MDA HEALTH PLAN BOARD MEETING
Preliminary Agenda
February 5, 2021 – 1:30 PM
Via Zoom

I. CALL TO ORDER **1:30 PM**

II. BOARD ELECTION (Att. 1)

III. ELECTION OF OFFICERS (Att. 2)

IV. APPROVAL OF MINUTES
The minutes of the 10/26/20 meeting were approved by email ballot with no changes.

V. PRESIDENT'S REPORT **1:35 PM** **START/WINN**

A. MDA Health Plan 2020 year-end financial statement (Att. 3)
B. Reserve Investments (Att. 4)

VI. BUSINESS PLAN **1:45 PM**

We would like to use the Business Planning section of this agenda to do some collaborative planning and strategizing with the Board. Staff and the consultants have created a list of topics they believe would improve the MEWA. This is an opportunity for the Board to provide feedback based on their own personal experience and what they are hearing and seeing at the local level. It is an opportunity to help improve the plan for the future. Staff will take the feedback and come back with specific recommendations for change at a future meeting.

A. C&B Update (Att. 5) **COTTINGHAM & BUTLER**

B. OB Alliance Agreement/ Continuation of Care **VOSS**

C. 2022 Changes to consider **GITTENS/DITOMASSO/VOSS**

1. Add Save on SP Specialty Coupon Program
2. Remove Spinal Centers of Excellence program
3. Evaluate/Consolidate Plans
4. Higher OOP and Deductible changes
5. Update Troop for 2021

D. Miscellaneous **START**

1. Renewal
    a. Rate Renewal Conference Call – Aug. 25, 2021
    b. Open Enrollment Period
2. Priority SOC1 Report (Att. 6)
3. Express Scripts SOC1 Report (Att. 7a and 7b)

VII. INFORMATIONAL ITEMS **2:45 PM** **START/GITTENS/VOSS**

A. Technology
   1. Ease Central

B. Government reporting
   1. 6066 6065 reporting - 1094A, 1095B
   2. PCORI + reinsurance fees
   3. M-1 Filing
   4. Form 5500
   5. Super notice for open enrollment
   6. Affiliate disclosure agreements (Att. 8)

VIII. EXECUTIVE SESSION - None at this time

IX. REVIEW PENDING LIST (Att. 9)

X. TRUSTEE COMMENTS

XI. BOARD MEETING DATES – 2021 **TULAK-GORECKI**

- Friday, February 5 – Okemos
- Friday, April 23 – Lansing
- Friday, June 25 – Traverse City
- Friday, November 5 - Okemos

BOARD MEETING DATES – 2022

- Friday, February 4 – Okemos
- Friday, April 29 – Novi
- Friday, June 17 – Lansing
- Friday, November 4 – Okemos

XII. ADJOURNMENT **3:30 PM**

Congratulations! The 2021 MDA Health Plan Trustee election results are in. We look forward to continuing to bring great benefits to the MDA membership and their staffs!

The names of the Plan Beneficiaries' are Trustees are as follows:

- Dr. Mark Johnston
- Dr. Josef Kolling
- Dr. Elizabeth Ralstrom
- Dr. David Schoonover
- Dr. Michele Tulak-Gorecki

IFG appointed Trustees:

- Dr. Michael Booth
- Dr. Toni Ausum
- Dr. Nick Fontana
- Dr. William Patchak

MEWA OFFICE BALLOT
2021

The following candidates have announced they are running for officer positions on the MDA Health Plan Board. Any member of the Board is eligible to run for officer positions. Please let Craig Start know if you would like your name added to the ballot. We will also accept nominations from the floor during the meeting. The Board will vote on the officer appointments at the February 5, 2021 board meeting.

Chair Candidate 1:	Dr. Michele Tulak-Gorecki
Chair Candidate 2:	_____
Treasurer/Secretary Candidate 1:	Dr. Dr. Joe Kolling
Treasurer/Secretary Candidate 2:	_____

Note: We will update this ballot if we receive other nominees.

michigan dental ASSOCIATION
YOUR CONNECTION TO ORAL HEALTH

November 24, 2020

Shenna L. Severance, CPA
Senior Financial Analyst
Office of Insurance Evaluation
Department of Insurance and Financial Services

RE: MDA Health Plan Trust

Dear Shenna,

As representatives of the MDA Health Plan Trust, we hereby affirm that the accompanying financial report represents the financial activities of the Plan's Multiple Employer Welfare Arrangement (MEWA) for the three month period ending September 30, 2020.

The following documents are also being provided:

- Incurred but Unpaid Claim Liability and Reserve Sufficiency Report as of September 30, 2020 as completed by The Terry Group
- Current stop loss coverage letter from Priority Health

Should you have any questions, please do not hesitate to contact us.

Regards,

Craig A. Start 11-24-20

Craig A. Start, President

D. W. Winn 11-24-2020

Donald W. Winn, Chief Financial Officer

MDA Health Plan Trust

Financial Reports

Quarter Ending September 30, 2020

MDA Health Plan Trust
Statement of Net Assets Available for Benefits and Benefit Obligations

ASSETS	9/30/2020	12/31/2019
Investments:		
Money Market Fund	$527,091.03	$38,162.83
U.S. Government Securities - Reserves	$6,299,600.89	$6,086,782.11
* State of Michigan Cash Reserves Requirement = $5,424,529		
Comerica Bank - Certificates of Deposit/Treasury Securities	$9,417,142.50	$9,573,163.75
Comerica Bank - Equities Account	$4,745,044.17	$4,643,708.26
U.S. Government Securities-Deposit Required by State of Michigan	$1,091,125.98	$1,048,612.64
Total Investments:	**$22,080,004.57**	**$21,390,429.59**
Accounts Receivable - Stop Loss Refunds	$0.00	$150,975.28
Accounts Receivable - Pharmacy Refunds	$0.00	$317,410.03
Accounts Receivable - Subrogation	$24,281.83	$24,281.83
Accounts Receivable - Miscellaneous	$0.00	$93,999.99
Due From MDAIFG	$0.00	$140,142.70
Accrued Interest and Dividends	$0.00	$50,701.35
Cash	$3,472,068.98	$2,232,802.05
Prepaid Expenses	$1,882.00	$1,785.34
Total Assets:	**$25,578,237.38**	**$24,402,528.16**
Liabilities		
Accounts Payable		$33,975.04
Unearned Premiums	$1,592,723.43	$1,568,337.97
Due to MDA Insurance & Financial Group	$699,152.00	$388,533.48
Total Liabilities:	**$2,291,875.43**	**$1,990,846.49**
Net Assets Available for Benefits	**$23,286,361.95**	**$22,411,681.67**
Benefit Obligations - Estimated Liability for Incurred but not Reported	$1,637,899.00	$1,770,534.00
Excess of Net Assets Available for Benefits Over Benefit Obligations	**$21,648,462.95**	**$20,641,147.67**

MDA Health Plan Trust
Statement of Changes in Net Assets Available for Benefits and Changes in Benefit Obligations

	9/30/2020	12/31/2019
Additions to Net Assets		
Contributions:		
Employee	$7,104,768.95	$10,022,592.18
Employer	$6,760,901.58	$9,757,319.00
Other Contributions		$0.00
Total Contributions:	**$13,865,670.53**	**$19,779,911.18**
Investment Income:		
Interest and Dividends	$214,889.26	$368,354.85
Net Realized and Unrealized Gains/(Losses) on Investments- U.S. Governmental Securities	$432,720.78	$1,350,137.92
Total Investment Income:	**$647,610.04**	**$1,718,492.77**
Less Investment Expenses:	**$0.00**	**$0.00**
Net Investment Income:	**$647,610.04**	**$1,718,492.77**
Total Additions:	**$14,513,280.57**	**$21,498,403.95**
Deductions from Net Assets		
Claims		
Medical	$7,852,588.71	$11,913,376.85
Prescription	$2,210,353.18	$3,055,198.09
Excess Loss Premiums	$1,084,797.29	$1,386,093.44
Administrative Expenses		
Administrative Expenses - IFG	$1,105,643.52	$1,456,859.00
Administration Fees - Priority Health	$922,650.23	$1,109,131.43
Professional Fees	$213,205.59	$189,113.62
Taxes & Assessments	$119,603.08	$170,299.95
Software Expense	$18,503.28	$27,658.11
Investment Fees	$25,957.92	$32,131.00
Public Relations/Marketing	$14,996.91	$35,052.79
Miscellaneous	$62,837.84	$85,104.96
Diabetes Prevention Program	$7,462.74	$11,897.59
Total Deductions:	**$13,638,600.29**	**$19,471,916.83**
Net Increase Before Other Changes	**$874,680.28**	**$2,026,487.12**
Change in Benefit Obligation - Estimated Liability for Claims Incurred but Not Reported	**$132,635.00**	**($26,740.00)**
Increase/(Decrease) in Net Assets Available for Benefits Over Benefit Obligations	**$1,007,315.28**	**$1,999,747.12**
Net Assets Available for Benefits Over Benefit Obligations		
Beginning of Period	**$20,641,147.67**	**$18,641,400.55**
End of Period	**$21,648,462.95**	**$20,641,147.67**

TERRY

Actuarial Opinion of Unpaid Claim Liabilities as of September 30, 2020

Prepared for: Michigan Dental Association

TERRY

Table of Contents

TERRY

I. Introduction

At the request of Michigan Dental Association Health Plan (MDA), The Terry Group ("TG") has estimated liabilities for claims incurred but not paid ("IBNP") for the MDA Multiple Employer Welfare Arrangement (MEWA) as of September 30, 2020. This report describes the methods and assumptions we used to determine the estimates of the IBNP liabilities including reasonable margins to absorb claim fluctuations. The report also certifies that the MDA MEWA satisfies the reserve sufficiency requirement stipulated in Section 500.7040 (1) (c) of the Michigan Insurance Code.

II. Summary of Results

We estimated the IBNP claim liability as of September 30, 2020, including margin for claim fluctuations and adjustment for expenses. We summarize this below.

MDA MEWA IBNP Claim Liability with Margin as of September 30, 2020

Best estimate of the IBNP Claims	$1,380,197
+ Margin & Admin runout	$257,702
IBNP Claim Liability	$1,637,899

III. Data Sources

For our analysis, we have relied on data and other information provided to us by MDA and Priority Health. A list of the materials we reviewed and relied on is as follows:

- Monthly membership by plan for the period January 2019 through September 2020 from Priority Health.
- Medical claim lag by month paid and month incurred for the period October 2017 through September 2020 from Priority Health.
- Year to Date financials statements for the period ending September 30, 2020 from MDA.
- Summarization of paid medical, pharmacy, and administrative totals by month for CY2020 from Priority Health.

We have not audited or verified this data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We have performed a review of the data used directly in our analysis for reasonableness and consistency, and have not found material defects in the data. If there are material defects in the data, it may be possible to uncover them through a detailed, systematic review and comparison of the data. Such a review would involve searching for questionable data values or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

IV. Disclosures

On March 18, 2020 due to the developing COVID-19 pandemic, CMS provided guidance to defer elective procedures which had impact for the months of March through July 2020 incurred claims and therefore the total liability as of September 30, 2020.

The following items were considered to have a potential impact on the Q2 2020 claims:

- Guidance issued by the Governor, days after CMS provided direction, to suspend elective procedures leading to decrease in claims incurred
- Delays in providers submitting claims
- Negligible delay in claims processing
- Regional presence of COVID-19 cases

As of September 30, 2020, incurred claim totals appear to be returning to amounts which are closer to experience periods prior to COVID-19. No further incurred estimates for COVID are being utilized for estimations of the reserve. The reduced claims experience that was observed in months March 2020 through July 2020 is now captured within the claims data.

V. Methodology

Before analyzing IBNP reserve, TG first checked the historic claims payment data provided for the impact of large claims or reinsurance recoveries. These large claims can skew the average lag in payment processing times in a way that is inconsistent with expected experience. An adjustment was made to account for atypically large and later duration payments for claims incurred in March 2019.

The medical IBNP reserve was developed using a standard actuarial lag factor based methodology. This methodology is a blend of two different reserving approaches. In the first method, we performed a lag analysis using historic claims payment data. We estimated incurred claims for each month based on the historic claims lag. This method is commonly called the lag factor method.

To determine the estimated incurred claims for more recent months, we used an alternate approach based on historic per member per month (PMPM) costs. This method is commonly called the PMPM method. As the first step in this approach, we calculated the average PMPM incurred claim cost for a recent 12-month period. For the next step, we projected this average PMPM to the most recent incurred claim months using a trend assumption. We then multiplied these projected PMPM costs by monthly membership to derive an alternate estimate of incurred claims.

For the Medical IBNP reserve, the PMPM method was used to develop the fully incurred claims for September 2020. The lag factor method was used to develop the fully incurred claims for months of August 2020 and prior.

The IBNP reserve consists of two claim pieces – unreported and unpaid. One piece represents those claims that have been incurred September 30, 2020 or prior, but which have not been reported. We refer to these as unreported claims. The second piece represents those claims

which have been reported, but which have not yet been paid as of September 30, 2020. We refer to these as unpaid claims. For each month, we estimated the unreported and unpaid claims (the IBNP reserve for that month) by taking the difference between the estimated incurred claims and the paid claims for that month. See the attached exhibit for the month by month development of the medical portion of the IBNP reserve.

For the Pharmacy IBNP reserve, no claims lag was provided. TG assumed that 50% of the most recent month of pharmacy payments represents claims incurred but not paid as of September 30, 2020. This assumption is based on the very quick payment pattern of pharmacy claims in which any given month of payments is usually representative only of claims incurred in that month and one month prior.

The below table illustrates the development of the combined medical and prescription drug IBNP reserve as of September 30, 2020 for the MDA MEWA.

	IBNP Reserve
Medical	$1,210,691
Prescription Drug	$169,506
Total Best Estimate	$1,380,197
Administrative Claim Runout	$188,692
5% Margin	$69,010
Total Estimate with Margin	$1,637,899

The best estimate of the total IBNP reserve was increased for administrative expenses related to claims runout. The calculation was based on an estimate of enrollment and current administrative fees for two months. In addition, the best estimate was increased by 5.0% to provide a reasonable margin to absorb adverse claim fluctuations.

VI. Reserve Sufficiency

Section 500.7040 (1) (c) of the Michigan Insurance Code requires that a MEWA licensed in the State of Michigan must maintain minimum cash reserves of the greater of:

- Not less than 25% of the aggregate contributions in the current fiscal year; or
- Not less than 35% of the claims paid in the preceding fiscal year.

TG used the most recent 12 months of contributions to determine the reserve amount needed based on contributions. The contributions billed for October 2019 through September 2020 total $18,734,346. The minimum cash reserves required according to the Michigan Insurance Code is 25% of these contributions which is $4,683,587.

TG used the net paid claims for 2019 as reported by MDA to determine the reserve amount needed based on claims paid. Net paid claims in FY2019 totaled $15,498,655. The minimum cash

reserves required according to the Michigan Insurance Code is 35% of these paid claims which is $5,424,529.

The greater of these two values is $5,424,529 and represents the value of cash reserves required by MDA.

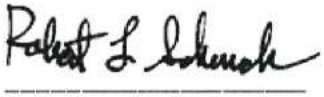
The MDA MEWA holds U.S. Government Securities required by the State of Michigan valued at $6,299,600 as of September 30, 2020. The State of Michigan has approved these securities for purposes of this reserve calculation. Since the value of the securities exceeds $5,424,529, the MDA MEWA satisfies the Michigan reserve requirement as of September 30, 2020.

VII. Variability of Results

Actual results may differ materially from actuarially derived estimates. The estimated liabilities for IBNP claims should include a safety margin to cover a reasonable range of claim scenarios. The extent of margin depends on factors such as the assumed risks, the variability of claim experience, and risk tolerance level of the plan. For the IBNP reserve, TG used an explicit provision for variance of 5.0% of the best estimate IBNP reserve.

VIII. Actuarial Certification

The author of this report, Robert Schenck, is a member of the American Academy of Actuaries, and meets the qualification standards for performing this analysis. The undersigned is available to answer any questions regarding this report:



Robert Schenck, ASA, MAAA

bobby.schenck@terrygroup.com

November 3, 2020

Date

Michigan Dental Association
Harmonic Mean (6 months)
PMPM Method

Summary of Outstanding Liabilities as of: 9/30/2020

Incurred Month	Members	Incurred Claims	PMPM	Paid Claims	Percent Complete	Outstanding Liability
Sep-20	4,128	$1,100,451	$266.58	$243,202	22.1%	$857,250
Aug-20	4,111	$1,092,038	$265.64	$904,827	82.9%	$187,210
Jul-20	4,103	$907,035	$221.07	$831,388	91.7%	$75,647
Jun-20	4,132	$846,665	$204.90	$801,712	94.7%	$44,953
May-20	4,124	$636,345	$154.30	$618,724	97.2%	$17,620
Apr-20	4,138	$417,369	$100.86	$410,865	98.4%	$6,504
Mar-20	4,118	$789,187	$191.64	$780,504	98.9%	$8,682
Feb-20	4,149	$887,125	$213.82	$881,613	99.4%	$5,512
Jan-20	4,155	$986,411	$237.40	$981,875	99.5%	$4,535
Dec-19	4,088	$1,346,557	$329.39	$1,343,780	99.8%	$2,777
Nov-19	4,090	$1,107,041	$270.67	$1,107,041	100.0%	$0
Oct-19	4,090	$1,327,335	$324.53	$1,327,335	100.0%	$0
Subtotal	49,426	$11,443,559	$231.53	$10,232,868	89.4%	$1,210,691
Prior						$0

Grand Total - Best Estimate **$1,210,691**

PriorityHealth

1231 East Beltline Ave. NE
Grand Rapids, MI 49525

616.942.0954
800.942.0954

priorityhealth.com

November 18, 2020

MDA Health Plan
3657 Okemos Road
Suite 100
Okemos, MI 48864-3927

RE: MDA Health Plan 2020 Stop Loss Policy

To whom it may concern,

Priority Health is currently providing specific and aggregate stop loss coverage for the MDA Health Plan membership for the contract period effective January 1, 2020 through December 31, 2020. This stop loss contract has been in place since the above effective date with no changes scheduled to the policy until the renewal period of January 1, 2021, and is paid to date.

Sincerely,

Shannon Dzyngel

Shannon Dzyngel
Director of Underwriting

MDA HP RESERVE INVESTMENTS - Comerica						
	Statement Balance on					
Account Number	Dec 31st, 2019	Mar 31st, 2020	Jun 30th, 2020	Sep 30th, 2020	Dec 31st, 2020	Change
Fixed Income	$9,611,327	$9,812,518	$9,953,724	$9,944,234	$9,984,118	$372,792
Fixed Income	$6,086,782	$6,283,805	$6,271,737	$6,299,601	$6,274,233	$187,451
Equities, Mutual Funds	$4,643,708	$3,700,278	$4,375,755	$4,745,044	$5,314,171	$670,463
TOTAL	$20,341,817	$19,796,601	$20,601,216	$20,988,879	$21,572,523	$1,230,706

PHILOSOPHY

- Current Philosophy
  - Maintain plans that are competitive for the majority of members
  - High utilizers pay more in their out-of-pocket expenses
  - Offer groups affordable rates and more specific plan design options through the current 12 plans (Family Focus & Living Fit)
  - Offer plan designs similar or slightly richer than the Blue Cross Blue Shield options to maintain a competitive advantage, e.g. 2021 out-of-pocket maximum for 2022
  - Monitor health care trends while maintaining affordability
  - Review Rx every 3 years for financial outcomes and performance
- Desired Outcome
  - Keep pace with health care trends via plan changes and management
  - Maintain competitive advantage against Blue Cross
  - Keep lower premiums by focusing on lifestyle plans and doing underwriting on groups entering the MEWA

WHAT MEWA DID FOR MEMBERSHIP IN 2020

- Rebated 50% of premiums for the month of April ($845,843)
- Rebated 25% of premiums for the month of May ($418,839)
- Covered COVID testing at 100% ($109,049)
- Updated the eligibility to accommodate lose of work
- Implemented a minor increase for 1/1/21 of 1.5%
- Added EAP program 8/1/2020 ($16,000)

December 22, 2020
Here is the information I received regarding the changes:
Yes, MDA will notice a few changes this year. First is that the report was issued by a different audit firm; BDO rather than Ernst & Young (EY). So the format and layout is slightly different. The most significant change is that the audit firm issued a qualified opinion over the following control objective:

- Control Objective 2 - Logical and Physical Access to Applications and Data: Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

What does this mean? MDA will see from BDO's opinion and the testing results section that our controls related to the timely removal of terminated users and periodic review of access removal were not consistently performed during the reporting period. As a result, controls were not operating effectively to achieve the logical access control objective. In response to the issues identified, management has provided responses in section V of the report. The responses indicate what was and/or is being done to address the issues identified.

Please let me know if you have other questions.
Kelly

Kelly Lahr
Key Account Manager

616.464.8358 (o)
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Priority Health Managed Benefits, Inc.

System and Organization Controls (SOC) 1 Type 2

Report on Priority Health Managed Benefits, Inc.'s Description of Its Medical and Pharmacy Claims Processing System and on the Suitability of the Design and Operating Effectiveness of Controls

Throughout the Period
November 1, 2019 to October 31, 2020

PriorityHealth

Contents

I. Independent Service Auditor's Report

Tel: 314-889-1100
Fax: 314-889-1101
www.bdo.com

101 South Hanley Road
Suite 800
St. Louis, MO 63105

Independent Service Auditor's Report

To the Management of
Priority Health Managed Benefits, Inc.
Grand Rapids, Michigan

Scope

We have examined Priority Health Managed Benefits, Inc.'s (Priority Health or service organization) description of its Medical and Pharmacy Claims Processing System entitled *Priority Health Managed Benefits, Inc.'s Description of Its Medical and Pharmacy Claims Processing System* for processing user entities' transactions throughout the period November 1, 2019 to October 31, 2020 (description), and the suitability of the design and operating effectiveness of controls included in the description to achieve the related control objectives stated in the description, based on the criteria identified in *Assertion of Priority Health Management* (assertion). The controls and control objectives included in the description are those that management of Priority Health believes are likely to be relevant to user entities' internal control over financial reporting, and the description does not include those aspects of the Medical and Pharmacy Claims Processing System that are not likely to be relevant to user entities' internal control over financial reporting.

The information included in Section V, *Other Information Provided by Priority Health Managed Benefits That Is Not Covered by the Independent Service Auditor's Report*, is presented by management of Priority Health to provide additional information and is not part of Priority Health's description of its Medical and Pharmacy Claims Processing System made available to user entities during the period November 1, 2019 to October 31, 2020. Information included in Section V has not been subjected to the procedures applied in the examination of the description of the Medical and Pharmacy Claims Processing System and of the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description of the Medical and Pharmacy Claims Processing System, and accordingly, we express no opinion on it.

Priority Health uses various subservice organizations to provide certain services. A list of these subservice organizations and the services performed is provided in Section III of this report. The description includes only the control objectives and related controls of Priority Health and excludes the control objectives and related controls of the subservice organizations. The description also indicates that certain control objectives specified by Priority Health can be achieved only if complementary subservice organization controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with the related controls at Priority Health. Our examination did not extend to controls of the subservice organizations and we have not evaluated the suitability of the design or operating effectiveness of such complementary subservice organization controls.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with related controls at the service organization. Our examination did not extend to such complementary user entity controls and we have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Service Organization's Responsibilities

In Section II, Priority Health has provided an assertion about the fairness of the presentation of the description and suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description. Priority Health is responsible for preparing the description and its assertion, including the completeness, accuracy and method of presentation of the description and the assertion; providing the services covered by the description; specifying the control objectives and stating them in the description; identifying the risks that threaten the achievement of the control objectives; selecting the criteria stated in the assertion; and designing, implementing and documenting controls that are suitably designed and operating effectively to achieve the related control objectives stated in the description.

Service Auditor's Responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description, based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether, in all material respects, based on the criteria in management's assertion, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description throughout the period November 1, 2019 to October 31, 2020. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

An examination of a description of a service organization's system and the suitability of the design and operating effectiveness of controls involves:

- performing procedures to obtain evidence about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description, based on the criteria in management's assertion.
- assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve the related control objectives stated in the description.
- testing the operating effectiveness of those controls that management considers necessary to provide reasonable assurance that the related control objectives stated in the description were achieved.
- evaluating the overall presentation of the description, suitability of the control objectives stated therein and suitability of the criteria specified by the service organization in its assertion.

Inherent Limitations

The description is prepared to meet the common needs of a broad range of user entities and their auditors who audit and report on user entities' financial statements and may not, therefore, include every aspect of the system that each individual user entity may consider important in its own particular environment. Because of their nature, controls at a service organization may not prevent, or detect and correct, all misstatements in processing or reporting transactions. Also, the projection to the future of any evaluation of the fairness of the presentation of the description, or conclusions about the suitability of the design or operating effectiveness of the controls to achieve the related control objectives, is subject to the risk that controls at a service organization may become ineffective.

Description of Tests of Controls

The specific controls tested and the nature, timing and results of those tests are listed in Section IV.

Basis for Qualification

Priority Health states in its description that it has controls in place to remove terminated access to programs, data and computer resources in a timely manner and to periodically review access removal. However, as noted in the description of test of controls and results thereof, controls related to the timely removal of terminated users and periodic review of access removal were not consistently performed throughout the period November 1, 2019 to October 31, 2020. As a result, controls were not operating effectively to achieve the logical access component of the control objective, *Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.*

Opinion

In our opinion, except for the matter in the preceding paragraph, in all material respects,

a. the description presents Priority Health's Medical and Pharmacy Claims Processing System that was designed and implemented throughout the period November 1, 2019 to October 31, 2020.

b. the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively throughout the period November 1, 2019 to October 31, 2020 and the subservice organizations and user entities applied the complementary controls assumed in the design of Priority Health's controls throughout the period November 1, 2019 to October 31, 2020.

c. the controls stated in the description operated effectively to provide reasonable assurance that the control objectives stated in the description were achieved throughout the period November 1, 2019 to October 31, 2020 if complementary subservice organization and user entity controls assumed in the design of Priority Health's controls operated effectively throughout the period November 1, 2019 to October 31, 2020.

Other Matter

The World Health Organization classified the COVID-19 outbreak as a pandemic in March 2020. Based on the rapid increase in exposure globally, the gravity or length of the impact of the COVID-19 outbreak cannot be estimated at this time.

Restricted Use

This report, including the description of tests of controls and results thereof in Section IV, is intended solely for the information and use of Priority Health, user entities of Priority Health's Medical and Pharmacy Claims Processing System during some or all of the period November 1, 2019 to October 31, 2020, and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities themselves, when assessing the risks of material misstatement of user entities' financial statements.

BDO USA, LLP

December 21, 2020

II. Assertion of Priority Health Managed Benefits, Inc. Management

PriorityHealth

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Assertion of Priority Health Managed Benefits, Inc. Management

We have prepared the description of Priority Health Managed Benefits, Inc.'s (Priority Health or service organization) Medical and Pharmacy Claims Processing System entitled *Priority Health Managed Benefits, Inc.'s Description of Its Medical and Pharmacy Claims Processing System* for processing user entities' transactions throughout the period November 1, 2019 to October 31, 2020 (description), for user entities of the system during some or all of the period November 1, 2019 to October 31, 2020 and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by the subservice organizations and user entities of the system themselves, when assessing the risks of material misstatement of user entities' financial statements.

Priority Health uses various subservice organizations to provide certain services. A list of these subservice organizations and the services performed is provided in Section III of this report. The description includes only the control objectives and related controls of Priority Health and excludes the control objectives and related controls of the subservice organizations. The description also indicates that certain control objectives specified by Priority Health can be achieved only if complementary subservice organization controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with the related controls at Priority Health. The description does not extend to controls of the subservice organizations.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with related controls at the service organization. The description does not extend to controls of the user entities.

We confirm, to the best of our knowledge and belief, that:

a. the description fairly presents the Medical and Pharmacy Claims Processing System made available to user entities of the system during some or all of the period November 1, 2019 to October 31, 2020, for processing their transactions as it relates to controls that are likely to be relevant to user entities' internal control over financial reporting. The criteria we used in making this assertion were that the description:

    i. presents how the system made available to user entities of the system was designed and implemented to process relevant user entity transactions, including, if applicable:

        (1) the types of services provided, including, as appropriate, the classes of transactions processed.

        (2) the procedures, within both automated and manual systems, by which those services are provided, including, as appropriate, procedures by which transactions are initiated, authorized, recorded, processed, corrected as necessary and transferred to the reports and other information prepared for user entities of the system.

        (3) the information used in the performance of the procedures, including, if applicable, related accounting records, whether electronic or manual, and supporting information involved in initiating, authorizing, recording, processing and reporting transactions; this includes the correction of incorrect information and how information is transferred to the reports and other information prepared for user entities.

        (4) how the system captures and addresses significant events and conditions other than transactions.

        (5) the process used to prepare reports and other information for user entities.

(6) services performed by a subservice organization, if any, including whether the inclusive method or the carve-out method has been used in relation to them.

(7) the specified control objectives and controls designed to achieve those objectives, including, as applicable, complementary user entity controls assumed in the design of the service organization's controls.

