOTE: If a Response/Explanation/Deviation is being provided, a "No" response must be selected and addressed in "FA 2 Attachment P-2: Explanations and Deviations.”**

| **Compliance Checklist** | | **Offeror’s Response** |
| --- | --- | --- |
| **Administrative Requirements** | | |
|  | The Contractor agrees to meet the Administrative Requirements for FA 2 in accordance with Offeror’s response to FA 1 Attachment P-6: Compliance Checklist CC-1 - CC-27. | Choose |
| **Communication Requirements** | |  |
|  | The Contractor agrees to meet the Communication Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC-28 - CC-34. | Choose |
| **Retail Pharmacy Network Requirements** | |  |
|  | The Contractor agrees to meet the Retail Pharmacy Network Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance** **Checklist** CC-35 - CC-43. | Choose |
| **Mail Order Pharmacy Requirements** | |  |
|  | The Contractor agrees to meet the Mail Order Pharmacy Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance** **Checklist** CC-44 - CC-54. | Choose |
| **Data Processing and Interface Requirements** | |  |
|  | The Contractor agrees to meet the Data Processing and Interface Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC-55 - CC-67. | Choose |
|  | The Contractor agrees to administering the enrollment of eligible members as represented in **Section 3.2.2.4** of the RFP. | Choose |
| **Reporting Requirements** | |  |
|  | The Contractor agrees to meet the Reporting Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC-68 - CC-76. | Choose |
| **EGWP Coverage** | |  |
|  | The Contractor agrees to provide a self-insured EGWP program to the State’s Medicare retirees. | Choose |
|  | The Contractor will maintain information as required for the State and/or Purchasing Pool Participant including but not limited to the following: |  |
| 1. drug lists and prior authorizations necessary to categorize Part B covered drugs for exclusion from claim submission; | Choose |
| 1. Storage of data for CMS audit, and participation in CMS audits, as needed; | Choose |
| 1. Exchange eligibility and enrollment data as necessary with the CMS COB Coordinator for accurate administration and processing of COB; | Choose |
| 1. Certificates of coverage at termination of Creditable Coverage, including postage and mailing; | Choose |
| 1. Record retention (claims, utilization management and eligibility data) for the period required by CMS; and | Choose |
| 1. Provide claims data necessary to support audit processes. | Choose |
|  | The Contractor will appropriately process electronic (in real time) and paper claim submissions for COB as secondary payor for Medicare Part D enrollees. | Choose |
| **Claims Processing** | |  |
|  | The Contractor agrees to meet the Claims Processing Requirements for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC- 77 - CC-88. | Choose |
| **Payment Specifications** | |  |
|  | The Contractor agrees to meet the Payment Specifications for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC-89 - CC-92. | Choose |
| **Special Provisions** | |  |
|  | The Contractor agrees to meet the Special Provisions for FA 2 in accordance with Offeror’s response to **FA 1 Attachment P-6: Compliance Checklist** CC-93 - CC-101. | Choose |

## FA 2 Attachment P-7: Questionnaire

**NOTE: Answers that are not concise and directly relevant may receive a lower valuation.**

**Instructions:** Complete each item with the requested information.  Items in the response column with the words**"Choose”** contain a drop down list of options. Select a response from those options as applicable.

**NOTE: For a "No" response for Q-25 – Q-36, please provide an explanation in "FA 2 Attachment P-2: Explanations and Deviations.”**