(8) other aspects of our control environment, risk assessment process, information and communications (including the related business processes), control activities and monitoring activities that are relevant to the services provided.

ii. includes relevant details of changes to the service organization's system during the period covered by the description.

iii. does not omit or distort information relevant to the service organization's system, while acknowledging that the description is prepared to meet the common needs of a broad range of user entities of the system and their user auditors, and may not, therefore, include every aspect of the system that each individual user entity of the system and its auditor may consider important in its own particular environment.

b. except for the effects of the matter described in the following paragraphs, the controls related to the control objectives stated in the description were suitably designed and operating effectively throughout the period November 1, 2019 to October 31, 2020 to achieve those control objectives if the subservice organizations and user entities applied the complementary controls assumed in the design of Priority Health's controls throughout the period November 1, 2019 to October 31, 2020. The criteria we used in making this assertion were that:

i. the risks that threaten the achievement of the control objectives stated in the description have been identified by management of the service organization.

ii. the controls identified in the description would, if operating effectively, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved.

iii. the controls were consistently applied as designed, including whether manual controls were applied by individuals who have the appropriate competence and authority.

Priority Health states in its description that it has controls in place to remove terminated access to programs, data and computer resources in a timely manner and to periodically review access removal. However, as noted in the description of test of controls and results thereof, controls related to the timely removal of terminated users and periodic review of access removal were not consistently performed throughout the period November 1, 2019 to October 31, 2020. As a result, controls were not operating effectively to achieve the logical access component of the control objective, *Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.*

Priority Health Managed Benefits, Inc.

December 21, 2020

III. Priority Health Managed Benefits, Inc.'s Description of Its Medical and Pharmacy Claims Processing System

Priority Health Managed Benefits, Inc.'s Description of Its Medical and Pharmacy Claims Processing System

Overview

This is a System and Organization Controls (SOC) 1 Type 2 report on Priority Health Managed Benefits, Inc.'s (Priority Health, service organization or Company) Medical and Pharmacy Claims Processing System for processing user entities' transactions throughout the period November 1, 2019 to October 31, 2020, which may be relevant to the internal control over financial reporting of user entities. The description has been prepared in accordance with the guidance contained in the American Institute of Certified Public Accountants' Statement on Standards for Attestation Engagements (SSAE) No. 18, specifically, AT-C section 320, *Reporting on an Examination of Controls at a Service Organization Relevant to User Entities' Internal Control Over Financial Reporting*.

Founded more than 30 years ago, Priority Health is the second-largest health plan in Michigan, servicing nearly one million members. Priority Health is a majority-owned subsidiary of Priority Health Managed Benefits, a wholly owned subsidiary of Spectrum Health System.

Services Provided

Priority Health Managed Benefits, Inc. provides contracted management and administrative services to Priority Health and its subsidiaries. Priority Health Managed Benefits is also a third-party administrator, supporting a variety of self-funded products, including medical, health reimbursement accounts, flexible spending accounts and dental. Priority Health offers a broad portfolio of health benefit options for employer groups and individuals, including fully funded commercial and administrative services only (ASO) and individual and government Medicare and Medicaid programs. Priority Health contracts with various health care providers to offer coverage for medical, hospital, pharmacy and other health care services throughout Michigan.

The scope of this report is limited to Priority Health Managed Benefits' third-party administrator services provided to self-funded employer groups. It does not include any other services provided by Priority Health Managed Benefits or any services provided by Priority Health.

Scope

This description addresses only Priority Health's Medical and Pharmacy Claims Processing System provided to user entities and excludes other services provided by Priority Health. The description is intended to provide information for user entities of the Medical and Pharmacy Claims Processing System and their independent auditors who audit and report on such user entities' financial statements, to be used in obtaining an understanding of the Medical and Pharmacy Claims Processing System and the controls over that system that are likely to be relevant to user entities' internal control over financial reporting. The description of the system includes certain business process controls and information technology general controls that support the delivery of Priority Health's Medical and Pharmacy Claims Processing System. The description does not encompass all aspects of the services provided or procedures followed for non-internal control over financial reporting activities performed at Priority Health.

The following applications are in scope for this report:

Application	Description	Operations Affected	Source Code Developed	Operating System	Database and Database Server
CES	Clinical editing software for medical claims	Claims	Vendor (Optum)	Windows	Oracle with Linux server
ECMPro	Interfaces with Facets for claims pricing	Claims	Vendor (Optum)	Windows	Oracle with Linux server
Electronic Data Interchange (EDI)	Process claims and enrollments received via EDI	Claims, enrollment	In-house	Windows	Oracle with Linux server
Facets	Administer and process medical claims	Claims, enrollment, group medical authorization, customer service, billing	Vendor (Trizetto)	Windows	Oracle with Linux server
Rate Manager	Interfaces with Facets for claims pricing	Claims	Vendor (Optum)	Windows	SQL with Windows server
Vital	Application used for patient authorization, disease management and utilization management NOTE: Effective September 14, 2020, Vital was replaced by Guiding Care, a third-party application hosted by Altruista Health. Refer to the 'Complementary Subservice Organization Controls (CSOCs)' section below for additional details.	Claims	Vendor (Change Healthcare)	Windows	Oracle with Linux server

The applications listed above are supported by the following tools:

- *Application Express (APEX)* – Internally developed tool used to process claims and enrollment data received via EDI
- *Business Objects* – Vendor-developed (SAP) reporting tool that pulls information from the database environment to support operations (e.g., monitoring claims aging)
- *OnBase* – Vendor-developed (Hyland Software) workflow tool used to support quality audits and medical authorization processes
- *RPX* – Internally developed tool that pulls information from the database environment to provide standardized reporting

Data housed in the database environments originates via interfaces and production applications (e.g. Facets) and is used for internal and external reporting and routine and ad hoc monitoring and analytics.

Internal Control Framework

This section provides information about the five interrelated components of internal control at Priority Health, including Priority Health's control environment, risk assessment process, monitoring activities, communication and information, and control activities.

Priority Health's internal control components include controls that may have a pervasive effect on the organization, specific processes, account balances, disclosures, classes of transactions or applications. Some of the components of internal control have more of an effect at the entity level, while other components are primarily related to specific processes or applications.

Control Environment

Management Philosophy

The control environment of Priority Health is influenced through the communication of several core organizational values that are intended to build employee awareness of overall goals, strategies and principles. The core values include (1) compassion, (2) collaboration, (3) curiosity and (4) courage. Highlighting these values to employees allows the organization to pursue its mission to improve health, inspire hope and save lives. Strategies and objectives adopted by executive management are based on the organization's mission and outlined annually in the organization's initiatives, which are communicated to employees.

Commitment to Integrity and Ethical Values

Priority Health has a formal Code of Excellence that obligates employees, providers, agents, contractors, consultants, students, vendors, suppliers and volunteers to maintain the highest ethical and legal standards in the conduct of the organization's business. The Code of Excellence is accessible via the Company's intranet and is accessible to third parties upon request. Personnel are required to read and accept the Code of Excellence, upon hire, and to formally reaffirm annually during continued training.

Prior to beginning work at Priority Health, all personnel undergo background screening against regulatory screening databases.

Corporate Governance

Priority Health entity has its own Board of Directors, which meets quarterly. The following committees of the Board of Directors are used to provide more specific oversight:

- *Finance and Audit Committee (FAC)* - provides oversight for the annual financial audit, internal audit activity, and financial performance and management functions.
- *Quality Integration Committee (QIC)* - provides oversight and final approval of the Compliance Program, which includes reviewing integration and continuous improvement in (1) the clinical quality of care and services delivered to Priority Health members; (2) the efficiency of clinical programs; and (3) compliance with laws, regulations, and good business and professional ethics.

In addition to the above committees, Information Services leadership provides periodic updates to the Board of Directors and shares content about the threat landscape and the Information Security Program's effectiveness and progress.

The authority and responsibilities of the Board of Directors and its designated committees are formally documented via bylaws or charters and they are reviewed periodically. The FAC is comprised of select individuals who are independent of management to provide oversight of internal controls. The FAC meets semi-annually to execute oversight of the Company's system of internal controls.

Organizational Structure and Responsibilities

Priority Health has implemented an organizational structure that details reporting lines and authorities that is available to the organization and updated as needed. Executive management and area/activity owners evaluate organizational structures regularly to align positions with the operational activities performed. Written job descriptions outlining roles and responsibilities are maintained.

Commitment to Attract, Develop and Retain

Hiring practices of Priority Health reflect the organization's commitment to hire and retain talented, qualified and ethical employees. Formal hiring policies are designed to confirm that individuals are hired based solely on their qualifications and ability to perform a given role.

Priority Health encourages continuous learning for personnel. Learning is achieved through on-site courses, off-site seminars and on-the-job training. Upon hire, and at least annually, employees and contractors are required to complete regulatory training that includes HIPAA security and privacy awareness. Failure to complete training is monitored by the Compliance Department and communicated to leadership.

In addition, the organization provides training programs covering strategic goals and objectives, specific organizational policies and procedures, and government regulations. Department management is responsible for identifying individual training needs and budgeting appropriately. Security members attend technical trainings on at least an annual basis to maintain or expand competencies.

Leaders are required to evaluate the performance of their employees at least once a year by calibrating with other leaders to obtain a full perspective on how well each individual performs essential job functions, achieves goals and expectations, and demonstrates behaviors aligned with Priority Health's values. A coaching and correction process is used as needed to facilitate team member performance improvement opportunities.

Accountability

Priority Health has established standards and guidelines in the Code of Excellence, which includes ethical behavior guidelines, reporting guidelines and a sanctions policy for personnel who violate the Code of Excellence. An anonymous third-party administered compliance hotline for internal users exists for reporting of incidents, concerns and complaints, which are monitored by the Compliance Department for resolution.

Risk Assessment Process

Priority Health has created a framework for an ongoing sustainable enterprise risk management (ERM) process aligned to the National Association of Insurance Commissioners' (NAIC) Own Risk and Solvency Assessment (ORSA) requirements. ERM is an internal process undertaken to assess the adequacy of Priority Health's risk management and current and prospective solvency positions under normal and severe stress scenarios.

Within this framework, Priority Health examines its complete portfolio of risks, considers how those risks interrelate and develops an appropriate risk mitigation approach and action plan to address high-risk areas in a manner that is consistent with the organization's long-term strategy and overall risk appetite. The following lower-level risk assessments act as inputs to the overarching ERM process:

- *Compliance Risk Assessment* - Compliance risks are assessed as part of the Compliance Program. The compliance risk assessment is facilitated by the Compliance Department and communicated to both the Compliance Committee and the QIC.
- *Operations Risk Assessment* - Operational risks are assessed as part of an annual risk assessment process for operational departments and for projects, events and factors spanning across multiple departments. Results and top risks and action plans are communicated to executive leadership for approval.
- *Finance Risk Assessment* - Financial risks are assessed as part of the recurring Model Audit Rule (MAR) audit and ERM process. Results of the MAR audit are communicated to executive leadership and the results of the ERM process are communicated to executive leadership and the Board of Directors.

- *Information Security Risk Assessment* – An annual information security risk assessment is performed to identify and evaluate significant risks to achieving organization objectives. Security risk assessments are communicated to the Priority Health ERM committee and IS Leadership. The assessment is facilitated by the Information Security Risk Team, under the direction of the CISO, and is designed to determine the current state of information security and provide recommendations for mitigation when vulnerabilities impacting risks are identified.

At least weekly, the Cyber Resilience and Response team summarizes threat intelligence updates outlining potential threats and distributes to Information Security management.

At least quarterly, the Privacy and Security teams meet to discuss changes in the industry and regulations to assess impact to the current environment.

Monitoring Activities

Internal Audit

Priority Health has an Internal Audit Department, lead by the Vice President of Internal Audit, which is independent of the management responsible for executing the controls. The Internal Audit Department develops an internal audit plan using a risk-based approach, which is approved by the FAC. The audit plan is revised annually to allow for changes in the risk environment, as noted through various organizational risk assessments, new or modified regulatory requirements, changes in the environment and coverage by other evaluation activities. The internal audit plan is focused on areas of high risk to the organization that are not covered through other recurring evaluations. Internal audit conducts activities in accordance with the approved audit plan. Internal audit personnel perform audit procedures using department guidelines, document their procedures and results in working papers, and prepare an audit report and the findings from those procedures.

Internal audit reports audit results to management and the FAC periodically. Internal Audit reviews management's status updates on open audit findings, focusing on those not completed by the original defined deadline, and follows up with responsible management to determine the cause of delay. Routine updates to the FAC include the status of management's remediation of open audit findings.

Monitoring of Subservice Organizations

Agreements are established with third parties and subcontractors that include clearly defined terms, conditions and responsibilities, as well as Priority Health's security commitments. Standard templates approved by Legal are used when contracting with third parties and subcontractors. Significant deviations from templates are reviewed with Legal prior to signing.

A vendor security risk management program has been instituted and includes the use of questionnaires over relevant critical vendors in order to assess risk that may be relevant to the internal system components. Prior to onboarding new vendors or services, Information Security Risk Management reviews the information collected from the questionnaires and assigns a risk level associated with the third-party services or software. Identified risks are assigned to vendor relationship owners.

Communication and Information

Internal Communication

Priority Health uses multiple communication channels to help provide timely employee awareness of organizational perspectives, events and performance. These channels can be categorized according to the audience to whom information is disseminated and include employees, management and executive leadership.

The Company intranet is used to provide communications regarding issues affecting the organization and access to organizational policies for all employees. Descriptions of key applications and supporting tools are posted on the entity's intranet and are available to the entity's internal users. This description delineates the boundaries of the system and key aspects of processing. Information Security policies are established, documented and maintained and reviewed periodically.

The organization's strategies are outlined in the company's strategic initiatives and communicated to all personnel during all staff meetings at least semi-annually. At least annually, Information Services personnel hold a meeting to address departmental initiatives impacting organizational goals and objectives.

Departmental and direct report meetings facilitated by managers allow information specific to business departments or individuals to be shared. Major changes to roles and responsibilities of key personnel are also communicated to affected personnel through email communications.

External Communication

External communications with members, providers, employers and agents are important and vary based on each group's needs and the type of information being disseminated. One form of communication consistent across parties is the Company website, priorityhealth.com. The Privacy Policy and Terms of Use descriptions are available on the Priority Health website and include information on policies and procedures used to protect Protected Health Information (PHI). The Company website also serves as a means to communicate the compliance hotline to external users. An anonymous third-party administered compliance hotline for external users exists to submit grievances and appeals, report fraud and abuse, and submit general inquiries and complaints around site security and accessibility, which are monitored by the Compliance Department for resolution.

Email communications are primarily used when communicating with external parties about updates to tools and applications. Marketing communicates changes and end user impact to provider and employer group portal users.

Agreements are established with vendors that include clearly defined terms, conditions, responsibilities and security commitments.

Control Objectives and Related Control Activities

The service organization has developed a variety of policies and procedures, including related control activities, to help ensure that the service organization's objectives are carried out and that

risks are mitigated. These control activities help ensure that services are administered in accordance with the service organization's policies and procedures.

Control activities are performed at a variety of levels throughout the organization and at various stages during the relevant business process. Controls may be preventive or detective in nature and may encompass a range of manual and automated controls, including authorizations, reconciliation and IT controls. Duties and responsibilities are allocated among personnel to ensure that a proper segregation of duties is maintained.

Priority Health has specified the control objectives and identified the controls that are designed to achieve the related control objectives. The specified control objectives and related controls are an integral component of the service organization's description of its Medical and Pharmacy Claims Processing System.

Numerical cross-references are used to reference controls in Section III to the related control and testing in Section IV.

Claims administration is the process by which a member's insurance benefits are applied to a claim to determine appropriate payment. In order for a claim (medical or pharmacy) to adjudicate properly, the following must be set up within the system: a provider network with a pre-established pricing agreement, benefit plans, group demographics and a member. Upon claim submission, certain services require further investigation by a Claims Examiner and/or review for medical necessity before the claim can adjudicate. The following represents the key processes and data sets required for a claim to adjudicate in accordance with the member's benefits, including the supporting information systems controls environment.

Control Objective 1 - Application Change Management
Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved and implemented.

To confirm that changes to existing databases and applications are authorized, tested, documented and approved prior to implementation, formal system development and change management policies are maintained. These policies include the necessary change management processes to deliver and manage the integration of processes, procedures, and technologies and to produce the desired deliverables. The change control process implemented at Priority Health is used to manage all changes, including the following types of changes relevant to the scope of this report:

- Vendor application upgrades and patches
- Custom code changes to applications and tools developed in-house
- OnBase workflow changes
- Database upgrades, patches and configuration changes

The Vendor Application Administration (VAA) team monitors the release of Business Objects, CES, ECM Pro, Facets, OnBase, Rate Manager and Vital patches by the vendor, and Infrastructure Services monitors the release of database security patches. Custom code changes to applications and tools

developed in-house and OnBase workflow changes are identified through normal business processes, system issues or strategic plans by business users. While APEX and RPX changes are subject to the same change management controls, the impact is limited to reports that support the claims administration process.

Once a change is identified, the relevant business user, developer or Information Service-related personnel initiates a change request within a service desk ticket. The ticketing system is used to manage the workflow of the respective change request, including approval gathering and notifications to responsible parties.

Database and application changes are tested in accordance with change management policies and procedures (1.1). A testing strategy is developed for significant application and database changes, which may include unit, system, integration and user acceptance testing, as appropriate for the type of change. During system implementations or upgrades involving data conversion or migration, appropriate testing is performed to verify the accuracy of data prior to go-live. For custom developed or modified code, the developer performs unit testing in the development environment.

Database and application changes are reviewed by responsible management in accordance with change management policies and procedures (1.2). This review step is recorded within the service desk ticket to authorize the change. The sponsor authorizing the change must either be the change requester's manager or a delegate provided by the change requester's manger.

Once the appropriate manager has authorized the change, it is forwarded to the relevant Information Systems Change Advisory Board (CAB) for approval. Database and application changes are approved for implementation in accordance with change management policies and procedures (1.3). Lower-risk changes (as identified by the requester and authorized by the sponsor) are reviewed daily by the Service CAB, which includes IS Service Operations, IS Service Assurance and the PAST (PH Production Application Support team). Higher-risk changes are reviewed weekly by the Enterprise CAB, which includes the Service CAB, along with Information Security and Enterprise Architecture. After the review of the change, the Enterprise CAB will approve the change for implementation and a delegate will submit the approval within CA Service Desk on behalf of the Enterprise CAB. Once the change request is approved by the CAB, it is scheduled for implementation.

The implementation process is managed and documented through the use of the ticketing system, along with the necessary documentation regarding the testing and rollout process. Changes are migrated into production either manually or systematically via CoPilot (in-house developed migration tool) or Bamboo (migration tool purchased from Atlassian). The ability to promote changes into production is limited to authorized individuals based on business need (1.4).

- Vendor application patches and OnBase workflow changes are migrated manually by the VAA team.
- Database updates, patches and configuration changes are manually migrated by Infrastructure Services.
- Custom code changes to applications and tools developed in-house are migrated through the use of CoPilot or Bamboo, which logs the activity and provides a mechanism for reversing a change if necessary.

Separate environments are used for development, testing and production (1.5). Custom code changes to applications and tools developed in-house are coded using the version control software SVN (Subversion) as well as Bitbucket/Stash (tools purchased from Atlassian). Bitbucket/Stash tracks the user, date, and time and the changes made each time an object is checked in or out of the software.

Certain authorized individuals have access to both the development and production environments based on business need. In order to help ensure all custom code changes are authorized, tested, documented and approved, PH has implemented the following compensating control. All custom code changes to applications developed in-house are reviewed each month by the PAST to ensure the appropriate change process was followed (1.6).

The process for emergency changes is similar to the process described for standard program changes with the exception that, due to the criticality of the change, the documentation and approvals can be completed prior to or after the change is implemented.

Control Objective 2 - Logical and Physical Access to Applications and Data
Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

To prevent individuals from gaining unauthorized logical and physical access to programs and data, Information Services policies and procedures are documented and maintained. The Primary Information Security Policy and Information Security Program Policy provide direction for security-related issues and are available to employees via the Company intranet.

User Access Administration Procedures

Requests for new user accounts and changes to existing user accounts for internal applications and infrastructure are initiated through a provisioning tool. Management and/or the appropriate application or data owner approve the addition of new users and changes to existing user access rights within in-scope applications (2.1). Once the request is approved, the associated tasks are automatically generated and managed through the provisioning tool.

Requests to remove employee or contractor access as the result of terminations or transfers are initiated by the terminating or transferring manager or Human Resources (HR) through the creation of a provisioning tool request. The associated tasks are generated in the provisioning tool and assigned to the administrators for logical security as a result of the request. A user's Active Directory (AD) account is locked or deleted upon notification of the user's termination, as outlined in the Separation from Employment policy (2.2). A user's access is revoked from in-scope applications upon notification of the user's termination, as outlined in the Separation from Employment policy (2.3). Management reviews terminated accounts to determine that, in instances of untimely removal from the network, access remained unused (2.4).

User Authentication

Prior to authenticating to specific applications, users must be authenticated through AD in order to access the Priority Health production applications and systems:

- EDI and CES users are set up with local accounts that are authenticated through the global AD Password Policy.
- Facets users are required to log in to an AD-authenticated Citrix portal before accessing the application.
- OnBase, ECM Pro, Rate Manager and Vital are authenticated through AD using single sign on (SSO).

Users are required to enter a valid username and password to access IS resources. Password complexity, minimum length, expiration, reuse and account lockout are systematically enforced and aligned with the requirements of the password standards (2.5). For privileged generic and service accounts, a Privileged Access Management (PAM) tool is used to manage the rotation of these accounts (expiration) and supplement Active Directory settings with computer generated passwords that are randomly generated (complexity and reuse) at a length that exceeds the Active Directory setting for those group policies (2.6).

User Access Reviews

Administrative access to in-scope applications and their supporting infrastructure is reviewed periodically to validate access is limited to authorized individuals based on business need (2.7)

The IS team reviews security rights annually to validate that users' Oracle access privileges are appropriate (2.8). Oracle role ownership is confirmed at the start of the review. Role owners review and validate that both the access rights and the individuals assigned to each role are appropriate.

Information Services coordinates reviews of security rights within Facets. The reviews include the following components:

- Annually, application owners review and validate that the rights associated within their application assigned to each security group are appropriate (2.9).
- Annually, security group owners review and validate that users are assigned to the appropriate security group (2.10).

Changes identified during these user access reviews are made following the user access administration process.

Pharmacy Benefit Manager (PBM) Application Access

Priority Health's employee access to the PBM's (ESI) application is requested through the Pharmacy Operations department (Pharmacy). Upon receipt, Pharmacy sends the request for access to the PBM for administration. Semiannually, Pharmacy reviews a list of users with access to the PBM's application and communicates any necessary modifications to the PBM for correction (2.11).

Physical Access

Priority Health operates its information systems out of two data center locations within the greater Grand Rapids area. Access to Information Services' critical environments is granted only when there is an identified business need. This includes a limited number of individuals within Information Services; Facilities, Services and Planning (FSP); Real Estate; and Security Operations. Data center access is controlled by ID card-based systems, or by granting physical access remotely by authorized personnel in the network operations center (NOC) (2.12). Visitors to the data center are escorted by authorized personnel and registered upon entering and leaving. Personnel who need to access the data center must complete a change request form detailing the reason access is required. Approval is provided by the NOC.

Access to Priority Health facilities is controlled by ID card-based systems (2.13).

Card key access to the data centers is reviewed quarterly to validate that individuals with access are appropriate (2.14). Findings of inappropriate access are investigated and changes are made following the user access administration process.

Control Objective 3 - Computer Operations
Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled appropriately and deviations are identified and resolved.

Job Scheduling

Priority Health uses the Master Job Scheduler (MJS), an in-house-developed job scheduling tool, for regularly scheduled core operational jobs, including claims adjudication, enrollment file processing and Facets interfaces. Job processes are systematically logged at end-of-job completion, and errors are investigated and resolved as appropriate (3.1). Tickets are created and initially assigned to Customer Support for resolution. Customer Support follows a predefined process and instructions to restart failed jobs and, in the event that a job is unable to be restarted, assigns the ticket to appropriate support personnel for resolution based on documented procedures.

Access to the MJS is administered according to job function, specifically those whose job responsibilities include schedule administration. Access to the automated and non-routine job scheduling tool is reviewed quarterly, and individuals with inappropriate access are removed (3.2).

Backups

The scheduling and running of backup jobs vary by system, in accordance with predefined policies and procedures. Backup software is configured to automatically perform database backups in accordance with the backup schedule and if scheduled backups fail, the appropriate team receives automatic notifications. Processing errors are investigated and resolved as appropriate (3.3). When a backup fails for more than two consecutive days, a ticket is created to track resolution of the issue in accordance with established policies.

Access to create, modify or delete schedules within the backup software is limited to authorized personnel with job responsibilities that require such access (3.4).

Data Integrity Validations

As records are updated within Facets, they are written to a Transaction Log within the source database. A series of jobs are scheduled to automatically replicate the information in the Transaction Log to the Priority Health database. A series of jobs are also scheduled to automatically replicate data between tables in the Priority Health database. Nightly data integrity checks for automated jobs are performed on key tables within the Priority Health database to verify the completeness and accuracy of data housed in the data store database back to the source. Any integrity issues are investigated and resolved as appropriate (3.5). Quarterly, database comparisons are performed to verify the completeness and accuracy of data within the Priority Health database back to the Facets application sources, and errors are investigated and resolved as appropriate (3.6). Information Services investigates and resolves errors identified during the nightly and quarterly integrity checks.

Control Objective 4 - Provider Setup and Maintenance
Controls provide reasonable assurance that changes made to provider and pricing data affecting medical claims processing are made in a complete, accurate and timely manner.

Key demographic information (e.g., address information, tax identification number, name change) is set up in Facets by Provider Credentialing and data management and pricing information is set up in Facets by Provider Reimbursement (PR). Ten percent (10%) of new participating provider setups and pricing setups are reviewed on a weekly basis in detail through quality review by someone independent of the setup (4.1). Two percent (2%) of new non-participating provider and modified provider configuration records are also reviewed on a weekly basis in detail through quality reviews by someone independent of the change (4.2). If information in Facets does not agree to source documentation, the necessary corrections are made. Pricing configuration setups (new and modified fee agreements) entered into Facets are audited to the original contract and request form (4.3). As errors are identified, the individual responsible for entering the agreement or fee schedule information is notified, and necessary corrections are made.

The amount a provider is paid for billed procedures and services depends on the fee agreement to which they are attached. A fee agreement comprises fee schedules, which are a group of procedure codes, and related services with payment amounts defined as a percentage of billed charges, flat rates or maximum allowable amounts. Provider Reimbursement Fee Agreement team (PRFA) prepares fee schedule and fee agreement documentation for input into Facets based on existing policies and procedures and information provided by Provider Contracting. Fee schedules can either be uploaded into Facets in a batch or sent to the Provider Reimbursement Contract Analyst (PRCA) for manual entry. PRFA sends batch fee schedule changes to Information Services for upload. Then, new and modified fee schedules uploaded by Information Services are independently reviewed in detail through quality reviews and identified errors are resolved (4.4).

Monthly, PR performs quality reviews over a defined sample of claims to determine if they are paying according to the terms specified with in the provider contract (4.5). As errors are identified, the appropriate department is notified, and incorrect/incomplete data is modified. The quality audit also has the opportunity to identify if changes to the provider or pricing record were made by an unauthorized individual.

Control Objective 5 – Group and Benefit Administration
Controls provide reasonable assurance that changes made to group and benefit data affecting medical claims processing are complete and accurate.

Group and benefit setup begins with the sale or renewal of a benefit plan. Once a sale or renewal is made, Sales and/or Legal provides Group Administration with standard group and product documentation as outlined in policies and procedures, which is subsequently uploaded or scanned into OnBase and then indexed by Sales and/or Group Administration. Data is then provided to Group Administration via the workflow tool in OnBase, a feature that routes documentation (e.g., enrollment, group) to appropriate departments for processing and tracks completion. Group Administration enters group information into Facets, and Product Configuration enters benefit information.

Group Administration enters group demographic and billing-related information received from Sales to facilitate administration of the plan. New and modified self-funded groups in Facets are then reviewed on a daily basis by someone independent of the change and identified errors are corrected (5.1).

Group plan selection involves identifying the services covered (e.g., medical, pharmacy) and coverage amounts (e.g., co-pays, deductibles) that will be offered by the employer. Product Configuration is then responsible for building those benefits so Group Administration can attach them to the group. New and modified benefit setups are reviewed by someone independent of the change and identified errors are corrected (5.2).

Both reviews consist of pulling the source documentation obtained from Sales to determine whether the group and benefit records in Facets are complete and accurate.

Group Administration has defined which individuals outside of Group Administration and Product Configuration departments are authorized to update group and benefit information within Facets. A defined percentage of product and group updates made by individuals outside of the Group Administration and Product Configuration departments are reviewed by a Quality Auditor on a monthly basis to verify the individuals who updated the group and benefit information within Facets was authorized to do so and the change made was appropriate (5.3). If transactions performed by unauthorized users are discovered during the quality audit, it is researched, and appropriate action is taken based on findings. Results are reported to department management.

Control Objective 6 – Member Enrollment
Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Enrollment information is received either manually (e.g., mail, fax, email, customer service inquiry) or electronically via EDI and Priority Health's secure file transfer protocol (SFTP) server.

Enrollment forms received manually are scanned into OnBase and indexed by Enrollment. Once this process is complete, the forms are added to the Enrollment workflow and manually keyed into Facets by an Enrollment Specialist and ultimately subjected to the quality audit audits described below. Procedures and job aids exist to outline the appropriate setup of enrollment records in the system.

Enrollment files received through the SFTP server are scanned for malicious content and moved to the EDI processor. Enrollment transactions received through EDI are subject to edits and validations for proper format, content and completeness throughout EDI processing (6.1). Enrollment information received through the EDI processor and passing certain edit/validation checks is automatically loaded into Facets. File processing is initiated once the enrollment information has been loaded into Facets.

EDI enrollment transactions resulting in errors or warnings during the EDI edits process are either suspended and automatically listed on an EDI service receipt sent to the Enrollment team for correction or rejected back to the submitter within two business days if the entire file fails the edits (6.2). Upon receiving the EDI service receipt, the Enrollment Specialist responsible for the group generates an EDI Edits Report out of RPX, reviews the errors and warnings identified, and resolves errors and warnings based on policy and procedure documentation.

A defined percentage of new or modified enrollment transactions are reviewed by auditors in quality operations a daily basis who are independent of the person making the change and identified errors are corrected (6.3). Volumes and frequency of reviews are indicated within established policies and procedures.

Enrollment management has defined which individuals outside of the Enrollment department are authorized to update enrollment information within Facets. A defined percentage of enrollment updates made by individuals outside the Enrollment department are reviewed by a Quality Auditor on a monthly basis to verify the individuals who updated the enrollment information within Facets was authorized to do so and the change made was appropriate (6.4). If transactions performed by unauthorized users are discovered during the quality audit, it is researched, and appropriate action is taken based on findings. Results are reported to department management.

Control Objective 7 – Claims Administration
Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Medical Claims Processing

Claims are loaded into Facets either electronically through the EDI process or manually by a Claims Examiner. Standard paper claims, which account for a very small percentage of total claims, are gathered by the Document Control Center (DCC) and Claims Services and are physically sent on a daily basis to a third-party vendor, Banctec, for optical character recognition (OCR) scanning. Banctec scans standard paper claims and, upon successfully completing OCR, transmits claims information back to Priority Health for loading into Facets via EDI. Nonstandard forms are scanned directly into OnBase by the DCC team and manually entered into Facets by Claims Services.

Incoming claim files loaded into Facets via the EDI process follow a similar process as enrollment files documented above and are subject to the following controls:

- Claim transactions are subject to edits and validations for proper format, content and completeness throughout EDI processing (7.1). Possible edits that may need to take place include claim lines missing the units, end dates that are either not present or are invalid, and missing diagnosis codes.

- Logic within EDI is configured to identify claims eligible for repricing and to send those claims to the appropriate repricing vendor (7.2).

Upon completion of the edit and validation process, a summary of EDI claims received from providers, including details regarding the claims EDI edits, is sent to the submitter(s).

New medical claims are subject to the following automated processes, which may result in a claim pending for additional review:

- Claims are evaluated for the possibility of duplication within Facets. A claim submission where a previous claim has been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code and provider ID is considered a definite duplicate and automatically denied by Facets. A claim submission where a previous claim has been submitted for the member with a combination of same date of service, charge amount, procedural code and/or revenue code is considered a potential duplicate and pended for further review by a Claims Examiner (7.3).
- During the adjudication process, Facets is configured to verify and process claims sequentially against predefined checkpoint rules to validate eligibility, provider, diagnostic and procedure codes, and coordination of benefits (COB), to pend claims for third-party liability cases, and to determine the appropriate contract fee schedules, deductibles and co-payments (7.4).
- Facets is also configured to flag a claim for authorization or medical necessity review during the adjudication process. The Medical Management department reviews claims flagged by Facets for authorization and/or medical necessity review and dispositions each based on written procedures and medical policy (7.5).
- Logic within CES is configured to identify claims for potential up-coding and fee unbundling and Facets uses code review software to identify claims with potential up-coding and fee unbundling (7.6). The Code Review department reviews potential up-coded and fee unbundled claims flagged by Facets for clinical edit accuracy (7.7).

The ability to process claims is limited to authorized personnel and is based on dollar limit thresholds. Access to process claims and the assigned dollar limit thresholds is part of the standard user administration.

Procedures and tools exist to help identify and investigate potential subrogation and third-party liability (TPL) cases based on predefined diagnosis codes. Once a potential case is identified, the claim is pended and reviewed by the Third-Party Liability Services (TPLS) team. The TPLS team determines whether the claim should be paid or denied and updates Facets accordingly. Once subrogation cases are closed, funds are returned to the self-funded group in accordance with the negotiated settlement and documented in the subrogation case file (7.8)

Claims Services personnel use the Inventory Management Policy to define expectations for timely claims inventory management. Management uses system-generated claim aging and turnaround time reports to monitor claims processing for compliance with the policy (7.9). Management also uses a dashboard to monitor claims inventory.

Once a claim is paid, additional information may become available that would have altered the amount a claim would have paid. Claims requiring adjustment as a result of provider, pricing, group or benefit changes are tracked in the Configuration Log. Claims are appropriately investigated and adjusted as a result of items added to the Configuration Log (7.10). When the original claim is adjusted in Facets based on the additional information, it is reprocessed and subjected to the same processing controls as a new claim. An adjustment typically results in either an overpayment or underpayment of the original claim. When an underpayment occurs, the difference is paid to the provider through the normal claims adjudication process. When an overpayment occurs, Facets is configured to deduct (auto-recover) up to a defined threshold amount from the provider's next payment or send overpayment request letters to the provider (7.12).

Claims requiring adjustment as a result of claim costs exceeding the member's deductible or out-of-pocket limit are identified through a daily automated report. Each claim is investigated, and the appropriate adjustments are made in Facets (7.11).

Claims Services provides new examiner and ongoing training programs to educate Claims Services personnel on proper procedures and system usage through audit types below:

- *Trainee* - Training programs are designed specifically by level for Claims Services personnel and are required to be taken in progression. Training is targeted at new hires and Claims Services personnel who require a refresher course. After training has occurred, the Claims Examiner is subject to a 100% audit of claims processed. Once the examiner reaches the desired performance results, the percentage of claims audited is gradually lowered through manager approval, until the percentage reaches the standard audit threshold.
- *Focused* - When an examiner who has knowledge of processing has been trained on a new task or retained on a specific subject or pend code, a focused audit may be performed. The percentage is determined by management, and time frames may vary based on experience.
- *Subject* - A subject audit is performed based on management request. Target areas include but are not limited to a person, job title, provider group, provider type, type of bill, type of service, dollar amount, employer group, type of business category, etc. Management determines the percentage and frequency.
- *Standard Claims Quality Audit* - Upon completion of training courses and the corresponding training audits, Claims Examiners are subject to the standard random claims quality audit.
    - From November 1, 2019 through October 16, 2020: Two percent (2%) of claims processed with human intervention are audited by someone independent of the claims processor and any audit findings were resolved (7.13).
    - Beginning October 17, 2020: One percent (1%) of claims processed with human intervention are audited by someone independent of the claim processor and any audit findings were resolved (7.14).

Deductible and Stop-Loss Notification

Group agreements define the specific and aggregate stop-loss amounts along with the group's chosen reinsurance carrier. Twice a month, OnBase automatically identifies cases where a self-funded group's total paid claims have reached 50% of the deductible amount or exceeded the stop-

loss amount at either a specific (individual) or aggregate (group) level. Notification is sent to the reinsurance carrier when a case reaches 50% of a specific deductible amount. The Claims department submits cases with claims exceeding the stop-loss amount to the appropriate reinsurance carrier (7.15).

Segregation of Duties

Information Services coordinates reviews of security rights within Facets. Quarterly, Claims leadership reviews the security rights for key business functions to validate proper segregation of duties is maintained and any individuals with conflicting access will either be removed or accepted by the business (7.16).

Control Objective 8 - Pharmacy Administration
Controls provide reasonable assurance that product, group, member and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

The pharmacy benefits manager (PBM), ESI, pays claims based on formulary, group, benefit and enrollment data provided by Priority Health. Changes to the Priority Health prescription drug formulary originate from Pharmacy and Therapeutics Committee (PTC) decisions and policies. The Pharmacy team completes documentation based on PTC decisions and policies and sends the completed request to the PBM Account Management team. To determine whether the change request is accurate prior to being sent to ESI for setup within its system, formulary changes are independently reviewed, and any errors identified are corrected before being submitted (8.1). The review includes comparing the completed change form to the original change request or PTC policy.

A daily scheduled job automatically extracts member information added or changed within Facets within the last day and sends it to the PBM. The PBM then sends reports detailing the total of updated, changed and rejected member records. Daily, Pharmacy reviews commercial group and member error reports received from the PBM. Any errors are investigated and corrected by the appropriate department (8.2).

A daily job automatically pulls group information from Facets and a designee from Group Administration submits the report via e-mail to the PBM for loading into its system. Benefit information submitted to the PBM is monitored within the Global Log by Pharmacy so requests are processed by the PBM promptly. The PBM notifies Pharmacy once a benefit build is complete. Daily, a defined percentage of new and modified pharmacy benefits sent to the PBM are audited by someone independent of the change and identified errors are corrected (8.3). The review includes comparing the benefit information communicated to ESI to the source documentation used by Product Configuration to complete the benefit build or change request.

Certain services outlined in the formulary also require a review for medical necessity and appropriateness before claims can be submitted and paid. Approvals and denials completed by a pharmacist or pharmacy coordinator are reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order before they are finalized (8.4).

At the end of each financial cycle defined by the PBM, Priority Health is provided a data file containing claim detail and an invoice (Summary Reports), which gives the total dollar amount of

pharmacy claims paid by line of business. Weekly, a Medical Cost Analyst reconciles the pharmacy claims data to the invoice received from the PBM, and differences are resolved as appropriate (8.5).

Complementary Subservice Organization Controls (CSOCs)

A list of the subservice organization in scope and the services performed is provided in the table below:

Subservice Organization	Services Performed
Altruista Health	Provides a cloud-based application, Guiding Care, used for patient authorization, disease management and utilization management.
Cigna	Prices claims for members who utilize national access to a commercial provider network. Claims are then sent back to Priority Health through EDI.
ESI	Provides pharmacy claims administration services, including hosting and maintaining the application used to process PBM claims.
PHCS/Multiplan	Provides medical claims repricing services. Repriced claims are then sent back to Priority Health through EDI.

Priority Health's controls relating to its Medical and Pharmacy Claims Processing System cover only a portion of the overall internal control for each user entity of Priority Health. It is not feasible for the control objectives relating to the Medical and Pharmacy Claims Processing System to be solely achieved by Priority Health. Certain control objectives specified in the description can be achieved only if CSOCs contemplated in the design of Priority Health's controls are suitably designed and operating effectively, along with controls at Priority Health. Therefore, each user entity's internal control over financial reporting should be evaluated in conjunction with Priority Health's controls and the related tests and results described in this report, taking into account the related CSOCs expected to be implemented and operating effectively at the subservices organizations, as described below.

Number	CSOCs	Applicable Control Objective
Cigna and PHCS/Multiplan		
1.	Controls provide reasonable assurance that changes to applications, databases and operating systems are authorized, tested and approved prior to implementation.	CO1
2.	Controls provide reasonable assurance that logical access to applications, databases and operating systems is restricted to authorized individuals.	CO2
3.	Controls provide reasonable assurance that system processing is scheduled and authorized and processing issues are identified and resolved in a timely manner.	CO3

Number	CSOCs	Applicable Control Objective
4.	Controls provide reasonable assurance that new clients and client updates with financial impact are set up accurately and with authorized approval prior to implementation in production.	CO4
5.	Controls provide reasonable assurance that new providers and provider demographic changes are set up accurately and with authorized approval prior to implementation in production.	CO4
6.	Controls provide reasonable assurance that rate sheet, fee schedule and repricing data are accurately set up, tested and approved prior to being placed into production.	CO4
7.	Controls provide reasonable assurance that claims are repriced in a timely manner, accurately and against the right provider.	CO4
ESI and Altruista Health		
1.	Controls provide reasonable assurance that changes to existing applications are authorized, tested, approved, implemented and documented, in accordance with management's policies.	CO1
2.	Controls provide reasonable assurance that physical access to computer equipment is limited to properly authorized individuals.	CO2
3.	Controls provide reasonable assurance that logical access to system resources (e.g., programs, data and parameters) is restricted to properly authorized individuals.	CO2
ESI		
1.	Controls provide reasonable assurance that processing is scheduled appropriately and deviations are identified and resolved.	CO3
2.	Controls provide reasonable assurance that member enrollment information is created and maintained based on proper authorization and is recorded in the system completely and accurately.	CO4
3.	Controls provide reasonable assurance that claims billing transactions are valid and are processed completely, accurately and only once.	CO7
4.	Controls provide reasonable assurance that benefit plan specifications, additions or changes are documented, approved and entered for processing completely and accurately.	CO8
5.	Controls provide reasonable assurance that changes or additions to the Integrated Drug Master File and Formulary Rules Station are authorized and entered for processing completely and accurately.	CO8
6.	Controls provide reasonable assurance that pharmacy information is created and maintained based on proper authorization and is recorded in the system completely and accurately.	CO8

Number	CSOCs	Applicable Control Objective
7.	Controls provide reasonable assurance that pharmacy claims transactions are valid and are processed completely, accurately and only once.	CO8

Complementary User Entity Controls (CUECs)

Priority Health's controls relating to its Medical and Pharmacy Claims Processing System cover only a portion of the overall internal control for each user entity of Priority Health. It is not feasible for the control objectives relating to the Medical and Pharmacy Claims Processing System to be solely achieved by Priority Health. Certain control objectives specified in the description can be achieved only if CUECs contemplated in the design of Priority Health's controls are suitably designed and operating effectively, along with controls at Priority Health. Therefore, each user entity's internal control over financial reporting should be evaluated in conjunction with Priority Health's controls and the related tests and results described in this report, taking into account the related CUECs identified below, where applicable. In order for user entities to rely on the controls reporting herein, each user entity must evaluate its own internal control to determine whether identified CUECs have been implemented and are operating effectively.

Number	CUECs	Applicable Control Objective
1.	User entities are responsible for reconciling submission of group transactions and enrollment transactions communicated to Priority Health with receipts of group transactions and enrollment transactions processed by Priority Health.	CO5, CO6
2.	User entities are responsible for assuring that group data and enrollment data input directly by personnel of the user organization is controlled, authorized, confirmed and validated to help ensure the accuracy of claims processing and master file information.	CO5, CO6
3.	User entities are responsible for reviewing and reconciling the claims output reports for completeness and accuracy.	CO5, CO7, CO8
4.	User entities are responsible for reviewing funding requests and reconciling the information to the organization's bank information.	CO7

IV. Description of Control Objectives and Related Controls, and Independent Service Auditor's Tests of Controls and Results of Tests

Description of Control Objectives and Related Controls, and Independent Service Auditor's Tests of Controls and Results of Tests

This report, when combined with an understanding of the controls at user entities, is intended to assist auditors in planning the audit of user entities' financial statements or user entities' internal control over financial reporting and in assessing control risk for assertions in user entities' financial statements that may be affected by controls at Priority Health Managed Benefits, Inc. (Priority Health). The examination was performed in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements No. 18, specifically, AT-C section 320, *Reporting on an Examination of Controls at a Service Organization Relevant to User Entities' Internal Control Over Financial Reporting*.

Our examination was limited to the control objectives and related controls specified by Priority Health in Section IV of this report and did not encompass all aspects of the services provided or controls of Priority Health or extend to controls performed by user entities. Unique processes or control situations not described in the report are outside the scope of this report.

The scope of the examination included tests of the operating effectiveness of controls over Priority Health's Medical and Pharmacy Claims Processing System, including controls related to changes to Medical and Pharmacy Claims Processing System applications, but did not include tests related to the functioning of or calculations performed by the software used in the delivery of the system or of reports generated by the software.

It is the responsibility of each user entity and its independent auditor to evaluate this information in conjunction with the evaluation of internal control over financial reporting at the user entity in order to assess the total internal control. If internal control is not effective at user entities, Priority Health's controls may not compensate for such weaknesses.

Priority Health's internal control represents the collective effect of various factors on establishing or enhancing the effectiveness of the controls specified by Priority Health. In planning the nature, timing and extent of our testing of the controls to achieve the control objectives specified by Priority Health, we considered aspects of Priority Health's control environment, risk assessment process, monitoring activities and information and communications.

Tests of Controls

Our testing of controls was restricted to the controls specified by Priority Health and was not extended to controls performed by user entities or other controls that were not documented as tested under each control objective listed in this section of the report.

The description of tests of controls and results of those tests are presented in this section of the report and are the responsibility of BDO USA, LLP, the service auditor. The description of control objectives, the related controls and the complementary subservice and user entity controls to achieve the objectives have been specified by, and are the responsibility of, Priority Health.

The basis for all tests of operating effectiveness includes inquiry of the individual(s) responsible for the control. As part of our testing of each control, we inquired of the individual(s) to determine the

fairness of the description of the controls and to evaluate the design and implementation of the control. As part of inquiries, we also gained an understanding of the knowledge and experience of the personnel managing the control(s) and corroborated evidence obtained as part of other testing procedures. While inquiries were performed for every control, our inquiries were not listed individually for every control activity tested and shown in Section IV.

Additional testing of the control activities was performed using the following methods:

Type	Description
Inquiry	Made inquiries of appropriate personnel and corroborated responses with management
Observation	Observed the application, performance or existence of the specific control(s), as represented by management
Inspection	Inspected documents and records indicating performance of the control

When using information produced by the service organization, we evaluated whether the information was sufficiently reliable for our purposes by obtaining evidence about the accuracy and completeness of such information and evaluating whether the information was sufficiently precise and detailed for our purposes.

Control Objective 1 - Application Change Management

Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved and implemented.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
1.1	Database and application changes are tested in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were tested in accordance with change management policies and procedures.	No exceptions noted.
1.2	Database and application changes are reviewed by responsible management in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were reviewed by responsible management in accordance with change management policies and procedures.	No exceptions noted.
1.3	Database and application changes are approved for implementation in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were approved for implementation in accordance with change management policies and procedures.	No exceptions noted.

Control Objective 1 - Application Change Management

Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved and implemented.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
1.4	The ability to promote changes into production is limited to authorized individuals based on business need.	Inspected system-generated access listings of users with access to implement database and in-scope application changes to determine that the ability to promote changes into production was limited to authorized individuals based on business need.	No exceptions noted.
1.5	Separate environments are used for development, testing and production.	Inspected the application environments to determine that separate environments are used for development, testing and production.	No exceptions noted.
1.6	All custom code changes to applications developed in-house are reviewed each month by the PAST to ensure the appropriate change process was followed.	Inspected supporting documentation for a selection of months to determine that all custom code changes to applications developed in-house were reviewed each month by the PAST to ensure the appropriate change process was followed.	**Exception noted.** For the months of January through July 2020, the PAST reviews were conducted; however, the reviews only evaluated the most recent custom code change and was therefore not inclusive of all custom code changes.

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
2.1	Management and/or the appropriate application or data owner approve the addition of new users and changes to existing user access rights within in-scope applications.	For a sample of new users and changes to existing user access rights within in-scope applications, inspected supporting documentation to determine that management and the application or data owner's approvals were obtained and that access was administered as requested.	No exceptions noted.
2.2	A user's Active Directory account is locked or deleted upon notification of the user's termination, as outlined in the Separation from Employment policy.	Inspected access termination requests and system-generated access listings for a selection of terminated employees and contractors to determine that Active Directory account access was locked or deleted in a timely manner upon the user's termination date.	**Exception noted.** For five of 45 terminated users selected for testing, Active Directory access was not removed timely.
2.3	A user's access is revoked from in-scope applications upon notification of the user's termination, as outlined in the Separation from Employment policy.	Inspected access termination requests and system-generated access listings for a selection of terminated employees and contractors to determine that application access was revoked in a timely manner upon the user's termination date.	**Exception noted.** For thirteen of 45 terminated users selected for testing, application access was not removed timely.

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
2.4	Management reviews terminated accounts to determine that, in instances of untimely removal from the network, access remained unused.	Inspected IS Compliance's terminated accounts review for a selection of months to determine that the review was completed for terminated accounts where Active Directory access was not removed within 30 days of the user's termination date and included a determination that the accounts were not used after the user's termination date.	**Exception noted.** For three of the four months selected for testing the terminated accounts review did not include two business units as part of the review. Upon further testing, it was determined that two new business units were created in February 2020 and not added to the report being used to perform the review. As such, these two business units were not included as part of the monthly reviews for the last nine months of audit period.
2.5	Users are required to enter a valid username and password to access IS resources. Passwords are managed through Active Directory to systematically enforce password complexity, length, expiration, reuse and account lockout settings that	Inspected system configurations for the in-scope applications, Active Directory and supporting infrastructure to determine that users are required to enter a valid username and password to access IS resources.	No exceptions noted.

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
	are aligned with Priority Health's password policy requirements.	Inspected Active Directory group policies to determine that password complexity, minimum length, expiration, reuse and account lockout are systematically enforced and aligned with Priority Health's password policy requirements.	**Exception noted.** Active Directory group policies are configured but deviate from Priority Health's password policy requirements for the following settings: minimum password length, maximum password age, password history, lockout attempts and reset account lockout counter.
2.6	New For privileged generic and service accounts, a PAM tool is used to manage the rotation of these accounts (expiration) and supplement Active Directory settings with computer generated passwords that are randomly generated (complexity and reuse) at a length that	Inspected a listing of privileged generic and service accounts from Active Directory and compared it to a listing of accounts managed in the PAM tool to determine that in scope generic and service accounts from Active Directory are enrolled in and being managed with the PAM tool.	No exceptions noted

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
	exceeds the Active Directory setting for those group policies.	Inspected the password settings for the privileged generic and service accounts being managed in the PAM tool to determine that passwords are scheduled to rotate on a defined basis and passwords are set to be computer generated using random characters at a length that exceeds the Active Directory setting for those group policies.	No exceptions noted
2.7	Administrative access to in-scope applications and their supporting infrastructure is reviewed periodically to validate access is limited to authorized individuals based on business need.	Inspected the administrative access review for a selection of quarters to determine that administrator access to in-scope applications and their supporting infrastructure was reviewed by the IS team to validate access was limited to authorized individuals based on business need.	No exceptions noted.
2.8	The IS team reviews security rights annually to validate that users' Oracle access privileges are appropriate.	Inspected supporting documentation for the annual Oracle user access review to determine that the IS team completed the annual review of Oracle user access privileges.	No exceptions noted.

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
2.9	Annually, application owners review and validate that the rights associated within their application assigned to each security group are appropriate.	Inspected supporting documentation for the annual application owner review to determine that the review was completed to validate that the rights associated within their application assigned to each security group are appropriate.	No exceptions noted.
2.10	Annually, Facets security group owners review the users assigned to each security group to validate that access privileges are appropriate.	Inspected supporting documentation for the annual security group owners review to determine that the review was completed to validate the users assigned to each security group and associated access privileges are appropriate.	No exceptions noted.
2.11	Semiannually, Pharmacy reviews a list of users with access to the PBM's application and communicates any necessary modifications to the PBM for correction.	Inspected supporting documentation for a selected semiannual review to determine that the list of users with access to the PBM application was reviewed by Pharmacy Operations and any requested modifications were performed as requested.	No exceptions noted.
2.12	Data center access is controlled by ID card-based systems, or by granting physical access remotely by authorized personnel in the NOC.	Observed the data center doors to determine that access was controlled by ID card-based systems.	No exceptions noted.
2.13	Access to Priority Health facilities is controlled by ID card-based systems.	Inspected listing of users with ID cards to determine that access to priority Health facilities is controlled by ID card-based systems.	No exceptions noted.

Control Objective 2 - Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
		Observed facility doors to determine that the facilities use a card key system to control access.	No exceptions noted.
2.14	Card key access to the data centers is reviewed quarterly to validate that individuals with access are appropriate	Inspected the physical access review for a selection of quarters to determine that the review was completed to validate that individuals with physical access were appropriate.	No exceptions noted.

Control Objective 3 - Computer Operations

Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled appropriately and deviations are identified and resolved.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
3.1	Job processes are systematically logged at end-of-job completion, and errors are investigated and resolved as appropriate.	Inspected supporting documentation for a selection of logged job schedule errors to determine that errors were investigated and resolved.	No exceptions noted.
3.2	Access to the automated and non-routine job scheduling tools is reviewed quarterly, and individuals with inappropriate access are removed.	Inspected supporting documentation for a selection of quarters to determine that access to the MJS automated job scheduling tool was reviewed.	No exceptions noted.
		Inspected access removal requests for a selection of quarters to determine that changes were made as requested.	No exceptions noted.
3.3	Backup software is configured to automatically perform database backups in accordance with the backup schedule and if scheduled backups fail, the appropriate team receives automatic notifications. Processing errors are investigated and resolved as appropriate.	Inspected the backup software configuration to determine that backups are scheduled daily.	No exceptions noted.
		Inspected the backup software configuration to determine that an alert is automatically sent when a backup fails.	No exceptions noted.
		Inspected the backup log for a selection of days to determine that the backup was successfully run or processing errors were investigated and resolved as appropriate.	No exceptions noted.

Control Objective 3 - Computer Operations

Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled appropriately and deviations are identified and resolved.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
3.4	Access to create, modify or delete schedules within the backup software is limited to authorized personnel with job responsibilities that require such access.	Inspected system- generated access listings of users with access to create, modify or delete schedules within the current backup software to determine that access was limited to authorized personnel with job responsibilities that require such access.	No exceptions noted.
3.5	Nightly data integrity checks for automated jobs are performed on key tables within the Priority Health database to verify the completeness and accuracy of data housed in the data store database back to the source. Any integrity issues are investigated and resolved as appropriate.	Inspected supporting documentation for a selection of job and date combinations to determine that the nightly data integrity checks for data pulled from Facets to key tables were performed and any integrity issues were investigated and resolved.	No exceptions noted.
3.6	Quarterly, database comparisons are performed to verify the completeness and accuracy of data within the Priority Health database back to the Facets application source, and errors are investigated and resolved as appropriate.	Inquired of management and inspected the script used to complete the database scans to determine that the scans are complete and accurate.	No exceptions noted.
		Inspected the database scan results for a selection of quarters to determine that the quarterly database scan of Priority Health database data to the Facets application source was performed to verify the completeness and accuracy of the data and any identified errors were investigated and resolved.	No exceptions noted.

Control Objective 4 - Provider Setup and Maintenance

Controls provide reasonable assurance that changes made to provider and pricing data affecting medical claims processing are made in a complete, accurate and timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
4.1	Ten percent (10%) of new participating provider setups and pricing setups are reviewed on a weekly basis in detail through quality review by someone independent of the setup.	Inspected documentation for a selection of weeks to determine that 10% of new participating provider and pricing setups were reviewed by someone independent of the setup and any errors identified were corrected.	No exceptions noted.
4.2	Two percent (2%) of new non-participating provider and modified provider configuration records are reviewed on a weekly basis in detail through quality reviews by someone independent of the change.	Inspected documentation for a selection of weeks to determine that 2% of new non-participating provider and modified provider configuration records were reviewed by someone independent of the change and any errors identified were corrected.	No exceptions noted.
4.3	Pricing configuration setups (new and modified fee agreements) entered into Facets are audited to the original contract and request form.	Inspected documentation for a selection of new and modified fee agreements to determine that the fee agreements were reviewed for accuracy by an independent person and identified errors were corrected and re-audited.	No exceptions noted.
4.4	New and modified fee schedules uploaded by Information Services are independently reviewed in detail through quality reviews and identified errors are resolved.	Inspected documentation for a selection of new and modified fee schedule uploads to determine that they were reviewed and identified errors were resolved.	No exceptions noted.
4.5	Monthly, PR performs quality reviews over a defined sample of claims to determine that if they are paying according to the terms specified with in the provider contract.	Inspected supporting documentation for a selection of months to determine that a quality review was performed.	No exceptions noted.

Control Objective 5 - Group and Benefit Administration

Controls provide reasonable assurance that changes made to group and benefit data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
5.1	New and modified self-funded groups in Facets are reviewed on a daily basis by someone independent of the change and identified errors are corrected.	Inspected supporting documentation for a selection of days to determine that new and modified groups are audited by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.
5.2	New and modified benefit setups are reviewed by someone independent of the change and identified errors are corrected.	Inspected supporting documentation for a selection of days to determine that new and modified benefit setups were reviewed by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.
5.3	A defined percentage of product and group updates made by individuals outside of the Group Administration and Product Configuration departments are reviewed by a Quality Auditor on a monthly basis to verify the individuals who updated the group and benefit information within Facets was authorized to do so and the change made was appropriate.	Inspected supporting documentation for a selection of months to determine that the defined percentage of product and group updates made by individuals outside of the Group Administration and Product Configuration departments were reviewed and updates were evaluated for appropriateness, if applicable.	No exceptions noted.