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
| **GENERAL** | |  |
|  | Describe the Offeror’s experience in providing pharmacy benefit management services (EGWP). | Click here to enter text. |
|  | Provide the number of years administering pharmacy benefits (EGWP). | Click here to enter text. |
|  | Provide the number of years administering pharmacy benefits (EGWP) in the State of Maryland. | Click here to enter text. |
|  | Provide a profile of your Pharmacy business (EGWP) for each of the most recent two calendar years. |  |
|  | **Calendar Year 2014** |  |
|  | Total Pharmacy premium volume | Click here to enter text. |
|  | Total number of Pharmacy clients | Click here to enter text. |
|  | Total number of Pharmacy participants covered | Click here to enter text. |
|  | Number of Pharmacy public sector clients | Click here to enter text. |
|  | Average size of Pharmacy public sector clients | Click here to enter text. |
|  | Number of Pharmacy public sector participants | Click here to enter text. |
|  | Number of Pharmacy claims handled | Click here to enter text. |
|  | Number of Pharmacy plans terminated | Click here to enter text. |
|  | Average size of terminated Pharmacy plans | Click here to enter text. |
|  | **Calendar Year 2015** |  |
|  | Total Pharmacy premium volume | Click here to enter text. |
|  | Total number of Pharmacy clients | Click here to enter text. |
|  | Total number of Pharmacy participants covered | Click here to enter text. |
|  | Number of Pharmacy public sector clients | Click here to enter text. |
|  | Average size of Pharmacy public sector clients | Click here to enter text. |
|  | Number of Pharmacy public sector participants | Click here to enter text. |
|  | Number of Pharmacy claims handled | Click here to enter text. |
|  | Number of Pharmacy plans terminated | Click here to enter text. |
|  | Average size of terminated Pharmacy plans | Click here to enter text. |
| **Employer Group Waiver Plan (EGWP)** | |  |
|  | Please indicate whether your firm is currently a CMS approved Medicare Part D prescription drug plan that can contract with plan sponsors to establish and manage EGWPs. | Choose an item. |
|  | Please indicate whether any EGWP functions are sub-contracted to other organizations. If so, please describe and complete a Subcontractor Questionnaire Form as part of your response to FA 2. (The entire EGWP program cannot be sub-contracted.) | Choose an item. |
|  | Will member services for EGWP retirees be handled by a separate unit than the one that supports actives employees? If so, please describe. | Choose an item. |
|  | Other than member services, please describe any other services that will be handled by a separate unit from the one that handles active employees (e.g. account service, billing, etc.). | Click here to enter text. |
|  | How will your organization handle split contracts (one Medicare, one non-Medicare)? | Click here to enter text. |
|  | The Medicare member will be covered by the EGWP but the non-Medicare member cannot be. What will the communication process be between your units/departments to guarantee that no member inadvertently loses coverage due to communication issues? | Click here to enter text. |
|  | Will you maintain the non-Medicare member as a separate contract holder under the non-Medicare plan even if that member is the spouse? | Choose an item. |
|  | Confirm that your P&T Committee meets CMS’ requirements for objectivity and validity. | Choose an item. |
|  | Confirm that you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis. | Choose an item. |
|  | Confirm that you will provide all CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements. | Choose an item. |
|  | Confirm that your member appeals process meets all CMS Medicare Part D requirements. | Choose an item. |
|  | Confirm that you provide all CMS required member communications. | Choose an item. |
|  | Confirm that you will mirror the current retiree plan design. | Choose an item. |
|  | Confirm that you will process low-income premium subsidy refunds to members and the Plan as well as low-income cost sharing refund requests to the members. | Choose an item. |
|  | Provide a description of your MTM program including the processes for enrollment, targeting, intervention, and outcomes reporting. | Click here to enter text. |
|  | Provide your book-of-business prescription drug event (PDE) error rate for 2014 and 2015. | Click here to enter text. |
|  | Describe the transition process you will utilize for members who are currently using non-formulary prescription drugs, drugs requiring prior authorization, step therapy, and quantity level limits. | Click here to enter text. |
|  | Describe the enrollment/ disenrollment process and include detail regarding the timing of when enrollment/disenrollment changes go into effect. | Click here to enter text. |
|  | Please confirm that your organization will provide monthly eligibility, detailed and summary claim reports, disclosure of subsidies, reinsurance, CGDP reimbursements, and rebates (even if only estimated pending approval), and utilization by category (mail, retail, brand, generic, etc.). | Choose an item. |
|  | How frequently will the reporting package be provided? | Click here to enter text. |
| How long after each month will they be available? | Click here to enter text. |
| **Customer Services** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Customer Services Q-20 - Q-37 of FA 1 is applicable to FA 2. | Choose |
| **Client Services** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Client Services Q-38 - Q-43 is applicable to FA 2. | Choose |
| **Network Structure / Access** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Network Structure / Access Q-44 - Q-55 of FA 1 is applicable to FA 2. | Choose |
| **Prescription Reimbursement Processes and Procedures** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Prescription Reimbursement Processes and Procedures Q-56 - Q-73 of FA 1 is applicable to FA 2. | Choose |
| **Mail Order** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Mail Order Q-74 - Q-101 of FA 1 is applicable to FA 2. | Choose |
| **Specialty Pharmacy Program** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Specialty Pharmacy Program Q-102 - Q-116 of FA 1 is applicable to FA 2. | Choose |
| **Clinical Capabilities** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire **Clinical Capabilities** Q-117 - Q-137 of FA 1 is applicable to FA 2. | Choose |
| **Formulary and Rebate Management** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Formulary and Rebate Management Q-138 - Q-144 of FA 1 is applicable to FA 2. | Choose |
| **Eligibility** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Eligibility Q-145 - Q-147 of FA 1 is applicable to FA 2. | Choose |
| **Implementation and Account Management** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Implementation and Account Management Q-148 - Q-152 of FA 1 is applicable to FA 2. | Choose |
| **IT Systems** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire IT Systems Q-153 - Q-160 of FA 1 is applicable to FA 2. | Choose |
| **Electronic Commerce** | | |
|  | The Offeror’s response to FA 1 Attachment P-7: Questionnaire Electronic Commerce Q-161 - Q-162 of FA 1 is applicable to FA 2. | Choose |

## FA 2 Attachment P-8a: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-8b: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

|  |
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|  |

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-8c: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond to yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

|  |
| --- |
|  |

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-8d: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

|  |
| --- |
|  |

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-8e: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

|  |
| --- |
|  |

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-8f: Subcontractors Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**Instructions:** Complete one **"FA 2 Attachment P-8: Subcontractors Questionnaire"** for each subcontractor the Offeror proposes to have perform any of the required functions under FA 2, except for those subcontractors also to be used in performing required functions under FA 1. For those subcontractors please respond yes on **"FA 1 Attachment P-8: Subcontractors Questionnaire**” to “**Will this Subcontractor also perform required functions for FA 2?”** Clearly indicate if a proposed subcontractor is a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

|  |
| --- |
|  |

**Subcontractor's Name** Click here to enter text.

**Subcontractor's MDOT Number** Click here to enter text.

| **Question** | | **Offeror’s Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what role will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-5 | Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership. | Click here to enter text. |
| SQ-6 | Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? | Choose an item. |
| If Yes, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-7 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

## FA 2 Attachment P-9: Performance Guarantees

**Representations made by the Offeror in this proposal become contractual obligations which must be met during the contract term.**

**NOTE: If the Response below is “No” any deviation(s) must be explained in "FA 2 Attachment P-2: Explanations and Deviations.”**

| **Performance Guarantees** | | **Offeror’s Response** |
| --- | --- | --- |
|  | | |
| PG-1 | The Contractor agrees to comply with the Performance Guarantees as stated in **FA 1 Attachment P-9: Performance Guarantees.** | Choose |