Control Objective 6 - Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
6.1	Enrollment transactions received through EDI are subject to edits and validations for proper format, content and completeness throughout EDI processing.	Inspected a list of enrollment edit checks and validations completed during the EDI process to determine that edits and validations related to proper format, content and completeness existed.	No exceptions noted.
		Inspected supporting documentation for a selection of edits and validations to determine that the system appropriately denied or processed the transaction.	No exceptions noted.
6.2	EDI enrollment transactions resulting in errors or warnings during the EDI edits process are either suspended and automatically listed on an EDI service receipt sent to the Enrollment team for correction or rejected back to the submitter within two business days if the entire file fails the edits.	Inspected the automated email for a test of one EDI enrollment batch resulting in automatically suspended EDI enrollment transactions to determine that errors and warnings were included on the EDI service receipt sent to the Enrollment team.	No exceptions noted.
		Inspected tickets and email communication for a selection of rejected EDI enrollment files to determine that the file was returned to the submitter within two business days.	No exceptions noted.
6.3	A defined percentage of new or modified enrollment transactions are reviewed on a daily basis by someone independent of the person making the change and identified errors are corrected.	Inspected a listing of Enrollment Specialists to determine that the appropriate percentage of enrollment transactions was reviewed by someone independent of the person making the change.	No exceptions noted.

Control Objective 6 - Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
		Inspected supporting documentation for a selection of errors and days to determine that appropriate action was taken on identified errors.	No exceptions noted.
6.4	A defined percentage of enrollment updates made by individuals outside the Enrollment department are reviewed by a Quality Auditor on a monthly basis to verify the individuals who updated the enrollment information within Facets was authorized to do so and the change made was appropriate.	Inspected the tables within OnBase to determine that the appropriate individuals outside of the Enrollment department were included within the monthly audit.	No exceptions noted.
		Inspected supporting documentation for a selection of updates made by individuals outside of the Enrollment department to determine that an audit was performed to verify the update was made appropriately and that the individuals who made the update was authorized to do so.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
7.1	Claim transactions are subject to edits and validations for proper format, content and completeness throughout EDI processing.	Inspected a list of claim edit checks completed during the EDI process to determine that edits and validations related to proper format, content and completeness existed.	No exceptions noted.
		Inspected supporting documentation for a selection of claim transactions that did not pass the edit and validation check to determine that the system appropriately failed the claims transactions.	No exceptions noted.
		Inspected supporting documentation for a selection of claim transactions that passed the edit and validation check to determine that the system appropriately passed the claims transactions.	No exceptions noted.
7.2	Logic within EDI is configured to identify claims eligible for repricing and to send those claims to the appropriate repricing vendor.	Inspected supporting documentation for a selection of claims matching each repricing scenario to determine that the EDI Processor application appropriately identified claims eligible for repricing and sent them to the appropriate repricing vendor.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
7.3	A claim submission where a previous claim has been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code and provider ID is considered a definite duplicate and automatically denied by Facets. A claim submission where a previous claim has been submitted for the member with a combination of same date of service, charge amount, procedural code and/or revenue code is considered a potential duplicate and pended for further review by a Claims Examiner.	Inspected the duplicate claim rules and a duplicate claim transaction where a previous claim had been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code and provider ID to determine that the Facets system automatically denied the claim.	No exceptions noted.
		Inspected the duplicate claim rules and one potential duplicate claim transaction where a previous claim had been submitted for the member with a combination of same date of service, charge amount, procedural code and/or revenue code to determine that the Facets system automatically pended the claim for further review.	No exceptions noted.
7.4	During the adjudication process, Facets is configured to verify and process claims sequentially against predefined checkpoint rules to validate eligibility, provider, diagnostic and procedure codes, and COB, to pend claims for third-party liability cases, and to determine that the appropriate contract fee schedules, deductibles and co-payments.	Inspected system settings from Facets for each edit check to determine that the Facets system pends or denies the claim according to the type of edit being executed.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
7.5	The Medical Management department reviews claims flagged by Facets for authorization and/or medical necessity review and dispositions each based on written procedures and medical policy.	Inspected supporting documentation for a sample of claims with procedure or diagnosis codes that require a medical authorization and/or necessity review to determine that claims were appropriately resolved timely based on written procedures and medical policy.	No exceptions noted.
7.6	Logic within CES is configured to identify claims for potential up-coding and fee unbundling and Facets uses code review software to identify claims with potential up-coding and fee unbundling.	Inspected CES rule sets for appropriate edits in place to identify claims for potential up-coding and fee unbundling.	No exceptions noted.
		Inspected supporting documentation to determine that code review edits exist within Facets to identify potential up-coding and fee unbundling.	No exceptions noted.
7.7	The Code Review department reviews potential up-coded and fee unbundled claims flagged by Facets for clinical edit accuracy.	Inspected supporting documentation for a selection of potential up-coded and fee unbundled claims flagged by Facets to determine that the Code Review department reviewed the claim for clinical edit accuracy.	No exceptions noted.
7.8	Once subrogation cases are closed, funds are returned to the self-funded group in accordance with the negotiated settlement and documented in the subrogation case file.	Inspected supporting documentation for a selection of closed subrogation cases to determine that funds were returned in accordance with the negotiated settlement and documented in the subrogation case file.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
7.9	Claims Services personnel use the Inventory Management Policy to define expectations for timely claims inventory management. Management uses system-generated claim aging and turnaround time reports to monitor claims processing for compliance with the policy.	Inspected policy and procedure documentation to determine that guidelines exist to direct Claims personnel in the timeliness of processing for clean claims.	No exceptions noted.
		Inspected the logic and claims aging reports to determine that clean claims were monitored for compliance with the department policy.	No exceptions noted.
		Inspected turnaround time reports for a selection of months to determine that claims were processed in accordance with the time frames defined within the Inventory Management Policy.	No exceptions noted.
7.10	Claims are appropriately investigated and adjusted as a result of items added to the Configuration Log.	Inspected supporting documentation for a selection of items added to the Configuration Log to determine that investigation and adjustments to claims were made and were approved by appropriate individuals.	No exceptions noted.
7.11	Claims requiring adjustment as a result of claim costs exceeding the member's deductible or out-of-pocket limit are identified through a daily automated report. Each claim is investigated and the appropriate adjustments are made in Facets	Inspected supporting documentation for a selection of days and member overages to determine that the out-of-pocket limits are monitored and adjustments were made in Facets.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
7.12	When an overpayment occurs, Facets is configured to deduct (auto-recover) up to a defined threshold amount from the provider's next payment or send overpayment request letters to the provider	Inspected supporting documentation for a selection of overpayments identified in Facets to determine that recoveries were made.	No exceptions noted.
7.13	From November 1, 2019 through October 16, 2020: Two percent (2%) of claims processed with human intervention are audited by someone independent of the claim processor and any audit findings were resolved.	Inspected system settings to determine that 2% of claims processed with human intervention was configured to be audited.	No exceptions noted.
		Inspected supporting documentation for a selection of days and Claims Examiners to determine that the appropriate percentage of claims were audited by someone independent of the claim processor and any audit findings were resolved.	**Exception noted.** For four of 25 days and Claims Examiners selected for testing, a daily audit of 2% was not completed. Upon further testing, it was also determined that the four exceptions occurred during the period August 1, 2020 through October 16, 2020 and for that period, the required number of claims to meet the defined 2% threshold was not achieved.
7.14	Beginning October 17, 2020: One percent (1%) of claims processed with human intervention are audited by someone independent of the	Inspected system settings to determine that 1% of claims processed with human intervention was configured to be audited.	No exceptions noted.

Control Objective 7 - Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
	claim processor and any audit findings were resolved.	Inspected supporting documentation for a selection of days and Claims Examiners to determine that the appropriate percentage of claims were audited by someone independent of the claim processor and any audit findings were resolved.	No exceptions noted.
7.15	Notification is sent to the reinsurance carrier when a case reaches 50% of a specific deductible amount. The Claims department submits cases with claims exceeding the stop-loss amount to the appropriate reinsurance carrier.	Inspected supporting documentation for a selection of cases that reached 50% of the deductible or the claims exceeded the stop-loss amount for self-funded groups to determine that a notification was evaluated to be sent by a Stop-Loss Coordinator to the appropriate reinsurance carrier for each case with a "warning" or "over" message.	No exceptions noted.
7.16	Quarterly, Claims leadership reviews the security rights for key business functions to validate proper segregation of duties is maintained and any individuals with conflicting access will either be removed or accepted by the business.	Inspected the segregation of duties review for a selection of quarters to determine that security rights for key business functions was reviewed to validate that proper segregation of duties is maintained.	No exceptions noted.
		Inspected supporting documentation for segregation of duties conflicts identified during the segregation of duties review to determine that the conflicts were researched and resolved or accepted by the business.	No exceptions noted.

Control Objective 8 - Pharmacy Administration

Controls provide reasonable assurance that product, group, member and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
8.1	To determine whether the change request is accurate prior to being sent to ESI for setup within its system, formulary changes are independently reviewed, and any errors identified are corrected before being submitted.	Inspected supporting documentation for a selection of formulary change requests to determine that Pharmacy Operations performed an independent review for accuracy and any issues identified were corrected.	No exceptions noted.
8.2	Daily, Pharmacy reviews commercial group and member error reports received from the PBM. Any errors are investigated and corrected by the appropriate department.	Inspected supporting documentation for a selection of errors to determine that the errors were investigated and resolved by the appropriate department.	No exceptions noted.
8.3	Daily, a defined percentage of new and modified pharmacy benefits sent to the PBM are audited by someone independent of the change and identified errors are corrected.	Inspected supporting documentation for a selection of days to determine that new and modified benefit setups were reviewed by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors across that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.
8.4	Approvals and denials completed by a pharmacist or pharmacy coordinator are reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order before they are finalized.	Inspected supporting documentation for a selection of pharmacy approvals and denials to determine that the approval or denial was completed by a pharmacist or coordinator and reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order prior to being finalized.	No exceptions noted.

Control Objective 8 - Pharmacy Administration

Controls provide reasonable assurance that product, group, member and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Tests of Controls Performed by BDO USA, LLP	Results of Tests
8.5	Weekly, a Medical Cost Analyst reconciles the pharmacy claims data to the invoice received from the PBM, and differences are resolved as appropriate.	Inspected the reconciliation between pharmacy claims data and the invoice received for a selection of weeks to determine that differences were resolved as appropriate.	No exceptions noted.

V. Other Information Provided by Priority Health Managed Benefits, Inc. That Is Not Covered by the Independent Service Auditor's Report

Other Information Provided by Priority Health Managed Benefits, Inc. That Is Not Covered by the Independent Service Auditor's Report

Management Responses to Exceptions Noted

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Results of Tests	Management Response
1.6	All custom code changes to applications developed in-house are reviewed each month by the PAST to ensure the appropriate change process was followed.	For the months of January through July 2020, the PAST reviews were conducted; however, the reviews only evaluated the most recent custom code change and was therefore not inclusive of all custom code changes.	Management performed a retroactive review for the months of January through July to ensure all custom code changes during that period followed the appropriate change process. Beginning in August 2020, the performance of the monthly review performed by the PAST was updated to include all custom code changes since the previous month's review.
2.2	A user's Active Directory account is locked or deleted upon notification of the user's termination, as outlined in the Separation from Employment policy.	For five of 45 terminated users selected for testing, Active Directory access was not removed timely.	Management revalidated access was removed and there was no end user activity following termination, despite access not being removed in accordance with our internal timeliness standard. Upon identification of the issues, root cause analysis was performed and determined the delay in access removal was caused by untimely notification from terminated user leaders to Information Services. This was further complicated by

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Results of Tests	Management Response
2.3	A user's access is revoked from in-scope applications upon notification of the user's termination, as outlined in the Separation from Employment policy.	For thirteen of 45 terminated users selected for testing, application access was not removed timely.	lack of automation in the termination process, which requires separate leader requests for employment termination through HR and access removal through IS, and manual processes to remove applications not tied to AD access. Once IS received notification, access was removed timely. Reviews executed within controls 2.7 through 2.10 operated effectively, which provide some additional comfort over access relevant to these exceptions. Training of relevant groups within the organization has also been performed to reinforce the importance and expectation of the timely termination requests. Implementation of a new enterprise resource planning (ERP) platform in January 2021 should allow for greater automation of the termination notification process and access removal from AD and applications. Governance of the termination process, ownership of related controls and monitoring procedures will be reevaluated to ensure measures are enacted to prevent and detect operating failures.
2.4	Management reviews terminated accounts to determine that, in instances of untimely removal from the network, access remained unused.	For three of the four months selected for testing the terminated accounts review did not include two business units as part of the review. Upon further testing, it was determined that two new business units were created in February 2020 and not added to the report being used to perform the review. As such, these two business units were not included as part of the monthly reviews for the last nine months of audit period.	Once the two excluded business units were identified, they were added to testing going forward. The units were added by HR within the period but not included in the population provided to management for testing. Management performed a retroactive review of the 13 contractors assigned to these business units during the period, and no concerns of access being used after termination were identified. These 13 contractors were also found to represent less than 2% of terminations, in comparison to overall employee and contractor terminations processed by the organization within the period. The process of obtaining the population of terminated users for testing has now been updated to include a manual inquiry of HR to identify any new business units, as well obtaining more detailed evidence to verify all business units are included for testing. Automation of population reporting will also be evaluated to ensure all business units are included.

Control Number	Controls Specified by Priority Health Managed Benefits, Inc.	Results of Tests	Management Response
2.5	Users are required to enter a valid username and password to access IS resources. Passwords are managed through Active Directory to systematically enforce password complexity, length, expiration, reuse and account lockout settings that are aligned with Priority Health's password policy requirements.	Active Directory group policies are configured but deviate from Priority Health's password policy requirements for the following settings: minimum password length, maximum password age, password history, lockout attempts and reset account lockout counter.	Our internal password standard was updated in early 2020 to more closely align to the NIST Cybersecurity Framework. However, due to system and related tool limitations, AD could not be readily updated to meet the standard. The password standard is on track to be updated by Q1 2021, with changes allowing for greater system adherence while still aligning with best practice. AD password parameters will then be adjusted to meet the standard, along with appropriate due diligence and investigation to ensure negative operational impact to the organization is limited. Active monitoring, such as failed login attempts, will also continue to be performed to detect unusual and suspicious activity that could indicate attempts to inappropriately obtain login credentials.
7.13	From November 1, 2019 through October 16, 2020: Two percent (2%) of claims processed with human intervention are audited by someone independent of the claim modification.	For four of 25 days and Claims Examiners selected for testing, a daily audit of 2% was not completed. Upon further testing, it was also determined that the four exceptions occurred during the period August 1, 2020 through October 16, 2020 and for that period, the required number of claims to meet the defined 2% threshold was not achieved.	Between August and October 16, 2020, management's desire to align their audit program with industry standards and best practice led to a deliberate shift in audit approach. Although less than 2% was audited during this time period, a number of claims were still audited. After consulting with experts and using an approved sample calculator, a new sample methodology was defined by leadership and approved by the Quality Governance Council. Effective October 17, 2020, the audit percentage was adjusted to 1%.

COVID-19 Impact

The World Health Organization (WHO) announced the coronavirus (COVID-19) as a global health emergency on January 30, 2020, which prompted national governments to begin putting actions in place to slow the spread of COVID-19. On March 11, 2020, the WHO declared COVID-19 a global pandemic and recommended containment and mitigation measures worldwide. To the extent that our normal procedures and controls related to our control environment at any of our locations were adversely impacted by the COVID-19 outbreak, we took appropriate actions and safeguards to reasonably ensure the controls were properly designed and operating effectively.

Standard Claims Reporting

The standard monthly reporting package offered to self-funded groups as part of their group agreement includes:

- *Check Register Report* - Listing of checks issued relevant to the employer group, including information such as check number, payee, check date, claim ID, paid amount and member name
- *Monthly Summary Report* - Financial summary displaying the paid amounts based on the line of business for the employer group
- *Specific Stop-Loss Report* - (see "Deductible and Stop-Loss Notification" section)
- *Aggregate Stop-Loss Report* - (see "Deductible and Stop-Loss Notification" section)
- *Authorized Inpatient Admits by Facility* - Inpatient hospital admissions via the prior authorization process
- *Network Performance and Benefit Utilization* - Utilization of in-network providers versus out-of-network providers for medical claims

Reports are generated monthly out of RPX via the MJS, and the Sales Coordinator and Account Manager are notified that the reports are available. Either the Sales Coordinator or the Account Manager releases the reports for distribution via the web-based Employer Center on priorityhealth.com. Groups are notified via email once the reports are available and are required to log in to the Employer Center to retrieve their information.

November 2, 2020

MDA Health Plan
3657 Okemos Road – Suite 200
Okemos, MI 48864

Dear Mr. Don Winn and Ms. Tina Voss:

This letter is to provide an update concerning the control environment as discussed in the SOC 1 Type II reports:

- Express Scripts Holding Company's Description of its ***Pharmacy Claims Processing System*** and on the Suitability of the Design and Operating Effectiveness of its Controls
  - Period of report: May 1, 2019 through April 30, 2020
- Express Scripts Holding Company's Description of its ***Rebate Share Processing System*** and on the Suitability of the Design and Operating Effectiveness of its Controls
  - Period of report: May 1, 2019 through April 30, 2020
- Express Scripts Holding Company's Description of its ***Workers' Compensation Pharmacy Claims Processing System*** and on the Suitability of the Design and Operating Effectiveness of its Controls
  - Period of report: November 1, 2018 through October 31, 2019

Each SOC 1 Type II report includes an Independent Services Auditor's report on the respective date noted herein from PricewaterhouseCoopers, LLP, describing and opining upon the relevant aspects of our internal controls that had been placed in operation and their test of controls covering the respective period noted herein.

To the best of our knowledge and belief, there have been no subsequent material changes between the respective period end of each report and the date of this letter to the overall control environment as described in the SOC 1 Type II reports referenced herein. We believe that the description of internal control environment continues to present fairly, in all material respects, the system, the controls, and their operating effectiveness, which were in place during the respective periods noted herein.

These reports are intended solely for use by management of Express Scripts, Express Scripts' client user organizations, and the independent auditors of those client user organizations.

In order to conclude upon the design and effectiveness of internal controls for Express Scripts, the SOC1 Type II report must be read. This letter is not intended to be a substitute for a SOC1 Type II report.

If you need further assistance, please contact your account manager.

Sincerely,

Jamie Kates
VP Finance
Enclosure

Confidential Information

Report on Express Scripts Holding Company's Description of its Pharmacy Claims Processing System and on the Suitability of the Design and Operating Effectiveness of its Controls

For the period May 1, 2019 through April 30, 2020

EXPRESS SCRIPTS®

The Report on Express Scripts Holding Company's Description of its Pharmacy Claims Processing System and on the Suitability of the Design and Operating Effectiveness of Controls is confidential. The Report is intended solely for the use by the management of Express Scripts Holding Company, its user entities and the independent auditors of its user entities, and is not intended for and should not be used by anyone other than these specified parties.

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Section I – Report of Independent Service Auditors

To the Management of Express Scripts Holding Company

Scope

We have examined Express Scripts Holding Company's ("Express Scripts") description of its Pharmacy Claims Processing system (the "system") entitled, "Express Scripts Holding Company's Description of Its Pharmacy Claims Processing System" for processing user entities' pharmacy claims transactions throughout the period May 01, 2019 to April 30, 2020 (the "description") and the suitability of the design and operating effectiveness of the controls included in the description to achieve the related control objectives stated in the description, based on the criteria identified in "Express Scripts Holding Company's Assertion" (the "assertion"). The controls and control objectives included in the description are those that management of Express Scripts believes are likely to be relevant to user entities' internal control over financial reporting, and the description does not include those aspects of the system that are not likely to be relevant to user entities' internal control over financial reporting.

The information included in Section V, "Other Information Provided by Express Scripts Holding Company", is presented by management of Express Scripts to provide additional information and is not a part of the description. Information about Express Scripts' Business Continuity Summary, Encryption Procedures, and Management Responses has not been subjected to the procedures applied in the examination of the description and of the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Express Scripts' controls are suitably designed and operating effectively, along with related controls at the service organization. Our examination did not extend to such complementary user entity controls, and we have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Service organization's responsibilities

In Section II, Express Scripts has provided an assertion about the fairness of the presentation of the description and suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description. Express Scripts is responsible for preparing the description and assertion, including the completeness, accuracy, and method of presentation of the description and the assertion, providing the services covered by the description, specifying the control objectives and stating them in the description, identifying the risks that threaten the achievement of the control objectives, selecting the criteria stated in the assertion, and designing, implementing, and documenting controls that are suitably designed and operating effectively to achieve the related control objectives stated in the description.

Service auditors' responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description, based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform our examination to obtain reasonable assurance about whether, in all material respects, based on the criteria in management's assertion, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description throughout the period May 01, 2019 to April 30, 2020. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

An examination of a description of a service organization's system and the suitability of the design and operating effectiveness of the service organization's controls to achieve the related control objectives stated in the description involves

- performing procedures to obtain evidence about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of those controls to achieve the related control objectives stated in the description based on the criteria in management's assertion.
- assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve the related control objectives stated in the description.
- testing the operating effectiveness of those controls management considers necessary to provide reasonable assurance that the related control objectives stated in the description were achieved.
- evaluating the overall presentation of the description, suitability of the control objectives stated in the description, and suitability of the criteria specified by the service organization in its assertion in Section II.

Inherent limitations

The description is prepared to meet the common needs of a broad range of user entities and their auditors who audit and report on user entities' financial statements and may not, therefore, include every aspect of the system that each individual user entity may consider important in its own particular environment. Because of their nature, controls at a service organization or a subservice organization may not prevent, or detect and correct, all misstatements in processing or reporting transactions. Also, the projection to the future of any evaluation of the fairness of the presentation of the description, or conclusions about the suitability of the design or operating effectiveness of the controls to achieve the related control objectives, is subject to the risk that controls at a service organization or a subservice organization may become ineffective.

Description of tests of controls

The specific controls tested and the nature, timing, and results of those tests are listed in Section IV.

Opinion

In our opinion, in all material respects, based on the criteria described in Express Scripts Holding Company's Assertion in Section II,

a. the description fairly presents the system that was designed and implemented throughout the period May 01, 2019 to April 30, 2020.

b. the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively throughout the period May 01, 2019 to April 30, 2020 and user entities applied the complementary controls assumed in the design of Express Scripts' controls throughout the period May 01, 2019 to April 30, 2020.

c. the controls operated effectively to provide reasonable assurance that the control objectives stated in the description were achieved throughout the period May 01, 2019 to April 30, 2020, if complementary user entity controls assumed in the design of Express Scripts' controls operated effectively throughout the period May 01, 2019 to April 30, 2020.

Restricted use

This report, including the description of tests of controls and results thereof in Section IV, is intended solely for the information and use of management of Express Scripts, user entities of the system during some or all of the period May 01, 2019 to April 30, 2020, and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities of the system themselves, when assessing the risks of material misstatements of user entities' financial statements. This report is not intended to be, and should not be, used by anyone other than these specified parties. If report recipients are not user entities that have contracted for services with Express Scripts for the period May 01, 2019 to April 30, 2020 or their independent auditors (herein referred to as a "non-specified user") and have obtained this report, or have access to it, use of this report is the non-specified user's sole responsibility and at the non-specified user's sole and exclusive risk. Non-specified users may not rely on this report and do not acquire any rights against PricewaterhouseCoopers LLP as a result of such access. Further, PricewaterhouseCoopers LLP does not assume any duties or obligations to any non-specified user who obtains this report and/or has access to it.

PricewaterhouseCoopers LLP

July 28, 2020

Section II – Express Scripts Holding Company's Assertion

We have prepared the description of Express Scripts Holding Company's (Express Scripts or the service organization) Pharmacy Claims Processing system (the "system") entitled, "Express Scripts Holding Company's Description of Its Pharmacy Claims Processing System," for processing user entities' pharmacy claims transactions throughout the period May 01, 2019 to April 30, 2020 (the "description") for user entities of the system during some or all of the period May 01, 2019 to April 30, 2020, and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities of the system themselves, when assessing the risks of material misstatement of user entities' financial statements.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Express Scripts' controls are suitably designed and operating effectively, along with related controls at the service organization. The description does not extend to controls of the user entities.

We confirm, to the best of our knowledge and belief, that

a. the description fairly presents the Pharmacy Claims Processing system made available to user entities of the system during some or all of the period May 01, 2019 to April 30, 2020 for processing their pharmacy claims transactions as it relates to controls that are likely to be relevant to user entities' internal control over financial reporting. The criteria we used in making this assertion were that the description

   i. presents how the system made available to user entities of the system was designed and implemented to process relevant user entity transactions, including, if applicable,

      (1) the types of services provided, including, as appropriate, the classes of transactions processed.

      (2) the procedures, within both automated and manual systems, by which those services are provided, including, as appropriate, procedures by which transactions are initiated, authorized, recorded, processed, corrected as necessary, and transferred to the reports and other information prepared for user entities of the system.

      (3) the information used in the performance of the procedures including, if applicable, related accounting records, whether electronic or manual, and supporting information involved in initiating, authorizing, recording, processing, and reporting transactions; this includes the correction of incorrect information and how information is transferred to the reports and other information prepared for user entities.

      (4) how the system captures and addresses significant events and conditions other than transactions.

      (5) the process used to prepare reports and other information for user entities.

      (6) services performed by a subservice organization, if any, including whether the carve-out method or the inclusive method has been used in relation to them.

(7) the specified control objectives and controls designed to achieve those objectives including, as applicable, complementary user entity controls and complementary subservice organization controls assumed in the design of the service organization's controls.

(8) other aspects of our control environment, risk assessment process, information and communications (including the related business processes), control activities, and monitoring activities that are relevant to the services provided.

ii. includes relevant details of changes to the system during the period covered by the description.

iii. does not omit or distort information relevant to the system, while acknowledging that the description is prepared to meet the common needs of a broad range of user entities of the system and their user auditors, and may not, therefore, include every aspect of the system that each individual user entity of the system and its auditor may consider important in its own particular environment.

b. the controls related to the control objectives stated in the description were suitably designed and operating effectively throughout the period May 01, 2019 to April 30, 2020 to achieve those control objectives if user entities applied the complementary controls assumed in the design of Express Scripts' controls throughout the period May 01, 2019 to April 30, 2020. The criteria we used in making this assertion were that

i. the risks that threaten the achievement of the control objectives stated in the description have been identified by management of the service organization.

ii. the controls identified in the description would, if operating effectively, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved.

iii. the controls were consistently applied as designed, including whether manual controls were applied by individuals who have the appropriate competence and authority.

Section III – Express Scripts Holding Company's Description of Its Pharmacy Claims Processing System

Overview of Operations

Express Scripts Holding Company ("Express Scripts") is a pharmacy benefit manager (PBM) company in the United States and a wholly-owned subsidiary of Cigna Corporation. Express Scripts offers a full range of services to our clients, which include managed care organizations, health insurers, third-party administrators, employers, union-sponsored benefit plans, workers' compensation plans, government health programs, providers, clinics, hospitals and others. We put medicine within reach of patients while helping health benefit providers improve access and affordability to prescription drugs. We improve patient outcomes and help control the cost of the drug benefit by:

- providing products and solutions that focus on improving patient outcomes and assist in controlling costs
- evaluating drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary
- offering cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors and better care for members
- leveraging purchasing volume to deliver discounts to health benefit providers
- promoting the use of generics and low-cost brands

Prescription drugs are dispensed to members of the health plans we serve primarily through networks of retail pharmacies under non-exclusive contracts with us, and through home delivery fulfillment pharmacies, specialty drug pharmacies and fertility pharmacies we operate. More than 67,000 retail pharmacies, which represent over 99% of all United States retail pharmacies, participated in one or more of our networks as of December 31, 2019. The ten largest United States retail pharmacy chains represent approximately 65% of the total number of stores in our largest network as of December 31, 2019.

A PBM is a link between the entities involved in the delivery of prescription drugs and health plan members. Health plans, employers, and third-party administrators hire a PBM to design, implement, and manage their overall drug benefits. Express Scripts offers services such as developing the drug formulary (the list of drugs covered in the plan), establishing a pharmacy network, and processing prescription claims.

Scope of the Description

Express Scripts provides PBM services for clients by processing (adjudicating) pharmacy claims through its proprietary F14 system. The core F14 systems are primarily mainframe applications supported by an IBM front-end processor, as well as certain other distributed applications that serve as front ends into the mainframe. The scope of this report covers the following systems:

- Benefit Administration Systems
  - Client Benefit Management (CBM)
  - Co-Pay Benefit Pricing System (CBPS)
  - Benefit Administration (BA) Module / Client Profile System (CPS)
  - Clinical Rules Station (CRS)
  - Bill Code Table (BCT) (Client Website)

- Benefit Administrator-Copay Module (Client Website)
- Pharmacy Level Benefits (PLB)
- Drug Administration Systems
- Point of Sale (POS)
- Formulary Rules Station (FRS) / Drug Coverage Rules Station (DCRS)
- Batch Testing Tool (BTT)
- Benefit Build Automation (BBA)
- Figaro

- Pharmacy Administration System
  - Phoenix
- Eligibility Systems
  - Eligibility
  - e-Service Delivery (eSD)
  - Consumer Driven Health (CDH)
- Claims Processing/Adjudication System
  - Point of Sale (POS)
- Claims Billing System
  - Integrated Billing System (IBS)
- Client Guarantee Settlements System
  - Client Guarantee System (CGS)
- Data Warehouse
  - Information Warehouse (IW)

Claims data is transmitted into the F14 system either directly or via pharmacy switches to the mainframe. Based on previously loaded and established client setup and member enrollment data, the F14 system validates member, group, and provider information, as well as coverage information, for each pharmacy claim based on client-specified parameters. Once this validation is completed, the F14 system calculates the drug coverage amounts based on the benefit plan and client specifications. Claims successfully adjudicated for Express Scripts clients are summarized in IW and billed through IBS.

The scope of this report includes only those Express Scripts Commercial and Medicare clients processing claims on the F14 system, regardless of the fulfillment method utilized. This report is not intended to cover rebate processing services. Additionally, the report does not include the mail-order fulfillment processes (i.e. the physical process of filling a drug for shipment) provided through Express Scripts' proprietary mail-order systems, pharmacy specific exception pricing setups, benefit setups for which validation and testing of setup is performed by the user entity, the processing of paper claims, other services provided by Express Scripts, or specialty direct services (including specialty pharmacy and distribution) provided through Express Scripts' Accredo and Curascript subsidiaries. The controls included within the guarantee objective (C-3) are only applicable to guarantees contained within PBM agreements that have been agreed upon and signed by the client.

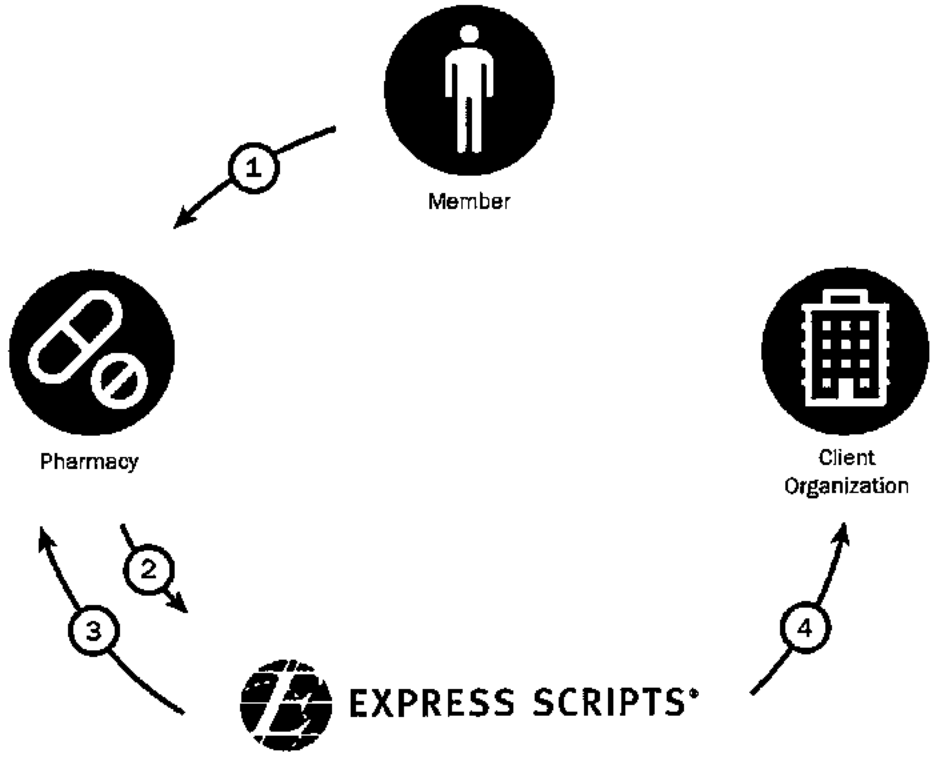
Additionally, the guarantee type included within the scope of this report is limited to Average Wholesale Price (AWP) ingredient cost discount guarantees associated with PBM agreements. The scope of this report does not include any other guarantee types, including those associated with dispensing fees, mail order acquisition cost (MOAC), generic dispense rates (GDRs) or other programs, products and services.

This report addresses reporting provided by Express Scripts to its user entities for use in preparing their financial statements including customer invoices, guarantee settlement packages, and eligibility pre-edit reports. Reporting provided to user entities beyond the reports previously identified and customized client reporting (e.g. reports generated from client portal) are not included in the scope of this report.

Changes from Prior Period Report

Batch Testing Tool (BTT), Benefit Build Automation (BBA), and Figaro were added as in-scope systems, which support the setup and maintenance of Benefit information within the B-1 objective. Existing ITGC controls within the report include coverage over these systems. An additional control (B-1i) was added to the B-1 objective to support the BBA load process. Additionally, as of October 21, 2019, the Mass Upload tool has been retired and related controls (B-3d and B-3e) have been end-dated.

The chart below depicts the PBM services as described above.



1. Members fill their prescription at a pharmacy which is part of the Express Scripts pharmacy network. When members fill or refill their prescription, the member only pays the co-pay amount, as determined by the member's benefit plan.
2. Claims data is transmitted to the F14 system to validate the member's benefit plan and drug coverage. After the validation is complete, the F14 system will calculate the drug coverage amounts based on the benefit plan and client specifications.
3. Express Scripts summarizes all the adjudicated (processed) pharmacy claims data and pays the pharmacy based on established contracts.
4. Express Scripts summarizes all the adjudicated pharmacy claims data, bills the client organization, and settles any AWP guarantees on a contractually determined basis.

Overview of Internal Control

A company's internal control is a process created by an entity's Board of Directors, management, and other personnel designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations. The following is a description of the five components of internal control.

Control Environment

The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values, and competence of the entity's people; management's philosophy and operating style; the way management assigns authority and responsibility and the way it organizes and develops its people; and the attention and direction provided by the independent Board of Directors over the development and performance of internal controls.

Integrity and Ethical Values

The compliance program formalizes ongoing compliance efforts and provides a framework with which violations of legal and ethical standards are prevented or detected and corrected. The compliance program includes a Code of Conduct, Code of Ethics, and Compliance Hotline. As part of the Code of Conduct process, the Code of Conduct is communicated to all employees upon hiring. In addition, upon hiring and each year thereafter, employees must acknowledge the Code of Conduct and complete a required training course. The web-based corporate compliance training course reinforces the importance of adherence to the Code of Conduct and the Code of Ethics. The annual acknowledgment and training course are conditions of employment. As such, all employees are well aware of the importance of appropriate conduct and compliance with rules, regulations, and laws. There is an independent compliance and ethics hotline, whereby employees can anonymously report various improprieties.

Commitment to Competence

We specify the competence levels for particular jobs during the formal hiring process and translate those levels into requisite knowledge and skills through technical and ethics training. Among the many factors considered in developing knowledge and skill levels are the nature and degree of judgment to be applied to a specific job and the extent of supervision required. Technical and ethics training is provided for all employees.

Management's Control Consciousness and Operating Style

Management is responsible for directing and controlling operations and for establishing, communicating, and monitoring policies and procedures. Management's control consciousness and operating style create a positive atmosphere conducive to effective processes and controls, as well as an environment in which the likelihood of an error is reduced.

Board of Directors

The Audit Committee of the Board of Directors has a high level of involvement with management, Internal Audit, and the independent external auditors. Pursuant to Cigna Corporation's (Cigna's) Audit Committee Charter, "the Audit Committee shall represent and assist the Board of Directors in fulfilling its oversight responsibilities with respect to: (i) the integrity of the Company's financial information reported to the public and the adequacy of the Company's internal controls; (ii) the qualifications, independence and performance of the Company's Independent Auditors; (iii) the performance of the Company's internal audit function; and (iv) the review and evaluation of the Company's enterprise risk management policies and processes." The Audit Committee has four regular meetings annually during which the Audit Committee meets with company management, Internal Audit, and the independent external auditors. In addition, the Audit Committee meets quarterly to review the SEC financial filings, press release and earnings guidance prior to public release.

Organizational Structure

Clearly defined reporting lines and controls exist to provide the overall framework for planning, executing, controlling and monitoring operations. The structure is such that all personnel have a clear understanding of their reporting relationships and responsibilities.

Human Resources

The Company has a formal hiring process in place which includes required forms, such as Request to Hire and Job Description. Job descriptions include the essential functions of the job being listed and the minimum requirements of applicants.

The Employee Handbook includes the Company's policy regarding hiring new employees. The policy requires that references of prospective employees be contacted and that the prospective employee be subject to an interviewing process, including testing where appropriate and lawful, to determine whether the applicant has abilities suitable to meet the job requirements. Applicants are also subject to pre-employment drug testing and a background check.

Risk Assessment Process

Risk assessment is the identification and analysis of relevant risks to the achievement of our objectives, forming a basis for determining how the risks should be managed. Because economic, industry, regulatory, and operating conditions continue to change, mechanisms are needed to identify and address the special risks associated with change.

An enterprise risk assessment is performed annually. Internal Audit considers a range of elements during its annual risk assessment, which includes processes for risk identification and risk analysis, in addition to management's responses to the risk assessment interview process. Additional factors include the following: financial significance, inherent risk factors, control factors, reputation impact, operations impact, prior audit results, technical platform, organizational changes, fraud risk and segregation of duties. The results of the risk assessment are utilized to determine Internal Audit's audit plan for the upcoming year, which is presented to the Audit Committee.

Information and Communication

Pertinent information, both financial and nonfinancial, relating to external as well as internal events and activities, is identified, captured, and communicated in a form and time frame which enable employees to carry out their responsibilities. IT produces reports containing operational, financial, and compliance-related information which make it possible to run and control the business.

This pertains not only to internally generated data but also to information about external events, activities, and conditions necessary for informed business decision-making and external reporting. Effective communication also occurs in a broader sense, flowing down, across, and up the organization.

Control Activities

Control activities are actions established by the policies and procedures which help ensure management directives are carried out. Control activities, in addition to automated controls and general controls over technology, help confirm that necessary actions are taken to address risks which threaten the achievement of the entity's objectives. Control activities occur throughout the organization, at all levels and in all functions. They include a range of activities as diverse as approvals, authorizations, verifications, reconciliations, reviews of operating performance, security of assets, and segregation of duties.

Specific control activities are provided in the "Control Environment" description previously described, as well as the "Information Technology General Controls" and "Pharmacy Claims Processing Controls" descriptions provided below.

Monitoring

Internal control systems need to be monitored – a process which assesses the quality of the system's performance over time. This is accomplished through ongoing monitoring activities, separate evaluations, or a combination of the two. Ongoing monitoring occurs in the course of operations. It includes regular management and supervisory activities, as well as other actions personnel take in performing their duties. The scope and frequency of separate evaluations depends primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures. Internal control deficiencies are reported upstream, with significant matters reported to top management and the Board of Directors.

Ongoing monitoring of internal controls is performed in various ways by the Audit Committee, the Board of Directors, Internal Audit, and Corporate Compliance.

Audit Committee and Board of Directors

The Audit Committee is actively engaged in compliance with the Sarbanes-Oxley Act. In addition, the Audit Committee monitors the status of Internal Audit's annual audit plan and the mitigation of key audit findings. This review identifies the key controls within each significant process which have the potential to impact financial statements. The Audit Committee is responsible for communicating significant risks to the full Board of Directors.

Internal Audit

Internal Audit independently performs a series of audits over controls supporting key processes and other areas based on their risk assessment, and conducts management's testing of key controls under Section 404 of the Sarbanes-Oxley Act. Control weaknesses identified as a result of testing are brought to the attention of the responsible process owners, business owners, and executives. Internal Audit is responsible for providing independent assessments of risks and controls, as well as proposing recommendations to strengthen the control environment. Internal Audit reports and significant financial, operational, and compliance issues are provided to senior management and the results are shared with the Audit Committee. The status of issues is tracked and monitored by management, and Internal Audit follows up on issues to closure.

Corporate Compliance

The Chief Compliance Officer formulates a Compliance Plan each year to monitor compliance with the Code of Conduct and the Code of Ethics.

Information Technology General Controls

In support of pharmacy claims processing, Express Scripts has established an IT department that supports and maintains all in-scope systems. The following activities are managed by the IT department at Express Scripts:

- Logical Access
- Physical Access
- Application Development and Change Management
- Computer Operations

Logical Access

Express Scripts has developed Corporate Information Security Policies and Standards which are followed by the Express Scripts workforce. In addition, the Security Administration group has written procedures for routine security tasks.

Windows System Level Security

The first point of access restriction for Express Scripts system users occurs on the network. Express Scripts uses native Windows system options to control Windows passwords; when attempting to log on to the network, a user must authenticate by using a valid user ID and password of a minimum of eight characters in length. User passwords are set to expire after sixty days, and users may not reuse one of the previous seven passwords. User access is disabled after six consecutive unsuccessful logon attempts. Once disabled, users must use the self-service "Unlock" feature in Identity Management, contact the Service Center to unlock/reset their password, or wait 30 minutes and the password will unlock automatically. Local Area Network (LAN) parameters for primary password settings are set in accordance with management's policies (A-1c). Additionally, Windows Administrators are reviewed periodically to verify that privileged access is restricted to authorized personnel. Users no longer requiring privileged access are removed (A-1i).

Mainframe System Level Security

IBM's Resource Access Control Facility (RACF) security software is used to control logical access to the IBM mainframe environments. RACF controls who can access Customer Information Control System transactions, data sets, and all other system resources. RACF security parameters are set according to Express Scripts' Information Security policies.

The Security Administration team is responsible for RACF user account administration. F14 RACF users are assigned unique user IDs. RACF parameters for password settings are set in accordance with management policy (A-1g). RACF passwords must be eight characters in length and they must be composed of at least one letter and one number. User passwords are set to expire after sixty days, and users may not reuse one of the previous seven passwords. Users are permitted three attempts to complete a successful log-on. After the third unsuccessful attempt, the user's profile is disabled, locking the user out of the system. A user whose RACF user ID is disabled must contact the Service Center to have his or her user profile reset.

UNIX Server Level Security

Express Scripts restricts direct access to UNIX servers by the use of the CyberArk password management tool. On a periodic basis, access to CyberArk Administrative accounts is reviewed to ensure access is appropriately restricted. Users no longer requiring this level of access are removed (A-1j). Additionally, on a periodic basis, access to the UNIX root account is reviewed to ensure access is appropriately restricted. Users no longer requiring this level of access are removed (A-1h).

Database Level Security

Express Scripts utilizes DB2 (IBM database technology), Teradata, and Oracle databases to support the Claims Processing systems. Database Administrator (DBA) account privileges are reviewed periodically for appropriateness. Users no longer requiring DBA access are removed (A-1e). Additionally, a periodic review of users with access to the "Oracle" account (CyberArk accounts) on in-scope databases is performed to confirm that access is restricted to appropriate individuals. Users no longer requiring this level of access are removed (A-1k).

Application Security

CRS parameters for primary password settings are set in accordance with management's policies (A-1l). When logging on to CRS, a user must authenticate by using a valid user ID and password of a minimum of eight characters in length.

In order to gain access to the Bill Code Table, BA-Copay, or external eSD, a user must first authenticate into Client Website. When attempting to log on to Client Website, a user must authenticate by using a valid user ID and password of a minimum of six characters in length. User passwords are set to expire after forty-five days, and users may not reuse their previous password. User passwords must contain both alpha and numeric characters. (A-1n)

Information Security – New Hires and Changes

New user IDs and modifications to existing user IDs for Express Scripts employees are requested via a standard setup form submitted to the ServiceNow workflow and approved by appropriate management prior to provisioning (A-1a).

Access to eSD is auto-provisioned based on pre-defined criteria from the HR system to the Governance & Lifecycle (G&L) identity management system (A-1p). All role changes in eSD are approved prior to changes being made in production. New roles in eSD are requested by business owners through ServiceNow and must be tested and approved prior to implementation into production (A-1q).

Requests for the creation or modification of Bill Code Table user IDs must be approved prior to provisioning. (A-1m).

Information Security – Terminations

Notification of the revocation of access for terminated employees is a joint responsibility between the department terminating the employee and Human Resources. Upon termination, the department terminating the employee notifies Human Resources personnel who then update the Human Resources system. A daily interface file is generated by the Human Resources system which is used by Identity Management to automatically disable LAN access for terminated employees. Additionally, a daily Termination Report is generated for Security Administration to revoke LAN access for terminated contract employees (A-1b). Privileges can be immediately revoked by Human Resources by contacting Security Administration directly.

Access to the Bill Code Table, BA-Copay, and external eSD applications is restricted using a Lightweight Directory Access Protocol (LDAP), which does not interface with our corporate LAN environment. The removal of Express Scripts employee access to the Bill Code Table, BA-Copay, and external eSD for terminated users is performed by removing a user's access to the Client Website. Access for Express Scripts terminated employees is removed from Client Website upon notification (A-10).

Information Security – User Access Reviews

Identity access reviews are performed on a periodic basis for in-scope applications to confirm access is appropriate. Users no longer requiring this level of access are removed (A-1d). Application reviews follow one of two common processes and are managed by the IG team. User access reviews are executed through either a manual review or through a review leveraging a tool (G&L) which partially automates the review process. RACF user IDs are reviewed periodically to verify that privileged attributes are restricted to authorized personnel. Users no longer requiring this level of access are removed (A-1f). A periodic review of users with access to the Figaro Application is performed to confirm access is restricted to appropriate individuals. Users no longer requiring this level of access are removed (A-1r).

Physical Access

Express Scripts' Piscataway, New Jersey and Franklin Lakes, New Jersey facilities house the Company's main data centers for the in-scope systems, as well as supporting office and mailroom space. The buildings are secured using a computerized card access system, which controls electronic locks on both interior and exterior doors (A-2a and A-2d). The electronic locks on all doors in the facility are active 24 hours a day, 365 days per year. Additionally, the Piscataway facility is equipped with centrally monitored door alarms, closed circuit television (CCTV), and a 24-hour, seven-day-per-week security guard service (A-2a). The Franklin Lakes facility is equipped with entrance door alarms, closed circuit television (CCTV), and a 24-hour, seven-day-per-week security guard service (A-2d). The data centers have multiple layers of protection and dual authentication card readers, tailgate detection, and all video is archived for 90 days.

Each employee requiring routine access to either the Piscataway or Franklin Lakes Data Centers is assigned a badge with a unique security code. Access rights to each individual access area are requested by completing a standard Access Request form. This form requests personal information followed by a list of specific limited access areas within the building. To gain access to any of these limited access areas, the Access Request form must include a valid reason as to why the employee requires access to the specific area and must be signed by the Department Head responsible for each limited access area. Access to the Data Center is granted based on job requirements, and is approved by appropriate management (A-2b).

Area Managers over all special areas within the Piscataway and Franklin Lakes Data Centers periodically review reports of personnel with authorized access to those areas. Area Managers audit these reports by ensuring the listed personnel require access. Individuals no longer requiring access are removed. Each recipient of this report is required to review and return his or her copy of the report to Data Center security with details regarding any necessary changes (A-2c). Reports can be electronically signed and returned via e-mail.

As of October 31, 2019, the Franklin Lakes Data Center is no longer in scope as the eSD server moved locations to Piscataway. The eSD server was the last remaining server housed at Franklin Lakes.

Application Development and Change Management

Guidelines for application development and change management have been established by Express Scripts to provide a consistent methodology for project management, project definition, documentation of business and system requirements, program development, testing and implementation, database integrity, and user training. Communication of these procedures to employees establishes consistency for all projects.

Application development projects go through an intake process to ensure proper planning occurs prior to initiating the development effort. A program epic is created to track the overarching status of the project as it proceeds through development. At this point, high-level requirements are identified with solutions being generated. This allows for the creation of lower level epics to be created for various work streams. A security review is performed at this step to identify potential security requirements to be considered. From this point, the work is sent to individual teams to plan and prioritize. User stories are created by teams to split work into manageable units with the rest of development following the normal change management process.

Each application change is categorized into one of the following classifications:

- Non-emergency Changes
- Emergency Changes (scheduled and unscheduled)

For each category, Express Scripts has defined the minimum control points that must be completed.

For nonemergency changes, test cases are created, performed, and their results documented in accordance with management's policies (A-3a). Prior to implementation into production, a Change Request (CHG) is documented and approvals are required per management's policies (A-3b).

For scheduled Emergency changes, a Change Request (CHG) is documented and approvals are required per management's policies prior to implementation. An unscheduled Emergency change to resolve critical impacts will be documented and approvals are required per management's policies after implementation (A-3c).

Database Change Control

The DBA support teams use ServiceNow to create change records for database modifications. These individual change records are combined and used to generate a list of changes to the environment. All proposed table and unique key changes to the database structure are reviewed by the Information Planning group before they are submitted to the Database Administration team for review.

Database Administration teams review proposed changes to the database structure for required documentation and approve each change via a ServiceNow ticket (A-3e). All changes to production have a checklist with the corresponding implementation and back-out plans indicating any information needed to implement the scheduled change successfully.

Source Code Management

When changes are necessary for mainframe applications, Endevor manages access to the program source code library. The development environments are separate from production environments. Once the element (i.e. production code) has been moved into the staging library, Express Scripts application project managers review and approve element changes for the mainframe and midrange applications.

Authorization for the move from the staging library into production is documented electronically in the Endevor move package for the mainframe. This electronic approval requires an authorized RACF user ID and password from Production Control Operations Analysts.

Production Control Operations Analysts use Endevor Library Management to move elements from the staging library into production. This configuration requires Production Control to move elements from the staging library into the production library and combined with RACF security, secures access to production libraries and restricts programmers from moving changes into production. On a periodic basis, management compares developers with access to modify code in Endevor with users who can migrate mainframe code into production to determine whether appropriate segregation of duties exists. (A-3f).

eSD is a web application that utilizes a code repository for managing code promotion to production for relevant business components and ensuring appropriate segregation of duties. On a periodic basis, management compares eSD developers to those with access to migrate code to production to determine whether appropriate segregation of duties exists (A-3h).

The Phoenix and BTT systems use Pivotal Cloud Foundry, which utilizes an automated pipeline to move code changes into production. The process begins with developers coding within the source code repository. The source code undergoes automated builds, then is released into production upon completion of the necessary requirements in the release coordination and tracking tool. On a periodic basis, management compares Phoenix and BTT developers to those with access to migrate Phoenix and BTT code to production to determine whether appropriate segregation of duties exists (A-3g).

CGS is an application that utilizes a code repository for managing code promotion to production for relevant business components and ensuring appropriate segregation of duties. On a periodic basis, management compares developers with access to modify CGS code to users who can migrate CGS code to production to determine whether appropriate segregation of duties exists (A-3i).

Application Change Monitoring

On a periodic basis, a review of system generated change reports is compared against change tickets by the Controls Assurance team to verify that the appropriate process and approvals are associated to each of the changes. (A-3d). Discrepancies identified during this reconciliation process are escalated to management for resolution.

Computer Operations

Computer Operations Responsibilities

Express Scripts' data center is staffed 24 hours per day, 365 days per year with members from Resource Management. This group monitors all online and batch systems, and is responsible for the escalation of any exceptions. Standard operating procedures manuals exist for computer operations processes.

Scheduling for New or Changed Production Jobs

All job scheduling requests come to the Scheduling department via a ServiceNow ticket. The Scheduling team verifies Enterprise Application Management (EAM) has completed their ServiceNow task successfully. Job scheduling requests for recurring jobs are reviewed for accuracy, scheduling instructions, potential impact to another production job flow, and authorized by appropriate individuals (A-4a).

Job scheduling requests for one-time-only (OTO) jobs are reviewed for accuracy, scheduling instructions, potential impact to another production job flow, and authorized by appropriate individuals (A-4d). Information from the job documentation is then entered into CA-7, the production job scheduling software. All adds/changes are forwarded via automated e-mail to the Resource Management group and the Production Manager for review. The Production Scheduling tasks are stored on the ServiceNow server.

After Scheduling has placed the changes in CA-7, Resource Management reviews an automated email to determine whether changes need to be made to the delivery targets and Service Level Agreements (SLA) in the production batch monitor (BATMON). BATMON is an automated graphical system that tracks the start and end times of all critical jobs. Depending on the job's schedule, BATMON displays green (on time), yellow (late start), or red (late end) status bars.

BATMON is displayed at all times in the Resource Management area on a large screen monitor and is viewable by all analysts. If any "yellow" or "red" jobs are displayed, the technicians diagnose and follow-up on the cause of the alert (e.g., failed job, long-running flow). All CA-7 operational exceptions in production are documented in the ServiceNow problem ticket tracking system and are researched and resolved (A-4b). A periodic review of users with access to the CA-7 job scheduling software is performed to confirm access is restricted to appropriate individuals. Users no longer requiring this level of access are removed (A-4c).

Phoenix utilizes Oracle's GoldenGate product for replicating data from Oracle to DB2. An automated script monitors the data replication process and generates ServiceNow tickets to the Oracle DBA prod support teams for diagnosis and resolution of any operational exceptions. Application teams would be engaged if GoldenGate cannot be restarted due to data inconsistencies between Oracle and the DB2 database (A-4e). Access to GoldenGate is restricted to DBAs with access to the Oracle system account, which is periodically reviewed for appropriateness (A-1k).

Data is loaded into CGS from IW on a weekly basis using a scheduled job. CGS EIW batch jobs are monitored periodically to ensure successful transfer of data from IW to CGS. A Service Now ticket is created for batch job failures to track remediation (A-4f).

Pharmacy Claims Processing Controls

There are three types of prescription claims entry:

- Electronic claims
- Mail-order claims
- Non-standard claims

All claims (regardless of method submitted) are processed through F14. F14 receives the claim data and adjudicates the claim, performing all edits and related functions. Based on the eligibility checks and pricing routines, F14 determines whether the claim should be accepted or rejected and sends a response to the pharmacy. Acceptance indicates that the network pharmacy should accept the patient's insurance and charge the appropriate indicated price for the prescription. Rejection indicates that the network pharmacy should not accept the patient's insurance, and the patient should be notified that the prescription is not covered by his or her insurance plan.

Client Setup and Member Enrollment

Benefit Administration

New Client Implementations

During the implementation process for new clients, the client's specifications are entered into the appropriate tables and fields contained within several systems including: BCT (which feeds into the mainframe), CPS (which serves as a repository for all Client Profile data), CBM (which feeds CPS), CBPS (which also feeds CPS), PLB (which contains pharmacy specific benefit overrides, e.g. copay, drug list), the BA Copay Module (which associates the copay structure to the client) and the BA Module (a front-end data-entry tool which feeds CBM and CBPS). The Client Profile data, which is stored within the F14 mainframe, contains the group, client or plan sponsor data necessary for claims processing. Client personnel are required to approve benefit plan implementation documentation containing system specifications before processing of live claims (B-1a).

The Benefit Configurations - Pricing Department is responsible for the accuracy of pricing setup. The Benefit Configurations - Pricing workflow applies to pricing setup changes for retail, direct, mail-order and specialty prescriptions for Express Scripts' book of business. Its objective is to allow Account Management and Pricing Financial Analysts to review and approve financial pricing changes at an early stage of the enrollment process.

A Financial Analyst or Pricing Analyst first enters client information in the Houston Contract Request Form and Pricing Data Intent File. Prior to submission of the Houston Contract Request Form and Pricing Data Intent File for setup, the Financial Analyst or Pricing Analyst performs a validation of the client information against requirements (B-1b). After receipt of the Houston Contract Request Form and Pricing Data Intent File, Benefit Configuration – Pricing completes the pricing configuration in the various POS pricing data stores. Benefit Configuration – Pricing utilizes Houston to track the installation activity and ensure all steps are followed.

Benefit Configuration – Pricing performs scans, queries and automated quality checks of the BCT, CBPS and CBM/Client Profile fields and reviews all against requirements. The Benefit Configuration – Pricing analyst, responsible for quality control of the Houston Service Request (SR), follows a Quality Control (QC) checklist, which lists all the QC tasks performed. Upon completion of the QC of the pricing implementation, an Analyst moves the Houston SR to "completed" status. In addition, Benefit Configuration – Pricing performs a QC review of the Pricing Systems and compares pricing arrangements to requirement intent (B-1b).

Non-pricing configurations require data to be entered into the BA Module, BA Copay Module, and PLB by Benefit Operations – Non-pricing team. All non-pricing related manual changes are entered by a Benefit Operations Analyst after all appropriate approvals are obtained. All non-pricing changes submitted for entry into the respective system are validated by control B-1c.

The Benefit Validation/Testing Team performs QC validation of manual client benefit implementations from setup by Benefit Configuration and Benefit Operations. This team uses the BTT tool to test sample claims through the POS system adjudication logic to determine if client setup meets client intent.

For copay, clinical, coverage, and client pricing, the Benefit Validation/Testing Team performs validation of new benefit plan implementations to verify system setup is accurate based on client intent documentation (B-1c). In instances where the configuration form utilized to perform system setup is not the approved client intent document, a QC is performed to ensure that client intent was appropriately transcribed into the configuration form. Benefit validation QC excludes automated setup associated with Automated Group Load (AGL), but includes any manual setup associated with AGL.

Consumer Driven Health Implementations

Consumer Driven Healthcare (CDH) vendors are health plans or Third Party Organizations that offer combined benefit plans that encompass all aspects of medical care, including doctor's visits, hospital stays and prescription medications. CDH vendors may already contract with Express Scripts for pharmacy benefit manager services, but would like to share deductible accumulators between Express Scripts and their medical vendor. This may occur, for example, when a vendor's deductibles include both pharmacy and medical claims. In these instances, Express Scripts builds an exchange with the health plan or Third Party for the client which allows for a secure exchange of information regarding accumulators to track the client's total deductible, out-of-pocket, or other accumulators on a real-time basis or batch file. Medical vendors work with Express Scripts to resolve any issues relating to new connection testing and validation. Once both parties are comfortable with the results, the vendor provides approval for the test results. In the absence of vendor approval, a negative confirmation email is sent to the vendor, before an Eligibility Manager can approve set-up based upon the review of the testing and validation results (B-1h).

Changes to Existing Client Profile Information

To make changes to CPS, maintenance requests are submitted by the client through the AGL process or requests to Account Management or other internal Express Scripts areas. Requests not submitted through the AGL process may be submitted through front-ends of the CPS. Requests are either submitted through online web form via the BA Module, CBPS, CBM, or via paper addendum.

Data submitted via AGL is subjected to edit validation checks to ensure group records contain valid data, and confirmation is sent to the client or plan sponsor (B-1e). If a group's data passes all the relevant edits, then the updates for the group are moved onto the production client profile file during the daily update processes.

If the group fails one or more of the edits, a group pre-edit report which lists all "hard rejects" is submitted back to the client to address all failures and resubmit the group data. If the group data fails due to non-client setup errors, daily automated reports which list all "soft rejects" are sent to Benefit Operations/Account Management to resolve. Group data failures could result in members in suspense. Members in suspense are listed within the eligibility pre-edit reports sent back to the client for review. See further discussion within "Member Eligibility" below (B-4d).

Changes and additions made to benefit information require approval (B-1d). Changes and additions to benefit information can be processed either manually or through an automated process. Changes and additions received from the client are entered into an appropriate manual setup form or Benefit Build Automation (BBA) Configurable Intent Template (CIT) for client approval, coding (manual or automated), and self-QC review.

After self-QC, the entire request including all relevant change documentation is sent to the Benefit Validation/Testing team for testing and validation against intent (approved CIT or manual setup form) as a part of control B-1c.

As is performed with new implementations, prior to submission of the Houston Contract Request Form and Pricing Data Intent File for setup, the Financial Analyst or Pricing Analyst performs a validation of the client information entered into the forms against requirements. Additionally, the Benefit Configuration – Pricing department performs a QC review of the BCT, CBPS and CPS fields and compares pricing arrangements to requirement intent (B-1b).

Non-pricing configurations require data to be entered into the BA Module, BA-Copay Module, or PLB by Benefit Operations – Non-pricing team. Non-pricing related manual changes are entered and automated changes are loaded by a Benefit Operations Analyst after all appropriate approvals are obtained. All non-pricing changes submitted into the respective system are validated by control B-1c.

The Benefit Validation/Testing Team performs QC validation of manual and automated client benefit changes from setup by Benefit Configuration and Benefit Operations. This team uses the BTT tool to test sample claims through the POS system adjudication logic to determine if client setup meets client intent. For copay, clinical, coverage, and pricing, the Benefit Validation/Testing Team performs validation of benefit plan changes to verify system setup is accurate based on client intent documentation (B-1c). In instances where the configuration form utilized to perform system setup is not the approved client intent document, a QC is performed to ensure that client intent was appropriately transcribed into the configuration form. Benefit validation QC excludes automated setups performed by the BBA/Figaro automated setup systems, but includes any manual setups associated with BBA/Figaro client setups. Some of the benefit setup process has been automated by the use of the BBA tool, which processes setup load files sent by the Figaro system. Figaro receives setup data files and passes on this data to BBA for processing. Figaro then receives the results of the BBA processing and reports on what portion of the setup was successfully completed by the automation and portions that could not be configured by the automation and require manual configuration. Benefit changes and/or additions configured by BBA are validated against the request to verify that benefit setup was complete, accurate, and consistent with client intent (B-1i). Manual changes as a result of fallout are further subjected to the Benefit Validation process as part of B-1c.

Changes to Benefit Configuration – Drug Coverage

The plan file contains the drug inclusions/exclusions and days' supply limitations necessary for claims processing. The paperwork which is required to set up or change this data is maintained electronically in the Benefit Configurations – Drug Coverage Documentum library.

The Benefit Configuration – Drug Coverage area receives drug coverage requests electronically from Clinical Operations. Requests are reviewed for completeness and logged and tracked until closure into the Benefit Configuration – Drug Coverage Tracker. The Benefit Configuration – Drug Coverage Clinical Specialist first assesses the clinical appropriateness of the request and then researches the drug database to identify the appropriate coding values for the drug coverage requirements selected by the client or plan sponsor.

The drug coverage plan literal is created or updated to reflect the requested individual drug plan coverage or drug list content. The request is authorized and approved by the client prior to data entry. Benefit Operations – Drug Coverage configures / keys "coding" into the Drug Coverage Rules Station or Rumba for newly created / updated plan literal or drug list changes. The request status is changed to "coded" signifying it has been: 1) reviewed for appropriateness and 2) keyed into the file.

The request then goes through the Quality Assurance (QA) process for review of coding accuracy.

Requests for changes to the plan file are reviewed for completeness by the plan file area and are subjected to a QA process to validate coding accuracy (B-1f).

Edits to drug coverage involving global updates, drug plan maintenance, and clinical program edits do not require the approval of the Account Management group.

Changes to Clinical Rules

The Clinical Benefit Configuration Department receives requests for clinical rules to be set up or an existing rule to be changed within the Clinical Rules Station (CRS), which is stored within the F14 mainframe, by system service requests. Using the requests, the Clinical Rules area creates or updates the CRS rule. The rule creations or updates are processed using a manual or automated process.

Changes and/or additions to clinical information entered into the Clinical Rules Station are validated against the request to verify system setup was complete and accurate. (B-1g)

Additionally, client specific clinical rule changes are validated by the Benefit Validation/Testing Team against client intent documentation, whether these changes are made through the manual or automated CRS change processes (B-1c).

Drug Administration/Formulary Management

The Integrated Drug File (IDF), which is stored within the F14 mainframe, is the authoritative source and single repository of drug, pricing, and clinical data which is obtained from multiple external and internal sources.

On a weekly basis, FDB sends a standard customer e-mail update which is received by key IDF staff members. The e-mail update contains information on data elements which are expected to change in the next week. On a daily basis, electronic transmissions from FDB and Medi-Span, third party data vendors, are received, which include updates to various drug data elements (e.g. new drug information, price changes, strength updates, description updates, therapeutic class updates). New Generic Code Numbers transmitted by FDB are identified and automatically suspended for further review before they are updated within the IDF (B-2a). As a part of the review, the changes are reviewed against the e-mail update received the week prior to ensure that all expected updates were received.

Of the fields received from Medi-Span, currently only Average Wholesale Price (AWP) and Wholesale Acquisition Cost (WAC) pricing are utilized; all other drug data elements are received from FDB. An edit check exists to ensure that the transmission pulled is the current date's transmission. Additionally, the third-party vendor files are subjected to a completeness check on the records submitted for processing. The IDF verifies the record count on files received in order to verify the total number of third party vendor input records is posted completely to the IDF (B-2b).

Third Party Vendor files are subjected to edit checks on the records submitted for processing. The IDF compares current drug information to vendor submitted updates to verify the accuracy of third party vendor input records (B-2d). This comparison is initiated by a CA-7 job scheduler (see Control Objective A-4).

MAC Pricing Updates

The Maximum Allowable Cost (MAC) price for a drug is a pricing strategy which sets thresholds for retail pharmacy reimbursement on a product-by-product basis. The MAC pricing strategy is negotiated by the Retail Pharmacy Contracting team and included in contracts with Pharmacies. The Supply Chain Department is responsible for creating and maintaining the MAC lists. New drug and drug price change reports are generated daily from the IDF and are reviewed by Supply Chain. These reports are reviewed for any material price changes on existing MAC drugs. Also, new drugs are considered for MAC inclusion. Changes to MAC price are made through an automated load. An automated email containing the load results is generated and reviewed by Supply Chain pricing personnel. If errors are noted within the results, they are investigated and corrected (B-2e).

Formulary Updates

The Formulary Operations department gathers new drug information on a daily basis. Although the group does not have any pricing function, they determine, via the Value Assessment Committee (VAC), which drugs are on the national formulary, and present their findings to clients to assist in their decision-making process. Formulary Operations personnel will then create a Track-Log Event, which assigns a unique identifier to each required update.

The Formulary Operations team then updates the coding in the F14 FRS, which is stored within the F14 mainframe. FRS coding updates are performed either manually or through automation, depending on the change request form submitted. Changes and/or additions to drug formulary information entered into the Formulary Rules Station are validated against the request to verify system setup was complete and accurate (B-2c).

Pharmacy Administration

The pharmacy administration process includes the establishment of various types of pharmacies into Express Scripts' network of pharmacies. As providers in Express Scripts' network, pharmacies are able to adjudicate pharmacy claims through Express Scripts. In turn, eligible members are able to select a particular pharmacy contained within Express Scripts' network to fill their prescriptions. Retail Contracting is responsible for recruiting and contracting with the pharmacies. Upon receipt of the final contract information, Network Operations enters the pharmacy provider and network information into Phoenix. There are two types of pharmacies which can be set up in Express Scripts' environment: (1) independent and (2) chain.

An independent pharmacy does not have an affiliation with a chain. However, it may have the desire to be included in Express Scripts' network of pharmacies and therefore must establish a contract with Express Scripts. Independent pharmacies may contract with Express Scripts directly or jointly with other independent pharmacies through a Pharmacy Services Administration Organization (PSAO) or a Group Purchasing Organization (GPO) by signing an affiliation letter. The PSAOs and GPOs then contract with Express Scripts on behalf of the independent pharmacies. PSAOs and their affiliated independents are identified by a chain code for contracting purposes.

Chain pharmacies are contracted in Express Scripts' network as a chain, and are identified by a chain code in Express Scripts' systems. The chain's contract applies to all pharmacies under its chain code. New pharmacy chains require the establishment of a new contract, which is coordinated by the Contract Account Managers.

The Retail Contracting department reviews and distributes the signed contracts to Network Operations to enroll the pharmacy. Express Scripts personnel are required to receive approval for rates, fees, and network affiliations prior to pharmacy setup (B-3a). Approval is received prior to set up within Phoenix by Network Operations. Changes to chain pharmacies are required to be validated by the pharmacy or the chains' corporate office. An individual independent of the original data entry process verifies pharmacy information specific to rates, fees, and network affiliations entered into the system for accuracy (B-3b). Initial contract pricing, including dispensing rates, MAC and drug level pricing, are set up within Phoenix by Network Operations based upon the contractual terms. The set up follows the same process as noted in control B-3a and B-3b above.

In order to allow for real time updates, Retail Network Pricing accesses a database and makes pricing adjustments as necessary for network claim adjudication. The Retail Network Pricing team updates pricing in accordance with contract terms using automated file loads (Mass Upload). Pricing adjustments are populated on an Excel pricing file for upload to the pricing tables. Pharmacy pricing updates in compliance with contract terms are reviewed and approved by a Retail Network Pricing Director or above prior to upload (B-3c). Through October 21, 2019, an individual independent of the original data entry process in the Mass Upload pricing file verifies pharmacy pricing information entered into the file for accuracy (B-3d). Additionally, both the individual who built the Mass Upload file and the independent reviewer's logins are recorded in the audit file.

Pricing adjustments can also be made utilizing the Flex Pricing Tool within Phoenix. After the pricing input file is loaded, pricing updates are simulated by an automated QC process within the Flex Pricing Tool. If the results are acceptable, Pricing management approves the updates prior to them being loaded into production (B-3f). If errors are noted within the results, they are investigated and corrected.

Through October 21, 2019, an automated job runs each evening to upload the Mass Upload pricing files into the DB2 tables. Pricing updates are made through an automated load to manage contractual obligations. A report containing the load results for Mass Upload is generated and reviewed by Pricing personnel. If errors are noted within the results, they are investigated and corrected (B-3e).

Member Eligibility

New client implementations

The Eligibility department is responsible for working with the Implementation team to successfully set up and launch a client organization's benefit eligibility process. The Eligibility department is specifically responsible for the implementation and maintenance of the eligibility interface for new and existing clients. The Eligibility Project team performs the following functions on a regular basis:

- Analysis of clients' eligibility requirements
- Setting up Express Scripts' Eligibility system parameters based on client requirements
- Testing clients' eligibility data (or changes to existing interfaces)
- Loading clients' initial eligibility data
- Supplying data for ID card production

Eligibility Technical Analysts are responsible for setting up Express Scripts clients in the Eligibility system to confirm new enrollment information can be received on a continuous basis. The team has a standard methodology to follow for the project management of eligibility implementations. This methodology covers the process for obtaining the client eligibility data as well as testing of client transmissions to confirm enrollment data is received completely and accurately for both the initial load of the client's eligibility and ongoing maintenance files.

To verify client eligibility files are received completely and accurately, Express Scripts documents each client's eligibility file information contents, format, medium, frequency, and volume. The Eligibility department also documents the client's matching criteria (system edits), such as the participant's date of birth, gender, relationship code, first name, last name, group ID, and dependent ID, to match against the values stored in the Eligibility File to verify the participant's coverage is in effect.

After the client has verified the documented eligibility file information and selected the specific criteria (system edits) to utilize, Express Scripts develops test plans for the Eligibility system. Eligibility personnel test system parameters for new client implementations and re-implementations to confirm that data is processed completely and accurately in accordance with client specifications.

Client data is validated by the client review and approval of either the test plan and results, test summary documents, or the eligibility pre-edit report. In the absence of client approval, a negative confirmation email sent to the client should be in effect, before an Eligibility Manager can approve set-up based upon review of the test plan and results, test summary documents, or the Eligibility pre-edit report (B-4a).

Existing client updates

The Eligibility department is responsible for the receipt and processing of eligibility data for existing clients and performs the following functions on a regular basis:

- Supports the processing of eligibility batch updates
- Resolves data discrepancies
- Supplies data for ID card production
- Performs emergency eligibility updates

The eligibility process begins when membership and group data are loaded to the Eligibility File via online screens or electronic file transmissions from off-site locations. Updates to eligibility information can be submitted in one of the following methods:

Positive or full files contain information on all active members/dependents; if a client or plan sponsor omits a record, the members/dependents will be terminated as of the day the file is processed (Generated Term Process)

Transactional or maintenance files provide information pertaining to new members/dependents and existing members/dependents which have a change to their eligibility record

Front-end data entry through the eSD application can be used to feed manual edits to individual member eligibility records into the Eligibility system. Manual edits approved by the client can be made to individual member eligibility records via eSD. eSD can be accessed by both internal personnel and external client users. Client personnel are responsible for reviewing all manual edits made to member eligibility records.

All electronic files are processed through the eligibility pre-edit step. During the eligibility pre-edit step, the client or plan sponsor's eligibility transactions are processed, and the expected impact on the client or plan sponsor's eligible population (at the group level) is identified. If the number of eligibility records received from the client does not match the number of records noted by the client in the trailer record, the Eligibility system will abend. The Eligibility Department will notify the client that a new file is necessary before the data can be loaded to the system (B-4d). The eligibility pre-edit reports sent back to clients include both correct and errored data for the client to review.

For files which do not abend based upon record count variances, additional edits are applied to the incoming transactions, and errors and rejected transactions are identified.

A set of statistical parameters & edits are built within the Eligibility system to determine if the file passes validation and should be applied. Edit checks include: Verification of Customer ID, Date of birth, Member number, and Client group must be established before records are accepted (B-4b).

The eligibility pre-edits are processed and systematically reviewed to determine if the file should be applied based on a set of statistical parameters. Criteria are based on the size of the input file and the number of changes to the existing file. If the system review of the eligibility pre-edit report determines the file exceeds the statistical parameters for updating with errors (such as a high volume of rejects, changes or terminations), an automated e-mail will be sent to the Account Manager or Eligibility Analyst supporting the particular client or plan sponsor.

The Account Manager or Eligibility Operations Analyst will review the issues with the client or plan sponsor and determine whether the file should be applied. If it is determined that the file should not be applied, the file is purged, and a corrected file is scheduled. Unprocessed Reports are generated from the eligibility pre-edit process which may be transmitted to the client or plan sponsor.

Eligibility data submitted via eSD is subjected to online edit validation checks on required fields in order to add/update records. Edit checks include: Date of birth, Member number, and Client group must be established before records are accepted (B-4e).

For clients who are enrolled in the Generated Term process, system logic confirms records within the Eligibility system are updated using the full population client file. Records sent on a full population client file which do not exist within the system are added, records within the system which do not exist on a full population client file are terminated, and records on a full population client file with updated fields are modified accordingly within the system (B-4c).

Claims Processing/Adjudication

Claims Processing

Pharmacy claims can be entered into the POS system via electronic transmission or manually when paper claims are submitted. Paper claims represent less than 1% of all network claims. Therefore, the scope of this report does not include controls in place supporting the processing of paper claims.

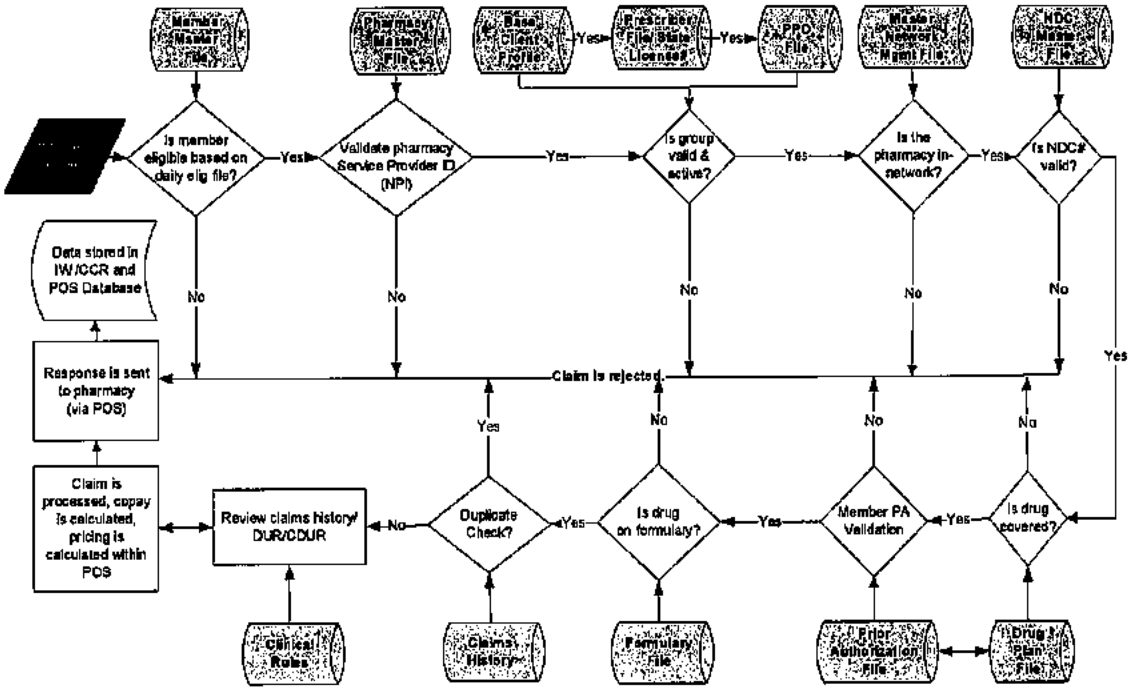
Mail-order claims are entered into the POS system via electronic transmission through Express Scripts' proprietary mail-order systems. The scope of this report does not include mail-order fulfillment processes which Express Scripts provides through its proprietary mail-order systems.

The majority of electronically received claims are sent to Express Scripts by pharmacy network providers. Pharmacies contract with external pharmacy network providers which route claims entered at the pharmacy to a pharmacy clearinghouse or switching company and then to Express Scripts. Electronic claims can be submitted directly to Express Scripts by chain pharmacies if the chain submits over 100,000 claims per month.

The POS system processes claims in several phases. Claim transaction field editing checks each field submitted for permissible values. Numeric fields are checked for non-numeric values. Alphanumeric fields are checked for non-alphanumeric characters. If any of these fields are not populated or do not contain valid data, the claim is rejected back to the submitter using standard National Council for Prescription Drug Programs (NCPDP) rejection codes.

The following list contains a subset of required fields:

- Basis of cost determination
- Sales tax
- Flat tax
- Percentage tax
- Percentage tax basis
- Percentage tax rate
- Bin number
- Cardholder ID
- Quantity dispensed
- Patient first name
- Patient last name
- Person code
- Prescription Service Reference Number
- Days' supply
- Date prescription written
- Date of birth
- Processor control number
- Compound code
- Relationship
- Gender code
- National Drug Code (NDC) (product/service ID)
- Dispensed as written code
- Usual and customary amount
- Version number
- Transaction count
- Service/provider ID



Claims data submitted into the POS system is subject to the following types of programmed system edit and validation checks: Eligibility member/group verification, Pharmacy verification, Prescriber verification, Ingredient cost, and NDC (C-1a). The POS system performs Coverage Edit checks in order to determine whether a claim is received from an authorized source. Claim eligibility involves finding a group in which the member, dependent, and pharmacy are eligible; identifying the patient (member or specific dependent) for whom the prescription was written; verifying the pharmacy; and checking for pharmacy participation in the applicable Pharmacy network. The Coverage Edit routine verifies that the group and subscriber, as well as the plan, drug and pharmacy information associated with a given claim, are valid.

This information is verified against the information on the subscriber master file and the plan specifications as defined in the client profile file. If the claim fails any of the Coverage Edits, the claim will be rejected. Additionally, the integrated drug file is read to validate that the NDC for the claim submitted is valid. The claim will be rejected if the NDC is invalid. FDB, a third-party vendor, provides drug information, including valid NDCs.

Any prescription which is filled for the same member, pharmacy, Rx and fill number, is considered a duplicate claim by POS system logic (C-1b). The history file is an extract of the historical claims file which contains a condensed version of claims from all previous cycles up to a client or plan sponsor-specific limit. The term 'dup history' refers to the combination of current cycle files plus the actual duplicate history file. In claims processing, the contents of both the current cycle files and the dup history file (relative to the member) are extracted and loaded to a single table for use by the duplicate/refill/drug utilization review modules.

If no duplicate record is found on either the POS payable claim file or the history file, then the same two files must be searched for refills using the same information as listed in the duplicate edit. Each refill found is counted, and if the number of refills exceeds the plan limit, the claim is rejected.

At this point, the POS system obtains the specific drug information necessary to price the claim. Next, the POS system reads the member's plan file to determine drug coverage. Specific plan files contain inclusions and exclusions for each client or plan sponsor. If the particular drug is excluded from the member's plan, the claim will be rejected. Next, the POS system reads the prior authorization file to determine whether the plan exclusions have been overridden, allowing acceptance of claims for otherwise excluded drugs.

The formulary file is read if the client or plan sponsor participates in a formulary management program. The formulary file contains information on an NDC or therapeutic level. Based on the setup of mandatory or voluntary plan status, edits within the POS system reject claims based on their formulary status (C-1c). If the NDC is not a formulary drug and the formulary file indicates there is a preferred drug, the POS system obtains the information on the preferred drug and uses this information to prepare the response back to the pharmacy. The claim is rejected if quantity or days' supply for the prescription exceeds the limits specified on the plan file. A message is sent to inform the pharmacy of the allowable days' supply or quantity and the claim exceeded plan limitations.

Claims accepted up to this point must be priced to determine the subscriber's co-insurance amount, as well as the amount to be reimbursed to the pharmacy and billed to the plan sponsor. The POS system calculates claims co-payment fees based on benefit plan specifications (C-1g). Based on the plan's benefit specifications, POS determines pricing and claim coverage through the following: drug price, client billed amount, pharmacy reimbursement, and member co-pay (C-1d). The POS system compares the drug price to AWP, MAC, and Usual & Customary (U&C) pricing and selects the amount based upon the client specifications within the system (C-1f). As part of the agreement to participate in the managed pharmacy networks, pharmacies must agree to accept the lower of discounted contracted reimbursement rate or the usual and customary price. Pharmacy networks and pricing agreements vary by user organization and network.

Next, the POS system reads information from the professional fees file, which stores each client's professional or dispensing fee. Information from the client profile, NDC, plan, pharmacy and PPO files obtained previously will be used to determine the professional fee, co-payment, payable ingredient cost and net check amount to be sent to the pharmacy.

POS Indemnity tables accumulate claim costs to determine maximum out-of-pocket limits, deductibles, and plan stop-loss limits (C-1e). Express Scripts stores payable and reject claims in an internal proprietary database which is accessed by downstream systems. Rejected and paid claims are also written to IW Staging Tables. This data is used for invoicing and reporting (for more information, see "Claims Billing Processing" below).

Based on the results of the eligibility checks and pricing routines, the system constructs a response to the pharmacist. The transactions conform to the NCPDP standard and display a message for the pharmacist indicating the claim's status (accepted or rejected). Payable responses are sent back with a unique authorization number using the NCPDP payable response format. For each accepted prescription on the claim, the system returns a response status of 'P' to indicate that the claim is payable. Additional response data consists of the member's co-payment amount, the ingredient cost payable, and the dispensing fee payable. Rejected responses are sent back in the standard NCPDP rejection response format using NCPDP rejection codes. Responses for rejected claims will include a response status of 'R' and the NCPDP error code(s) citing the reason(s) for rejection.

Claims Billing

Claims Billing Processing

Automated billing of claims is performed using the IBS system and claims data from the IW. At the conclusion of each day, claims adjudicated within POS are written to the IW. The POS Summary table is then referenced to obtain summarized counts by transaction type (i.e., retail/mail claims, retail/mail rejects, and retail/mail adjustments). Once this process has completed, the POS system data is compared by transaction type to the IW summarized claims data to verify that the claim counts agree. A balancing report is generated and any exception (current threshold is claim difference of 1,500) is noted by a system abend, researched, and resolved (C-2a).

The IW file records claims as Pending 'P' or Billable 'B'. On a daily basis, the mainframe scheduler runs a claim extract from IW Staging into IBS based on a claim's (1) billable date field and (2) status. The extract will pull claims with a status of Billable 'B' into IBS.

On a weekly basis, a Revenue Cycle Management Analyst runs a query identifying claims in IW Staging with a status of 'P' or 'B' and claims greater than 45 days old, but less than 365 days old, are monitored and investigated when the unbilled claims exceed $1,000,000 to determine if resolution is required (C-2d). Claims aged 365 days or greater are considered write-offs/uncollectable.

Once claims have been billed, claims within IW Staging are marked with a billed status. Once claims have been marked with a billed status, the claim cannot be re-selected for billing (C-2b).

Bi-weekly, an automated process reconciles the summarized IBS billing invoice data, for the specific billing period, to the claims data stored in IW Staging. If a discrepancy is identified, the job which moves claims from the IW Staging tables to the History tables abends and a ticket is generated by Resource Management (RM) flagging the discrepancy (C-2e). Additionally, the Billing PSO team investigates out-of-balance reported items between IW Staging and IBS billed claims and documents resolution to ensure out-of-balance discrepancies do not result in an inaccurate or incomplete client invoice (C-2f).

Claims and administrative fee data is downloaded at the client level from the IBS file and may be adjusted prior to or after invoicing. Account Managers and other groups may send a form to the Contracts Department for a manual billing or an adjustment to a client balance. The standard form utilized is the Manual Billing Request Form, which specifies the reason for the adjustment and provides a section for required approval/sign-off by Finance.

Adjustments initiated in Finance, such as Net Effective Discount (NED) invoice adjustments, may already contain the necessary Finance approval/sign-off as part of the Finance process prior to completion of the Adjustment Request Form. Only approved adjustments are forwarded to the Contracts Department and/or Billing to be processed.

The Adjustment System is composed of programs and online screens which control the input and processing of adjustments to user organization invoices and claims history. Adjustments may be made for a variety of reasons, such as prescriptions not dispensed (i.e., reversals) or prescriptions submitted incorrectly which require correction (e.g., incorrect dispense as written, quantity, NDC).

Adjustments to prescription claims are processed using three basic transaction types: Flat, Re-price, and Reversal. Adjustments are applicable to integrated client or plan sponsors only. Departments authorized to enter adjustments are Finance, Pharmacy Audit, and Pharmacy Services.

The Revenue Cycle Management Team will obtain the necessary approvals as outlined in Express Scripts company policy documentation before processing adjustments or manual billings (C-2c).

Client Guarantee Settlements

Guarantee Setup

Included in the Contract Request Form (CRF) completed by the Financial Analyst/Pricing Analyst is AWP pricing guarantee setup information, which include guarantee rates, exclusions, and other data necessary for the guarantee calculation. The Contract Request form is included within an SR that is sent to Financial Client Operations (FCO) for setup. An FCO Analyst then enters the guarantee information into CGS based on the Contract Request Form. Once guarantee information is input and submitted in CGS, it is independently reviewed and electronically verified after a reviewer compares the information placed in CGS against the client contract information. New setups and changes are not included in the guarantee calculation until approved electronically by an individual independent of the setup. (C-3a)

Guarantee Calculation

Once guarantee setup is complete and approved within CGS, claim information is automatically pulled from the IW into CGS. On a weekly basis, an automated sync of IW and CGS occurs. If there is a discrepancy in the load, the process is aborted and the production resource management team notifies the Information Warehouse (IW) Team of the issue. All issues are then investigated and resolved by the IW Team. (A-4f).

The guarantee is setup within CGS to link to a client and a date range to pull claims from the IW. Additionally, there are several reference lists used in the guarantee calculation, as certain transactions are often excluded from the guarantees, including Single Source Generics, New Generics, and Patent-Litigated Drugs, among others. CGS automatically calculates guarantee performance by applying profile and exclusion rules and parameters input into CGS for each client guarantee according to a client's contract. CGS automatically queries claim data and reference lists from IW based on CGS profile and exclusion rules to gather guarantee performance results. (C-3b)

Guarantee Settlement

At the end of the guarantee period, CGS automatically creates a task within the payment workflow and generates the settlement report, which compiles all final claim data for the client during the applicable settlement period and shows actual results compared to the guarantee. The analyst assigned to the task will review all guarantee rates, exclusions and offsetting per the CGS setup to the contract to validate the accuracy and completeness of the settlement calculated. The completed report is uploaded to the payment workflow where it is assigned to a second independent reviewer. Guarantee settlement packages are independently reviewed for completeness and accuracy prior to client submission. (C-3c) Guarantee settlement packages are provided to clients regardless of whether or not a payment is due. If a guarantee payment is due, guarantee payments to clients are approved by authorized management based upon the Grants of Authority (GOA) grid. (C-3d)

Control Objectives and Related Controls

Express Scripts has specified the control objectives and identified the controls that are designed to achieve the related control objective. The control objectives specified by Express Scripts and the controls that achieve those objectives, including complementary user entity controls, are presented in Section IV, "Express Scripts Holding Company's Control Objectives and Controls, and PricewaterhouseCoopers' Tests of Operating Effectiveness and Results of Tests" and are an integral component of Express Scripts' description of its Pharmacy Claims Processing system.

Complementary User Entity Controls

Express Scripts' controls related to the Pharmacy Claims Processing system cover only a portion of overall internal control for each user entity of Express Scripts. It is not feasible for the control objectives related to claims processing to be achieved solely by Express Scripts. Therefore, each user entity's internal control over financial reporting should be evaluated in conjunction with Express Scripts' controls and the related tests and results described in Section IV of this report, taking into account the related complementary user entity controls identified for each control objective, where applicable. In order for user entities to rely on the controls reported on herein, each user entity must evaluate its own internal control to determine whether the identified complementary user entity controls have been implemented and are operating effectively.

User entities should have the following controls designed, implemented, and operating effectively throughout the period:

Complementary User Entity Control Description	Relevant Control Objective
Access to Eligibility Systems User organizations are responsible for ensuring that access to eSD is appropriately restricted to authorized individuals.	CO A-1
Written Benefit Plan Parameters Correspond to the F14 System User organizations are responsible for verifying their written benefit plan parameters are complete and accurate as described in the Express Scripts Benefit Design document completed during implementation and ensuring the parameters are approved by their appropriate management. Examples of these documents include the Benefit Intent Document (BID), Clinical Intent Document (CID) and Clinical Addendum (CA).	CO B-1
Benefit Plan Additions or Changes User organizations are responsible for ensuring their management has reviewed and approved benefit plan additions or changes which are communicated to Express Scripts.	CO B-1
Group Data Submitted via AGL User organizations are responsible for ensuring group data submitted via AGL is complete, accurate and authorized prior to submission to Express Scripts. User organizations are responsible for reviewing the group pre-edit report. Corrective action must be taken to correct the issue(s) and the data must be resubmitted to Express Scripts for reprocessing.	CO B-1

Complementary User Entity Control Description	Relevant Control Objective
Consumer Driven Healthcare User organizations that participate in Consumer Driven Healthcare are responsible for management of member accumulators and ensuring that medical claim information shared with Express Scripts is complete, accurate, and authorized.	CO B-1
Review of Drug Formulary Lists User organizations utilizing Medicare formularies are responsible for reviewing formulary content, as provided to them by Express Scripts on at least an annual basis, prior to the clients' submission to the CMS.	CO B-2
External Formulary Management User organizations that utilize external formularies are responsible for providing valid formulary information to Express Scripts.	CO B-2
Review of Test Results User organizations are responsible for ensuring their management has reviewed and approved client-specific system test results prior to processing claims in a production environment.	CO B-4
Member Eligibility Data User organizations are responsible for ensuring member eligibility data is complete, accurate, and authorized prior to submission to Express Scripts.	CO B-4
Eligibility Summary and Reconciliation of Error Reports User organizations are responsible for ensuring all individual manual edits, including those entered via eSD, as well as all Eligibility Summary and Error reports, which summarize electronic file loads, are reconciled to documentation of transactions sent to Express Scripts to identify input exceptions. Corrective action should be taken to correct the issue(s) and the data should be resubmitted to Express Scripts for reprocessing.	CO B-4
Reconciliation of Claims Billings User organizations are responsible for the review and comparison of Claim Billing reports generated from the IBS system to the invoice to determine invoices generated by Express Scripts reconcile to the claims adjudicated.	CO C-2
Review of Settlement Packages User organizations are responsible for the review of guarantee settlement packages generated by Express Scripts.	CO C-3
Review of Executed PBM Agreements User organizations are responsible for obtaining a copy of their executed agreement prior to the effective date to ensure the terms and conditions were applied accurately.	CO C-3

Section IV – Express Scripts Holding Company's Control Objectives and Controls, and PricewaterhouseCoopers' Tests of Operating Effectiveness and Results of Tests

Testing Performed and Results of Tests

This section presents the following information provided by Express Scripts:

- The control objectives specified by management of Express Scripts
- The controls established and specified by Express Scripts to achieve the specified control objectives

Also included in this section is the following information provided by PricewaterhouseCoopers LLP (PwC), the service auditor:

- A description of the tests performed by PwC to determine whether Express Scripts' controls were operating with sufficient effectiveness to achieve specified control objectives. PwC determined the nature, timing, and extent of the testing performed
- The results of PwC's tests of controls

The control objectives and related controls in Section IV are an integral part of management's description of Express Scripts' Pharmacy Claims Processing System for processing user entities' pharmacy claims transactions outlined in Section III of this report. Express Scripts sometimes modifies or expands controls to meet the processing requirements for specific user entities. PwC's testing covered only those controls provided by Express Scripts for the broad range of user entities and did not cover controls which may be specific to individual user entities of Express Scripts. PwC's tests of the control environment, risk assessment, monitoring, and information and communication included 1) inquiry of appropriate management, supervisory, and staff personnel, 2) observation of Express Scripts' activities and operations, and 3) inspection of Express Scripts' documents and records. The results of these tests were considered in planning the nature, timing, and extent of our testing of the controls designed to achieve the control objectives described on the following pages.

PwC's tests of the operating effectiveness of the controls included procedures which were considered necessary in the circumstances to evaluate whether such controls, and the extent of compliance with them, were sufficient to provide reasonable, but not absolute, assurance that the specified controls were achieved during the period from May 01, 2019 to April 30, 2020. The testing of the operating effectiveness of controls was designed to cover a representative number of transactions and procedures throughout the period May 01, 2019 to April 30, 2020, for each of the controls listed, which was designed to achieve the specified control objectives. The following were considered in selecting particular tests of the operating effectiveness of controls: (a) the nature of the control being tested; (b) the types and competence of available evidential matter; (c) the nature of the control objectives to be achieved; (d) the assessed level of control risk; and (e) the expected efficiency and effectiveness of the tests.

Additionally, observation and inspection procedures were performed as it relates to system generated reports, queries, listings, and reporting noted in management's description to assess the completeness and accuracy (reliability) of the information utilized in the performance of our testing of the controls. For exceptions identified during the course of our testing, Management Responses to the exceptions identified have been provided and are located within Section V of the report. The types of testing procedures used to evaluate the fairness of the description of the control and to evaluate the operating effectiveness of specified controls are indicated below.

Type	Description
Inquiry	Interviewed appropriate personnel. Inquiries seeking relevant information or representation from Express Scripts' personnel were performed to obtain: o Knowledge and additional information regarding the policy or procedure; o Knowledge of Express Scripts' organizational structure, including segregation of functional responsibilities, policy statements, processing manuals, and personnel policies; o Knowledge of management, operations, administrative and other personnel who are responsible for developing, ensuring adherence to, and applying control structure policies and procedure; and o Corroborating evidence of the policy or procedure. As inquiries were performed for all controls, the test was not listed individually for every control shown in the control matrices below.
Inspection	Inspected documents and client records indicating performance of the control. This includes procedures such as: o Examination of source documentation and authorizations; o Examination of documents or records for evidence of performance and authorization (i.e. existence of initials or signatures); and o Inspection of Express Scripts' systems documentation, such as operation manuals, policies and procedures documentation, system flowcharts, and system audit logs.
Observation	Observed the application or existence of specific control structure policies and procedures as represented. This includes procedures such as: o Observations of personnel in performance of their assigned duties; and o Observation of various system tasks performed by Express Scripts' personnel.
Reperformance	Reperformed the control or processing of the control to determine the accuracy of its operation. This includes procedures such as: o Reperformance of the control, for example, by checking prices, effective dates, or specifications within the processing system; and o Obtaining evidence of the mathematical accuracy and correct processing of transactions by performing independent calculations and/or the submission of test transactions.

Testing Performed and Results of Tests when Using the Work of Internal Audit

In performing our examination of the description, PwC has used the work of the Express Scripts Internal Audit Department (Internal Audit) to assist in determining whether the controls related to the control objectives stated in the description were operating with sufficient effectiveness to provide reasonable assurance that those control objectives were achieved throughout the period May 01, 2019 to April 30, 2020. Internal Audit's work was used to provide evidence for select controls in the following processes:

- Logical Access (Control Objective A-1)
- Application Development and Change Management (Control Objective A-3)
- Computer Operations (Control Objective A-4)
- Client Setup and Member Enrollment (Control Objectives B-1 & B-2)
- Claims Billing (Control Objective C-2)

The testing performed by Internal Audit related to controls over routine processes, and the nature of testing included inquiry of relevant parties who performed the controls, observation of the performance of the controls at different times during the examination period, inspection of samples of documents evidencing the functioning of controls, and/or reperformance of the operation of certain controls. The results of testing performed, including any exceptions identified, by Internal Audit are included in the "Results of Tests" below.

In connection with using the work of Internal Audit, PwC obtained the work papers supporting the tests performed and reviewed the work papers to evaluate whether the work was: (1) performed by a person having the appropriate skill and expertise, (2) properly supervised, reviewed and documented, (3) supported by sufficient, appropriate evidence to draw reasonable conclusions which were appropriate in the circumstances and consistent with the work performed, and (4) any exceptions or unusual matters were appropriately resolved. In addition, PwC (1) inspected the supporting documentation for all controls to evaluate the consistency of the working papers to the supporting documentation, and (2) for selected controls, reperformed the testing for a sub-sample of the sample selected.

Information Technology General Controls

Logical Access

Control Objective A-1: Controls provide reasonable assurance that logical access to system resources (e.g. programs, data and parameters) is restricted to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-1a	Requests for the creation or modification of system user IDs must be approved prior to provisioning.	• For a sample of new or modified users, inspected the requests for the creation or modification of system user IDs to determine whether the IDs were approved prior to provisioning.	No exceptions noted.
A-1b	LAN access for users who leave the company is removed upon notification via the Human Resource system Termination Report.	• For a sample of terminated employees, inspected system access records to determine whether LAN access was removed.	No exceptions noted.
A-1c	LAN parameters for primary password settings are set in accordance with management's policies.	• Inspected LAN parameters for primary password settings to determine whether they were set in accordance with management's policies.	No exceptions noted.
A-1d	Identity access reviews are performed on a periodic basis for in-scope applications to confirm access is appropriate. Users no longer requiring this level of access are removed.	• For a sample of in-scope applications, inspected supporting documentation to determine whether an entitlement validation was performed and appropriate approval was obtained. • For a sampled semi-annual identity access review for in-scope applications, inspected the review for a sample of users to determine whether access was reviewed and users no longer requiring access were removed.	No exceptions noted. No exceptions noted.

Logical Access

Control Objective A-1: Controls provide reasonable assurance that logical access to system resources (e.g. programs, data and parameters) is restricted to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-1e	DBA account privileges are reviewed periodically for appropriateness. Users no longer requiring this level of access are removed.	• Inquired of IT personnel to confirm the process used to determine whether DBA account privileges are reviewed periodically for appropriateness and users no longer requiring this level of access are removed.	**Exception noted.** Access to the DB2 databases that support the Integrated Drug File (IDF) was not included in management's DB2 access review process until Q1 of 2020 and therefore access was not reviewed during Q2, Q3 or Q4 of 2019. No exceptions were noted for the remaining in-scope DB2 Databases. Refer to Section V of the report for additional information provided by management in response to this exception.
		• For a sample of quarterly access reviews for DB2 databases, inspected the reviews for a sample of users to determine whether DBA account privileges were reviewed for appropriateness and users no longer requiring access were removed.	No exceptions noted.
		• For a sample of quarterly access reviews for Teradata databases, inspected the reviews for a sample of users to determine whether DBA account privileges were reviewed for appropriateness and users no longer requiring access were removed.	No exceptions noted.

Logical Access

Control Objective A-1: Controls provide reasonable assurance that logical access to system resources (e.g. programs, data and parameters) is restricted to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-1e (continued)		• For a sampled semi-annual Oracle database review, inspected the review for a sample of users to determine whether DBA account privileges were reviewed for appropriateness and users no longer requiring access were removed.	No exceptions noted.
A-1f	RACF user IDs are reviewed periodically to verify that privileged attributes are restricted to authorized personnel. Users no longer requiring this level of access are removed.	• For a sample of quarterly access reviews of RACF user IDs for the F14 system, inspected the reviews for a sample of users to determine whether RACF user IDs were reviewed to verify that privileged attributes were restricted to authorized personnel and users no longer requiring access were removed.	No exceptions noted.
A-1g	RACF parameters for primary password settings are set in accordance with management's policies.	• Inspected RACF parameters for primary password settings to determine whether they were set in accordance with management's policies.	No exceptions noted.
A-1h	On a periodic basis, access to the UNIX root account is reviewed to ensure access is appropriately restricted. Users no longer requiring this level of access are removed.	• For a sample of quarterly UNIX root account reviews, inspected the reviews for a sample of users to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.
A-1i	Windows Domain Admins are reviewed periodically to verify that privileged attributes are restricted to authorized personnel. Users no longer requiring this level of access are removed.	• For a sample of quarterly Windows Domain Admin reviews, inspected the reviews for a sample of users to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.

Logical Access

Control Objective A-1: Controls provide reasonable assurance that logical access to system resources (e.g. programs, data and parameters) is restricted to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-1j	On a periodic basis, access to CyberArk Administrative accounts is reviewed to ensure access is appropriately restricted. Users no longer requiring this level of access are removed.	• For a sample of quarterly reviews, inspected the reviews for a sample of CyberArk Administrative accounts to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.
A-1k	A periodic review of users with access to the "Oracle" account (CyberArk accounts) on in-scope databases is performed to confirm that access is restricted to appropriate individuals. Users no longer requiring this level of access are removed.	• For a sample of quarterly "Oracle" account reviews, inspected the reviews for a sample of users to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.
A-1l	CRS parameters for primary password settings are set in accordance with management's policies.	• Inspected CRS parameters for primary password settings to determine whether they were set in accordance with management's policies.	No exceptions noted.
A-1m	Requests for the creation or modification of Bill Code Table user IDs must be approved prior to provisioning.	• For a sample of users granted update access, inspected the requests for the creation or modification of Bill Code Table user IDs to determine whether the IDs were approved prior to provisioning.	No exceptions noted.
A-1n	Client Website parameters for primary password settings are set in accordance with management's policies.	• Inspected Client Website parameters for primary password settings to determine whether they were set in accordance with management's policies.	No exceptions noted.

Logical Access

Control Objective A-1: Controls provide reasonable assurance that logical access to system resources (e.g. programs, data and parameters) is restricted to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-1o	Client Website access for employees who leave the company is removed upon notification.	• For a sample of terminated employees, inspected system access records to determine whether Client Website access was removed.	No exceptions noted.
A-1p	Access to eSD is auto-provisioned based on pre-defined criteria from HR system to the G&L identity management system.	• Inspected a sampled user to determine whether access to eSD was auto-provisioned based on pre-defined criteria from HR system to the G&L identity management system.	No exceptions noted.
A-1q	Role changes in eSD are approved prior to changes being made in production.	• For a sample of role changes, inspected supporting documentation to determine whether the changes were approved prior to being made in production.	No exceptions noted.
A-1r	A periodic review of users with access to the Figaro Application is performed to confirm access is restricted to appropriate individuals. Users no longer requiring this level of access are removed.	• Inspected the annual review for a sample of Figaro accounts to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.

Physical Access

Control Objective A-2: Controls provide reasonable assurance that physical access to computer equipment is limited to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-2a	The Piscataway Data Center is secured using a computerized card access system, which controls electronic locks on both interior and exterior doors. Additionally, the facility is equipped with centrally monitored door alarms, CCTV, and a 24-hour, seven-day-per-week security guard service.	• Observed the Piscataway Data Center to determine whether the data center was secured using a computerized card access system, which controlled electronic locks on both interior and exterior doors. • Observed the Piscataway Data Center to determine whether the facility was equipped with centrally monitored door alarms, CCTV, and a 24-hour, seven-day-per-week security guard service.	No exceptions noted. No exceptions noted.
A-2b	Access to the Data Center is granted based on job requirements, and is approved by appropriate management.	• For a sample of users granted access to the Data Center, inspected access request forms to determine whether access was granted based on job requirements and access was approved by appropriate management and accurately provisioned.	No exceptions noted.
A-2c	Area Managers over all special areas within the Data Center periodically review reports of personnel with authorized access to those areas. Individuals no longer requiring access are removed.	• For a sample of monthly Data Center reviews, inspected supporting documentation to determine whether access was appropriately restricted and individuals no longer requiring access were removed.	No exceptions noted.

Physical Access

Control Objective A-2: Controls provide reasonable assurance that physical access to computer equipment is limited to properly authorized individuals.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-2d	Through October 31, 2019, the Franklin Lakes Data Center is secured using a computerized card access system, which controls electronic locks on both interior and exterior doors. Additionally, the facility is equipped with entrance door alarms, CCTV, and a 24-hour, seven-day-per-week security guard service.	• Observed the Franklin Lakes Data center to determine whether the data center was secured using a computerized card access system, which controlled electronic locks on both interior and exterior doors.	No exceptions noted.
		• Observed the Franklin Lakes Data Center to determine whether the facility was equipped with entrance door alarms, CCTV, and a 24-hour, seven-day-per-week security guard service.	No exceptions noted.

Application Development and Change Management

Control Objective A-3: Controls provide reasonable assurance that changes to existing applications are authorized, tested, approved, implemented, and documented, in accordance with management's policies.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-3a	Non-emergency changes are tested in accordance with policy.	• For a sample of non-emergency changes, inspected supporting documentation to determine whether the changes were tested in accordance with policy.	No exceptions noted.
A-3b	Non-emergency changes are documented and approved prior to implementation into production in accordance with policy.	• For a sample of non-emergency changes, inspected supporting documentation to determine whether the changes were documented and approved prior to implementation into production, in accordance with policy.	No exceptions noted.
A-3c	Emergency changes must be documented and approved in accordance with policy.	• For a sample of emergency changes, inspected supporting documentation to determine whether the changes were documented and approved in accordance with policy.	No exceptions noted.
A-3d	On a periodic basis, a review of system generated change reports is performed and changes identified are compared against change tickets to verify that the appropriate process and approvals are associated to each of the changes.	• For a sample of daily system scans, inspected the change reports to determine whether review was performed and, if necessary, changes identified were mapped to change tickets and supporting documentation.	No exceptions noted.
A-3e	Database Administration team reviews proposed changes to the database structure for required documentation, and approves each change via a ServiceNow ticket.	• For a sample of Oracle database changes, inspected supporting documentation to determine whether the Database Administration team reviewed and approved the change.	No exceptions noted.

Application Development and Change Management

Control Objective A-3: Controls provide reasonable assurance that changes to existing applications are authorized, tested, approved, implemented, and documented, in accordance with management's policies.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-3e (continued)		• For a sample of Teradata database changes, inspected supporting documentation to determine whether the Database Administration team reviewed and approved the change.	No exceptions noted.
		• For a sample of DB2 database changes, inspected supporting documentation to determine whether the Database Administration team reviewed and approved the change.	No exceptions noted.
A-3f	On a periodic basis, management compares developers with access to modify code in Endevor with users who can migrate mainframe code into production to determine whether appropriate segregation of duties exists.	• Inspected the annual review to determine whether it was completed and, if necessary, users no longer requiring access were removed.	No exceptions noted.
A-3g	On a periodic basis, management compares Phoenix and BTT Developers to those with access to migrate Phoenix and BTT code to production to determine whether appropriate segregation of duties exists.	• Inspected the annual review to determine whether it was completed and, if necessary, users no longer requiring access were removed.	No exceptions noted.

Application Development and Change Management

Control Objective A-3: Controls provide reasonable assurance that changes to existing applications are authorized, tested, approved, implemented, and documented, in accordance with management's policies.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-3h	On a periodic basis, management compares users with access to eSD code affecting eligibility with those who can migrate code into production to determine whether appropriate segregation of duties exists.	• Inspected the annual review to determine whether it was completed and, if necessary, users no longer requiring access were removed.	No exceptions noted.
A-3i	On a periodic basis, management compares developers with access to modify CGS code to users who can migrate CGS code to production to determine whether appropriate segregation of duties exist.	• Inspected the annual review to determine whether it was completed and, if necessary, users no longer requiring access were removed.	No exceptions noted.

Computer Operations

Control Objective A-4: Controls provide reasonable assurance that processing is scheduled appropriately and deviations are identified and resolved.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-4a	Job scheduling requests for recurring jobs are reviewed for accuracy, scheduling instructions, and potential impact to another production job flow, and authorized by appropriate individuals.	• For a sample of job scheduling requests for recurring jobs, inspected supporting documentation to determine whether the requests were reviewed and authorized by appropriate individuals.	No exceptions noted.
A-4b	CA-7 operational exceptions are documented in the ServiceNow problem ticket tracking system and exceptions are researched and resolved.	• For a sample of operational exceptions, inspected supporting documentation to determine whether CA-7 operational exceptions were researched and resolved.	No exceptions noted.
A-4c	A periodic review of users with access to the CA-7 job scheduling software is performed to confirm access is restricted to appropriate individuals. Users no longer requiring this level of access are removed.	• For the sampled semi-annual access review for the CA-7 job scheduling software, inspected the review for a sample of users to determine whether access was appropriately restricted and users no longer requiring access were removed.	No exceptions noted.
A-4d	Job scheduling requests for one-time-only (OTO) jobs are reviewed for accuracy, scheduling instructions, potential impact to another production job flow, and authorized by appropriate individuals.	• For a sample of OTO job scheduling requests, inspected supporting documentation to determine whether the requests were reviewed and authorized by appropriate individuals.	No exceptions noted.

Computer Operations

Control Objective A-4: Controls provide reasonable assurance that processing is scheduled appropriately and deviations are identified and resolved.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
A-4e	GoldenGate operational exceptions are documented in the ServiceNow problem ticket tracking system and exceptions are researched and resolved.	• For a sample of operational exceptions, inspected supporting documentation to determine whether the GoldenGate operational exceptions were researched and resolved.	No exceptions noted.
A-4f	CGS EIW batch jobs are monitored periodically to ensure successful transfer of data from IW to CGS. A Service Now ticket is created for batch job failures to track remediation.	• For a sample of weeks, inspected supporting documentation to determine whether CGS batch jobs completed and, if necessary, operational exceptions were researched and resolved.	No exceptions noted.

Pharmacy Claims Processing Controls

Client Setup and Member Enrollment

Control Objective B-1: Controls provide reasonable assurance that benefit plan specifications, additions, or changes are documented, approved, and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-1a	Client personnel are required to approve benefit plan implementation documentation containing system specifications before processing of live claims.	• For a sample of benefit plan implementations, inspected supporting documentation to determine whether client approval was obtained prior to processing of live claims.	No exceptions noted.
B-1b	Configuration Delivery Services (CDS) - Pricing department performs a QC review of the Pricing Systems and compares pricing arrangements to requirements (including client's intent).	• For a sample of pricing arrangements, inspected supporting documentation to determine whether Configuration Delivery Services (CDS) - Pricing performed a QC review and, where relevant, the Pricing Analyst performed a validation of the client information entered into the pricing forms against requirements.	No exceptions noted.
		• For a sample of pricing arrangements, inspected supporting documentation to determine whether system setup was accurate based on requirements.	No exceptions noted.
B-1c	The Benefit Validation/Testing Team performs validation of new benefit plan implementations and benefit plan changes to verify system setup is accurate based on client intent documentation.	• For a sample of benefit plan implementations and changes, inspected supporting documentation to determine whether the Benefit/Validation Testing Team performed validation to verify system setup was accurate based on client intent documentation.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-1: Controls provide reasonable assurance that benefit plan specifications, additions, or changes are documented, approved, and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-1c (continued)		• For a sample of benefit plan implementations and changes, inspected supporting documentation to determine whether system setup was accurate based on client intent documentation.	No exceptions noted.
B-1d	Changes and additions made to benefit information require approval.	• For a sample of changes and additions made to benefit information, inspected supporting documentation to determine whether approval was obtained.	No exceptions noted.
B-1e	Data submitted via AGL is subjected to edit validation checks to ensure group records contain valid data and confirmation is sent to the client or plan sponsor.	• Observed data submitted via AGL to determine whether it was subjected to edit validation checks and errors were accurately captured within the pre-edit reporting that is provided to the client or plan sponsor.	No exceptions noted.
B-1f	Requests for changes to the plan file are reviewed for completeness by the plan file area and are subjected to a QA process to validate coding accuracy.	• For a sample of changes to the plan file, inspected supporting documentation to determine whether requests were reviewed for completeness and were subjected to a QA process to validate coding accuracy.	No exceptions noted.
		• For a sample of changes to the plan file, inspected supporting documentation to determine whether the system was coded accurately based on request.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-1: Controls provide reasonable assurance that benefit plan specifications, additions, or changes are documented, approved, and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-1g	Changes and/or additions to clinical information entered into Clinical Rules Station are validated against the request to verify system setup was complete and accurate.	• For a sample of changes and/or additions to clinical information, inspected supporting documentation to determine whether the updates were validated against the request to verify system setup was complete and accurate.	No exceptions noted.
		• For a sample of changes and/or additions to clinical information, inspected supporting documentation to determine whether updates within CRS were accurate.	No exceptions noted.
B-1h	Medical vendors work with Express Scripts to resolve any issues relating to new connection testing and validation. Once both parties are comfortable with the results, the vendor provides approval for the test results. In the absence of vendor approval, a negative confirmation email is sent to the vendor, before an Eligibility Manager can approve set-up based upon the review of the testing and validation results.	• For a sample of Medical vendor implementations, inspected supporting documentation to determine whether testing of system parameters was completed by and results were reviewed and approved by the vendor or Eligibility Manager.	No exceptions noted.
B-1i	Benefit changes and/or additions configured by BBA are validated against the request to verify that benefit setup was complete, accurate, and consistent with client intent.	• For a sample of BBA changes and/or additions, inspected supporting documentation to determine whether the updates were validated against the request to verify that benefit setup was complete, accurate, and consistent with client intent.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-1: Controls provide reasonable assurance that benefit plan specifications, additions, or changes are documented, approved, and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-1i (continued)		• For a sample of BBA changes and/or additions, inspected supporting documentation to determine whether the system was updated accurately based on intent.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-2: Controls provide reasonable assurance that changes or additions to the Integrated Drug Master File and Formulary Rules Station are authorized and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-2a	New Generic Code Numbers transmitted by FDB are identified and automatically suspended for further review before they are updated within the IDF.	• Observed new Generic Code Numbers transmitted by FDB to determine whether they were identified and automatically suspended for further review.	No exceptions noted.
		• For a sample of New Generic Code Numbers transmitted by FDB, inspected supporting documentation to determine whether the suspended records were further reviewed before they were updated within the IDF.	No exceptions noted.
B-2b	Third-Party Vendor files are subjected to a completeness check on the records submitted for processing. The IDF verifies the record count on files received in order to verify the total number of third-party vendor input records is posted completely to the IDF.	• Observed the submission of a third-party vendor file to determine whether the IDF update program verified the total number of input records was posted completely to the IDF.	No exceptions noted.
		• For a sample of NDC's, inspected supporting documentation to determine whether AWP pricing information from the third-party vendor agrees to AWP pricing information in the IDF.	No exceptions noted.
B-2c	Changes and/or additions to drug formulary information entered into the Formulary Rules Station are validated against the request to verify system setup was complete and accurate.	• For a sample of changes and/or additions to drug formulary information, inspected supporting documentation to determine whether they were validated against the request to verify system setup was complete and accurate.	No exceptions noted.
		• For a sample of changes and/or additions made to drug formulary information, inspected supporting documentation to determine whether the changes and/or additions were authorized and entered into FRS accurately.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-2: Controls provide reasonable assurance that changes or additions to the Integrated Drug Master File and Formulary Rules Station are authorized and entered for processing completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-2d	Third-Party Vendor files are subjected to edit checks on the records submitted for processing. The IDF compares current drug information to vendor submitted updates to verify the accuracy of third-party vendor input records.	• Observed the submission of a third-party vendor file to determine whether programmed system edit and validation checks were completed on key fields to verify that vendor information was posted accurately to the IDF.	No exceptions noted.
B-2e	Changes to MAC price are made through an automated load. An automated email containing the load results is generated and reviewed by Supply Chain pricing personnel. If errors are noted within the results, they are investigated and corrected.	• For a sample of days, inspected supporting documentation to determine whether Supply Chain pricing personnel reviewed the automated email containing the load results and, if errors were noted with the results, they were investigated and corrected.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-3: Controls provide reasonable assurance that pharmacy information is created and maintained based on proper authorization and is recorded in the system completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-3a	Express Scripts personnel are required to receive approval for rates, fees, and network affiliations prior to pharmacy setup.	• For a sample of rates, fees, and network affiliations, inspected supporting documentation to determine whether the rates, fees, and network affiliations were approved prior to pharmacy setup.	No exceptions noted.
B-3b	An individual independent of the original data entry process verifies pharmacy information specific to rates, fees, and network affiliations entered into the system for accuracy.	• For a sample of rates, fees, and network affiliations, inspected supporting documentation to determine whether an individual independent of the original data entry process verified the information entered into the system for accuracy.	No exceptions noted.
		• For a sample of rates, fees, and network affiliations, inspected supporting documentation to determine whether pharmacy information specific to rates, fees, and network affiliation was entered accurately into the system.	No exceptions noted.
B-3c	Pharmacy pricing updates in compliance with contract terms are reviewed and approved by an ESI Pricing Director or above prior to upload.	• For a sample of pharmacy pricing updates, inspected supporting documentation to determine whether the pricing updates were approved by an ESI Pricing Director or above prior to upload.	No exceptions noted.
B-3d	Through October 21, 2019, an individual independent of the original data entry process in the pricing file verifies pharmacy pricing information entered into the file for accuracy.	• For a sample of pharmacy pricing updates entered into the system through October 21, 2019, inspected supporting documentation to determine whether an individual independent of the original data entry process verified the information entered into the system for accuracy.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-3: Controls provide reasonable assurance that pharmacy information is created and maintained based on proper authorization and is recorded in the system completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-3d (continued)		• For a sample of pharmacy pricing updates entered into the system through October 21, 2019, inspected supporting documentation to determine whether the updates were entered accurately into the system.	No exceptions noted.
B-3e	Through October 21, 2019, pricing updates are made through an automated load, based on contract rates. A report containing the load results is generated and reviewed by the Supply Chain Pricing Team personnel. If errors are noted within the results, they are investigated and corrected.	• For a sample of pharmacy pricing updates entered into the system through October 21, 2019, inspected supporting documentation to determine whether the Supply Chain Pricing Team reviewed the load results and, if necessary, errors were investigated and corrected.	No exceptions noted.
B-3f	Pricing updates are simulated by an automated QC process within the Flex Pricing Tool. If the results are acceptable, the Pricing Director or above approves the updates prior to them being loaded into production.	• For a sample of pricing updates submitted through the Flex Pricing Tool, inspected supporting documentation to determine whether the Pricing Director or above validated the updates prior to them being loaded into production.	No exceptions noted.
		• For a sample of pricing updates entered into the system, inspected supporting documentation to determine whether the pricing updates were authorized and entered into Phoenix accurately.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-4: Controls provide reasonable assurance that member enrollment information is created and maintained based on proper authorization and is recorded in the system completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-4a	Eligibility personnel test system parameters for new client implementations and re-implementations to confirm that data is processed completely and accurately in accordance with client specifications. Client data is validated by the client review and approval of either the test plan and results, test summary documents, or the Eligibility pre-edit report. In the absence of client approval, a negative confirmation email sent to the client should be in effect, before an Eligibility Manager can approve set-up based upon review of the test plan and results, test summary documents, or the Eligibility pre-edit report.	• For a sample of eligibility implementations and reimplementations, inspected supporting documentation to determine whether testing of system parameters was completed by the Eligibility personnel and results were reviewed and approved by the client or Eligibility Manager.	No exceptions noted.
B-4b	A set of statistical parameters & edits are built within the Eligibility system to determine if the file passes validation and should be applied. Edit checks include: • Verification of Customer ID • Date of birth • Member number • Client group must be established before records are accepted	• Observed eligibility data received to determine whether edit and validation checks were completed on the key fields as outlined within the control.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-4: Controls provide reasonable assurance that member enrollment information is created and maintained based on proper authorization and is recorded in the system completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-4c	For clients who are enrolled in the Generated Term process, system logic confirms records within the Eligibility system are updated using the full population client file. Records sent on a full population client file which do not exist within the system are added, records within the system which do not exist on a full population client file are terminated, and records on a full population client file with updated fields are modified accordingly within the system.	• Observed processing of Generated Term clients to determine whether records on a client file which did not exist within the system were added, records within the system which did not exist on a client file were terminated, and records on a client file with updated fields were modified accordingly within the system.	No exceptions noted.
B-4d	If the number of eligibility records received from the client does not match the number of records noted by the client in the trailer record, the Eligibility system will abend. The Eligibility Department will notify the client that a new file is necessary before the data can be loaded to the system.	• Observed eligibility data submitted into the eligibility application to determine whether the Eligibility system abended when the number of eligibility records received from the client did not match the number of records noted by the client in the trailer record.	No exceptions noted.

Client Setup and Member Enrollment

Control Objective B-4: Controls provide reasonable assurance that member enrollment information is created and maintained based on proper authorization and is recorded in the system completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
B-4e	Eligibility data submitted via eSD is subjected to online edit validation checks on required fields in order to add/update records. Edit checks include: • Date of birth • Member number • Client group must be established before records are accepted	• Observed eligibility data received to determine whether edit and validation checks were completed on the key fields as outlined within the control.	No exceptions noted.

Claims Processing/Adjudication

Control Objective C-1: Controls provide reasonable assurance that pharmacy claims transactions are valid and are processed completely, accurately, and only once.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-1a	Claims data submitted into the POS system is subject to the following types of programmed system edit and validation checks: • Eligibility member/group verification • Pharmacy verification • Prescriber verification • Ingredient cost • NDC	• Observed claims data submitted into the POS system to determine whether programmed system edit and validation checks were completed on key fields as outlined within the control.	No exceptions noted.
C-1b	Any prescription which is filled for the same member, pharmacy, Rx and fill number, is considered a duplicate claim by POS system logic.	• Observed claims data submitted into the POS system to determine whether a prescription filled for the same member, pharmacy, Rx and fill number was considered a duplicate claim by POS system logic.	No exceptions noted.
C-1c	Based on the setup of mandatory or voluntary plan status, edits within the POS system reject claims based on their formulary status.	• Observed claims data submitted into the POS system to determine whether edits rejected claims based on their formulary status.	No exceptions noted.
C-1d	Based on the plan's benefit specifications, POS determines pricing and claim coverage through the following: drug price, client billed amount, pharmacy reimbursement, and member co-pay.	• For a sample of adjudicated claims, inspected benefit specifications in the POS system to determine whether the system accurately determined pricing and claim coverage for the drug price, client billed amount, pharmacy reimbursement, and member co-pay.	No exceptions noted.

Claims Processing/Adjudication

Control Objective C-1: Controls provide reasonable assurance that pharmacy claims transactions are valid and are processed completely, accurately, and only once.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-1e	POS indemnity tables accumulate claim costs to determine maximum out-of-pocket limits, deductibles, and plan stop-loss limits.	• Observed claims data entered into POS to determine whether POS indemnity tables accumulated claim costs and determined maximum out-of-pocket limits, deductibles, and plan stop-loss limits.	No exceptions noted.
C-1f	The POS system uses and/or compares multiple drug prices such as: AWP, MAC and U&C, and prices the claim based upon the client specifications within the system.	• For a sample of adjudicated claims, inspected claims data in the POS system to determine whether the system compared the drug price to AWP, MAC, and U&C pricing and selected the amount based upon the client specifications within the system.	No exceptions noted.
C-1g	The POS system calculates claims co-payment fees based on benefit plan specifications.	• For a sample of adjudicated claims, inspected claims data in the POS system to determine whether the system accurately calculated claims co-payment fees based on benefit plan specifications.	No exceptions noted.

Claims Billing

Control Objective C-2: Controls provide reasonable assurance that claims billing transactions are valid and are processed completely, accurately and only once.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-2a	At the conclusion of each day, the POS Summary table is referenced to obtain summarized counts by transaction type (i.e., retail claims, retail rejects, and retail adjustments). The POS data is compared by transaction type to the IW summarized claims data to verify that the claim counts agree. A balancing report is generated and any exception (current threshold is claim difference of 1,500) is noted by a system abend, researched, and resolved.	• Inspected system settings to determine whether claims data is transferred completely and accurately from POS to IW.	No exceptions noted.
		• Inspected system logic to determine whether the system was configured to generate a balancing report.	No exceptions noted.
		• Inspected system logic to determine whether the system was configured to abend when claim count differences are greater than 1,500.	No exceptions noted.
		• Inspected supporting documentation to determine whether the system accurately calculated the claim count difference between POS and IW, per the balancing report, for a sampled date.	No exceptions noted.
		• For a sample of system abends, inspected supporting documentation to determine whether the abends were researched and resolved.	No exceptions noted.
C-2b	Once claims have been billed, claims within IW Staging are marked with a billed status. Once claims have been marked with a billed status, the claim cannot be re-selected for billing.	• Observed claims data submitted into IW to determine whether claims marked with a billed status were unable to be re-selected for billing.	No exceptions noted.

Claims Billing

Control Objective C-2: Controls provide reasonable assurance that claims billing transactions are valid and are processed completely, accurately and only once.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-2c	The Revenue Cycle Management Team will obtain the necessary approvals as outlined in Express Scripts company policy documentation before processing adjustments or manual billings.	• For a sample of adjustments and manual billings, inspected supporting documentation to determine whether approval was obtained prior to processing the adjustment or manual billing.	No exceptions noted.
C-2d	On a weekly basis, a Revenue Cycle Management Analyst runs a query identifying claims in IW Staging with a status of 'P' or 'B' and claims greater than 45 days old, but less than 365 days old, are monitored and investigated when the unbilled claims exceed $1,000,000 to determine if resolution is required.	• For a sample of weeks, inspected supporting documentation to determine whether claims greater than 45 days old, but less than 365 days old, were monitored and investigated, as necessary. • For a sample of weeks, reperformed the review of claims in staging to determine whether claims greater than 45 days old, but less than 365 days old, and greater than $1,000,000 were identified for investigation.	No exceptions noted. No exceptions noted.
C-2e	Bi-weekly, an automated process reconciles the summarized IBS billing invoice data, for the specific billing period, to the claims data stored in IW Staging. If a discrepancy is identified, the job which moves claims from the IW Staging tables to the History tables abends and a ticket is generated by Resource Management (RM) flagging the discrepancy.	• Observed the automated process to determine whether the system reconciles the summarized IBS billing invoice data, for the specific billing period, to the claims data stored in IW Staging. • For a sample of bi-weekly reconciliations, inspected supporting documentation to determine whether a ticket was generated by Resource Management (RM) flagging any discrepancies, if identified, and properly routed for resolution.	No exceptions noted. No exceptions noted.

Claims Billing

Control Objective C-2: Controls provide reasonable assurance that claims billing transactions are valid and are processed completely, accurately and only once.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-2f	Billing PSO investigates out-of-balance reported items between IW Staging and IBS billed claims and documents resolution to ensure out-of-balance discrepancies do not result in inaccurate or incomplete client invoice.	• For a sample of out-of-balance items reported, inspected supporting documentation to determine whether Billing PSO investigated out-of-balance reported items and documented resolution.	No exceptions noted.

Client Guarantee Settlements

Control Objective C-3: Controls provide reasonable assurance that client contracted AWP pricing guarantees are setup and settled completely and accurately.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests
C-3a	Once guarantee information is input and submitted, it is reviewed and electronically verified by a second individual within the FCO Team, who compares the information in CGS to the contract or CRF. New setups and changes are not included in the guarantee calculations until approved electronically by an individual independent of the setup.	• For a sample of guarantees setup within the CGS system, inspected supporting documentation to determine whether a QC review was performed by an individual independent of the system setup. • For a sample of guarantee configuration elements, inspected supporting documentation to determine whether system setup was accurate based on supporting documentation.	No exceptions noted. No exceptions noted.
C-3b	CGS calculates guarantee performance by applying profile and exclusion rules and parameters input into CGS for each client guarantee according to a client's contract. Performance results are gathered by querying claim data and reference lists from IW based on CGS profile and exclusion rules.	• For a sampled guarantee, reperformed the guarantee calculation to determine whether CGS calculated the guarantee performance in accordance with the client's contract.	No exceptions noted.
C-3c	Guarantee settlement packages are independently reviewed for completeness and accuracy prior to client submission.	• For a sample of settled guarantees, inspected supporting documentation to determine whether guarantee settlement packages were independently reviewed for completeness and accuracy prior to client submission.	No exceptions noted.
C-3d	Guarantee payments to clients are approved by authorized management based on the GOA grid.	• For a sample of guarantee payments, inspected supporting documentation to determine whether the guarantee payments were approved by authorized management based on the GOA grid.	No exceptions noted.

Section V – Other Information Provided by Express Scripts Holding Company

The information included in this Section is presented by Express Scripts to provide additional information to user organizations and has not been subjected to the procedures applied by PricewaterhouseCoopers LLP in their examination of the description of the controls related to pharmacy claims processing and accordingly, PwC does not express an opinion on it.

Business Continuity Summary

Express Scripts has established a comprehensive Business Continuity program to quickly and effectively respond to crisis, emergency, or disaster events. The program utilizes industry best practices and continues to improve and mature in order to meet the needs of a growing and successful company. The key foundational components of the Express Scripts Business Continuity program include: Crisis Management/Emergency Preparedness, Business Continuity Planning, Disaster Recovery Planning, Operational Risk Management, Program Oversight, Express Scripts' Network- Point-of-Sale Contingency Capabilities, Express Scripts' Pharmacy Operations/Home Delivery Distribution Backup/Contingency Capabilities, Call Center Customer Service Operations Backup/Contingency Capabilities, Recovery Strategies, and System and Application Data.

The Business Continuity program documents the coordination of safety, continuity, and/or recovery responses to disruptions ranging from minor to major incidents. The Business Continuity program focuses on four key areas of recovery: People, Facilities, Technology and Operations.

COVID-19 Global Pandemic

Following the emergence of the novel strain of coronavirus (COVID-19), the Company has been actively monitoring the impact to all aspects of our business, including, but not limited to, the Pharmacy Claims Processing services covered in this SOC 1 report. The Company has performed a thorough assessment and concluded that there has not been any adverse impact to the processes and controls described in this report.

Crisis Management/Emergency Preparedness

Express Scripts has a formal, approved Crisis Management Plan defining incident identification, declaration triage, and escalation procedures. The Crisis Management Team consists of Executive Leadership, key business leaders, and individuals from Corporate Communications, Corporate Procurement, Corporate Real Estate, Corporate Compliance, Human Resources, IT – Information Technology, Legal, Local Crisis Response Teams, Public Affairs, Security and Safety teams, Senior Leadership, and Site Leadership.

On a daily basis, the Business Continuity Team monitors weather and events (i.e., hurricanes, wildfires, delivery disruptions, etc.) which could interrupt critical business processes and/or impact clients, members, employees or facilities.

Depending on the event and potential impact, the Business Continuity Team follows the appropriate Crisis Management procedures and engages operational response teams to manage the event to closure.

Business Continuity Planning

Business Continuity Planning's goal is to ensure all necessary steps are taken to identify the impact or potential losses, validate recovery strategies, create business recovery plans and ensure continuity services through plan testing and maintenance. The annual BIA identifies the financial exposure, operational, client and member impacts for each critical business process. This drives and supports the establishment of a target recovery time objective (RTO) for each critical process or group of related processes. Business Continuity Planning ensures critical business processes resume operations within a specific time frame, should an incident impact business operations.

Disaster Recovery Planning

Express Scripts has a formal Disaster Recovery (DR) Planning program to respond to a disaster or an interruption. The DR plan identifies steps to stabilize and restore the organization's critical systems and technical environment. The plan addresses recovery of critical IT facilities, IT systems, applications, and telephone systems. The DR plan defines the resources, actions, tasks, equipment and data required to manage the technology recovery effort. DR Planning is a component of the overall Business Resiliency Plan describing how to recover and restore IT technology to operation if it is interrupted or destroyed by a disastrous event. This includes IT systems and applications, telephone systems and features, telecommunications connectivity, and data center availability.

Operational Risk Management

Operational Risk Management prepares a performance risk analysis and develops mitigation solutions to allow Business Continuity to better manage events which could negatively impact business operations. Risk mitigation is the first line in Express Scripts' defense against unplanned business process disruptions. Additionally, the identification of potential points of failure in business processes is essential. This allows for the mitigation and planning to avoid or diminish a disruption to the business.

Program Oversight

The Business Continuity and Disaster Recovery program has three key oversight committees:

1. Business Continuity Steering Committee
2. DR Governance Council
3. Board of Directors' Audit Committee

Express Scripts' Network - Point-of-Sale Contingency Capabilities

Network architecture is designed to ensure entire portions of the system could be shut down without impact to production. Express Scripts, Verizon or AT&T can re-route traffic to maintain connectivity. Internet feeds are provided by multiple carriers, and sites are connected through redundant network links. In addition, a separate hot backup site for Express Scripts' web site is available.

Express Scripts' Pharmacy Operations/Home Delivery Distribution Backup/Contingency Capabilities

Express Scripts' regional home delivery pharmacies provide complete backup/contingency and redundant capabilities in the event of a disaster at any pharmacy site. The Rx Router allows dispensing of medication from any pharmacy in the national network. In the event of a failure at one home delivery pharmacy, prescription records are easily transferred to other pharmacies for fulfillment without significant processing interruption. Express Scripts' dispensing process allows automatic sorting and isolation of packages by destination zip code or shipping carrier, facilitating alternate delivery methods. Express Scripts maintains relationships with several shipping carriers, reducing shipping carrier failures. The shipping carriers work closely with Express Scripts during natural disasters, such as a hurricane, flood and wildfire to determine alternate delivery or pick-up locations, minimizing delivery disruptions.

Call Center Customer Service Operations Backup/Contingency Capabilities

In the event of a disruption at a call center, calls can be readily routed to an alternate site. Call routing assures uninterrupted service to members in the event of a disaster at a site.

Recovery Strategies

A BIA is completed by the business owners to identify processes and their respective dependency on IT resources. The BIA ranking assigned to a business process determines how quickly a system or application must be recovered and how much data loss is acceptable. The acceptable time required to recover a process or application is called the RTO and the Recovery Point Objective (RPO) identifies the acceptable amount of data loss. Based on the BIA ranking, recovery strategies are implemented. Business recovery strategies include: workload shifting, recovery at alternate sites, work from home, overtime, flexible staffing, cross-training, engaging support staff into daily operations, and third-party vendor engagements. Express Scripts' IT systems and applications are comprised of various interdependent applications, data, and underlying hardware. The RTO and RPO of an application determine the approach and technologies available for a successful recovery in the event of a disaster. Our primary and secondary data center locations are geographically dispersed throughout the United States to provide geographic distance, continual data access and critical data availability.

System and Application Data

The process for data backups includes:

- Transactions are backed up daily, replicated to the secondary recovery datacenter.
- Incremental backups of member information, client and relevant data are performed daily, along with disk replication and virtual tape replication between the production data center and secondary recovery data center sites. Multiple generations (30 days) of data backups are retained to minimize data lost in the event of a disaster.
- Production servers, with the use of image level backups, are fully recoverable.
- Software tools such as FDR (Fast Dump Restore), SRDF (Symmetrix Remote Data Facility), and DFDSS (Data Facility Data Set Services) are deployed on a daily basis to capture critical data for recovery of the system infrastructure.

- Daily backups are reported on and audited allowing for any exceptions to be identified and corrected. System and database files are copied and saved on a daily basis, and replicated to the secondary recovery site, ensuring security and recoverability of the data if needed for recovery.

Express Scripts has developed a testing methodology and employs a range of testing strategies to validate recovery strategies and ensure plan validity. Critical operational business areas and associated technology solutions are exercised annually. Express Scripts contracts with third party vendors which provide site recovery and technology solutions. This ensures production processes and technology at both Express Scripts and vendor sites remain compatible. Internal Express Scripts recovery sites are also tested to validate recovery strategies and ensure recovery time objectives are met.

Encryption Procedures

Express Scripts file transmissions of non-public information are either PGP encrypted, routed via encrypted VPN tunnel, performed using NDM (an encrypted mainframe-to-mainframe method), or performed over a dedicated line. Express Scripts uses 128-bit SSL encryption on external websites or web services processing confidential information.

Servers at Express Scripts are hardened and have access restrictions to control against the possibility that a server will be subverted to intercept communication in server-to-server paths. All mainframe backups are encrypted. All mainframe data stored on disc is encrypted at both the primary Express Scripts data center and at the Disaster Recovery Facility.

Additionally, Express Scripts has deployed full-disk encryption on laptops and desktops, and has implemented the ability to save encrypted information to USB and/or CD. All CDs generated by the Express Scripts data center are encrypted by default. Information is encrypted in transit and at rest on mobile devices. Backups of the distributed environment are also encrypted.

Management Responses

Management has provided the following responses as it relates to the exceptions noted in Section IV - Express Scripts Holding Company's Control Objectives and Controls, and PricewaterhouseCoopers' Tests of Operating Effectiveness and Results of Tests.

No.	Controls Specified by Express Scripts	Testing Performed by PricewaterhouseCoopers	Results of Tests	Management Response
A-1e	DBA account privileges are reviewed periodically for appropriateness. Users no longer requiring this level of access are removed.	Inquired of IT personnel to confirm the process used to determine whether DBA account privileges are reviewed periodically for appropriateness and users no longer requiring this level of access are removed.	**Exception noted.** Access to the DB2 databases that support the Integrated Drug File (IDF) was not included in management's DB2 access review process until Q1 of 2020 and therefore access was not reviewed during Q2, Q3 or Q4 of 2019. No exceptions were noted for the remaining in-scope DB2 Databases.	Upon identification of the inclusion of the IDF into the scope of the report, management integrated the user access review for the databases supporting IDF into the existing A-1e review process. The user access review will be included in all subsequent reviews going forward.

Multiple Employer Welfare Arrangements (MEWA) Affiliate Disclosure Statement

To be completed by all members of the board of trustees, executive committee or other governing board or committee, and officers of the MEWA. Please type or print. For any of the questions 12 – 26 that are answered "yes," please explain on a separate sheet(s). Also, put the question number it relates to next to the response.

Name of MEWA: _____

Your present or proposed position with MEWA: _____

1. Individual's full legal name:

☐ Mr.
☐ Mrs.
☐ Ms. _____
(Last) (First) (Middle) (Suffix i.e. Jr., Sr., III)

2. Have you ever changed your name? ☐ Yes ☐ No

   If **yes**, state the reason for the change:

   _____

   List other names used: _____

   _____

   _____

3. Social Security Number: _____

4. Date of Birth: _____/_____/_____

5. Place of Birth:

   _____
   (City) (State)

6. List your residence for the last five years, starting with your current address:

   (Address) (City) (State) (Zip Code)

   _____

   _____

   _____

   _____

7. List your business address:

   _____
   (Address) (City) (State) (Zip Code)

   List your daytime telephone: _____

8. Employment record for the past 5 years (director, officer or member):

Date	Name of Organization/ Employer and Address	Title/ Office Held

Business of current employer: _____

9. Present employer may be contacted? ☐ Yes ☐ No

Former employers may be contacted? ☐ Yes ☐ No

10. Identify any organization you currently hold a position with which has, or anticipates having, a contract, agreement, or other arrangement with the MEWA, a MEWA provider, or any other person having a financial relationship with the MEWA:

_____

_____

_____

11. Have you or your spouse ever been affiliated or associated with an insurance entity regulated by any Department of Insurance?

☐ Yes ☐ No

If **yes**, list such entities and state of domicile.

_____

_____

Name of spouse, if applicable:

_____

(Last) (First) (Middle)

12. a. Do you or any member of your family have a financial interest (**exceeding 5% of the stock or assets**) in any legal entity, which has a contract, agreement or other arrangement with the MEWA, an MEWA provider, or any other person concerning a financial relationship with the MEWA?

☐ Yes ☐ No

b. If **no**, do you anticipate that the relationship described above will occur in the succeeding three years?

☐ Yes ☐ No

13. List any entity in which you control directly/indirectly, or own legally/beneficially, **10% or more of the outstanding stock** (in voting power):

_____

_____

Is any of the stock is pledged or hypothecated?

☐ Yes ☐ No

14. a. Have you even been in a position that required a fidelity bond?

☐ Yes ☐ No

b. If yes, were claims made on the bond?

☐ Yes ☐ No

c. Have you ever been denied an individual fidelity bond, or had a bond canceled or revoked?

☐ Yes ☐ No

15. Have you been refused a professional, occupation or vocational license by a public or governmental licensing agency or regulatory authority, or has such a license been suspended or revoked?

☐ Yes ☐ No

16. Have you ever participated in the formation of a MEWA?

☐ Yes ☐ No

If **yes**, provide the name and address of each MEWA, date, position held, and reason for leaving on a separate sheet.

17. Have you ever declared bankruptcy?

☐ Yes ☐ No

18. Have you ever had a civil judgment against you?

☐ Yes ☐ No

19. Have you ever been found liable in a civil action for fraud?

☐ Yes ☐ No

If **yes**, include date, nature of action, name of accusing party, and address on a separate sheet.

20. Have you ever been the subject of a cease and desist order, or entered into a settlement with any state or Federal regulatory agency?

☐ Yes ☐ No

If **yes**, please list date, nature of action, name of agency, and address on a separate sheet.

21. Have you ever been an officer, director, trustee, key employee, or controlling stockholder of any entity that, while in such position(s), became insolvent, was placed under supervision, receivership, rehabilitation, liquidation or conservatorship?

☐ Yes ☐ No

22. Has a certificate of authority or license to do business of any entity of which you were an officer, director, key management person, or controlling stockholder been suspended or revoked while you occupied such position(s)?

☐ Yes ☐ No

23. Have you ever been named a defendant in a suit or administrative hearing brought by any public or governmental licensing agency or regulatory authority for violation of, or to prevent the violation of, any securities or insurance law?

☐ Yes ☐ No

If **yes**, explain date, nature of action, name of accusing party, and address on a separate sheet.

24. a. Have you been convicted, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned for conviction of or plead guilty or nolo contendere to an information or indictment charging a felony, misdemeanor involving embezzlement, theft, larceny, mail fraud, a violation of corporate securities statute, or have you been subject to disciplinary proceedings by a federal or state regulatory agency?

☐ Yes ☐ No

b. Has any company been so charged, allegedly as a result of any action or conduct on your part?

☐ Yes ☐ No

25. Have you ever been found in violation of, pled no contest to, or settled any proceeding involving insurance law, regulation or rule, or state or federal securities laws, regulations or rules?

☐ Yes ☐ No

26. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporation form?

☐ Yes ☐ No

I certify, under penalty of perjury, that I have examined each of the questions asked in this Affiliate Disclosure Statement and affirm that my responses are true and complete to the best of my knowledge and belief. I understand that if there is any substantial change to the information given in this statement, I am required to amend this statement and submit it to the Director of the Department of Insurance and Financial Services within 30 days of the change.

_____
Individual's Signature

_____
Typed Name

_____
Date

The above named individual personally appeared before me and/or is personally known to me. The individual deposes and says that he/she executed the above Affiliate Disclosure Statement and the responses are true and correct to the best of his/her knowledge and belief.

Subscribed and sworn to before me this _____ day of _____ 20 _____.

_____
Notary Public Signature

_____
My Commission Expires (Date)

PA 218 of 1956 as amended requires submission by *all members of the board of trustees, executive committee or other governing board or committee, and officers of a MEWA applying for a Certificate of Authority in Michigan. Failure to properly complete and file this statement may result in denial or revocation of a MEWA's Certificate of Authority, or other compliance action.*

MDA HEALTH PLAN BOARD MEETING
PENDING REFERRALS

STATUS	***REFERRAL:***
	MEETING OF FEBRUARY 8, 2019
Ongoing	Review the Plan investment portfolio manager every five years beginning in 2022. **(START/STUMP)**
	MEETING OF JUNE 26, 2020
___X__	Ms. Voss to implment EAP for members of health plan effective 8-1-20. **(VOSS)**
___X__	Comerica to recommend changes to our portfolio in November 2020. **(HILLARY)**
___X__	Board to evaluate maturing CD's for renewal. **(WINN/HILLARY)**
	MEETING OF NOVEMBER 6, 2020
___X__	Board to set meeting when Mr. Hillary to discuss fixed income investments.
_____	Staff will renew Living Fit and Family Focus plans to see if modifications are needed. (**VOSS/GITTENS)**