Medco Health

Pharmacy Services Manual

PSM2004A
FORM# OTHG2349

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The payment rates contained in this Agreement are confidential between the parties.

Prescription claims must be submitted through the TelePAID® System only for the Eligible Person for whom the prescription is written by the Prescriber.

Any requests for an interpretation of the Pharmacy Services Manual should be submitted in writing. Inquiries regarding this Manual, claims processing, claims adjustments, nonpayment of claims, or professional questions should be directed to:	**Medco** **Pharmacy Services Department** **(E1-MS1)** **100 Parsons Pond Drive** **Franklin Lakes, NJ 07417** **or** **www.medcohealth.com/rph** **or** **Medco Health Pharmacy Services Help Desk at 1 800 922-1557**
For special financial issues **only**, such as: A lost check, the need to recreate the tape or print version of the Remittance Advice, or the need to reconcile the Remittance Advice with the check you received:	**1 800 208-4842** **or** **www.medcohealth.com/rph**
For MAC inquiries and eligibility issues, contact the **Pharmacist Resource Center:**	**www.medcohealth.com/rph**
Hours of Operation:	**Medco Health's Pharmacy Services Call Center is available 7 days a week, 24 hours a day, including holidays.**
For Pharmacies in Puerto Rico, use Medco Health's Spanish-Info Line:	**1 800 528-2671** **<u>Monday through Saturday</u>** **8:30 a.m. to 8:30 p.m., eastern time** **<u>Sunday</u>** **Closed** **<u>Holidays</u>** **8:30 a.m. to 4:30 p.m., eastern time** **Closed Thanksgiving and Christmas Day**

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MEDCO HEALTH STANDARDS OF PRACTICE

- Telephone calls from Provider Pharmacies into Medco Health's Pharmacy Services Help Desk are answered with an average speed of answer ("ASA") of 30 seconds.
- Medco Health's Pharmacy Services Call Center successfully responds to 95% of Medco Health Provider Pharmacy inquiries at the initial point of contact.
- Medco Health's Pharmacy Services Call Center Representatives are available 24 hours a day, 7 days a week to service Medco Health Provider Pharmacies via our toll-free phone number.
- Medco Health utilizes multiple call centers to service and support our retail pharmacists. In the event of natural or technological disaster, Medco Health's Pharmacy Services Help Desk is capable of providing uninterrupted service to our Provider network.
- Each Medco Health Pharmacy Services Call Center Representative receives two weeks of classroom and on-the-phone training when hired. In addition, recurrent training is conducted throughout the year as industry practices and client plans change. This training is intended to provide Medco Health Provider Pharmacies with professional, accurate, and courteous answers to all incoming calls from Pharmacists.
- Medco Health reimburses Provider Pharmacies every two weeks according to the payment schedule included with this Manual.
- National Drug Code ("NDC") and Average Wholesale Price ("AWP") files are updated on a daily basis.
- Eligible Pharmacies will be enrolled as Medco Health Providers within 5 business days of receipt of their completed application.
- Eligible Medco Health Provider Pharmacies will be enrolled in Medco Health networks within 30 days of receipt of their signed contract.
- The TelePAID® System will be available 99.5% of the time, excluding routine scheduled maintenance.
- TelePAID® claims will be adjudicated, on average, within 3 seconds.
- TelePAID® claims can be reversed during the cycle in which the specific transaction adjudicated and up to 30 days after that cycle's claims cut-off date. Medco Health's Check Cycle Mailing Schedule and POS Cut-off dates are detailed in this Manual.
- Medco Health will highlight pharmacies with the highest performance ranking to Medco Health cost and quality standards in directories, proposals, and client reports.
- Substitute generic drug products for multisource brand drug products according to prevailing pharmacy laws and regulations.

- When a multisource brand drug product is dispensed, process the claim with the appropriate Dispense as Written ("DAW") Code according to the DAW Code Standards Section of this Manual.
- Dispense preferred co-branded drug products for nonpreferred co-branded drug products where applicable, in accordance with prevailing pharmacy laws and regulations.
- Reinforce the use of generic and preferred brand products with Medco Health cardholders and prescribers.
- Display all Drug Utilization Review ("DUR") alerts to the dispensing pharmacist.
- Inform Medco Health cardholders as to the proper storage, dosing, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.
- Submit accurate Drug Enforcement Administration ("DEA"), State Medical Board License Number, or other prescriber identifier on all claims in the correct NCPDP data field.
- Notify Medco Health within 7 days of any change in the status of Pharmacy's or Pharmacist's license.
- Submit claims via the TelePAID® System only for the patient for whom the prescription was written by the prescriber.
- Maintain at least the level of professional liability insurance required, currently $1,000,000/$3,000,000.
- Collect from each Eligible Person the applicable co-payment/coinsurance.
- Use an approved "Signature Log" for all Medco Health prescriptions dispensed.
- Submit Pharmacy's Usual and Customary ("U&C") price, which represents the amount the patient would have paid were they paying cash.
- Dispense medications from the largest package size on hand and submit the corresponding NDC number.
- Reverse claims for any drug product returned to stock within 14 days of the date the claim was originally billed.
- Pharmacy shall not undermine U&C or compound pricing as a component of the compensation contemplated in this Agreement in any way, including but not limited to: (1) owning, operating, or affiliating with a nonparticipating Pharmacy; or, (2) separating cash and third party prescription business. Pharmacy shall not participate in the Medco Health Participating Pharmacy Network if Medco Health determines in its sole discretion that Pharmacy has taken actions to undermine U&C or compound pricing.
- Pharmacy is required to submit a completed and signed Pharmacy Verification Form on an annual basis within 30 days of receipt.

Overview of the Medco Health Solutions, Inc., Programs

Medco Health Solutions, Inc., provides each Eligible Person with a prescription ID card that contains the Medco Health logo or some other indication that the program is administered by Medco Health (see section on "Samples of the Medco Health prescription ID cards"). Pharmacy is required to honor this card regardless of the State in which the member lives. The cards contain information such as the Eligible Person's identification number and group number that enables the claim to be processed through the TelePAID® System.

Medco Health has many plans. Each has its own guidelines as to such things as days supply, ingredient cost pricing, co-payment/coinsurance, drug coverage, as well as, informational drug utilization messaging. Therefore, rely on the TelePAID® System to receive accurate information regarding the specific patient, group, prescription drug, co-payment/coinsurance, and pricing pertaining to the claim submitted. Answers to most questions about Medco Health can be obtained by reading this Pharmacy Services Manual. For questions not covered in this Manual, please contact Medco Health at:

The Pharmacy Services Help Desk
1 800 922-1557

or write to:

Medco
Pharmacy Services Help Desk
(E1-MS1)
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

IDENTIFICATION OF ELIGIBLE PERSONS

Medco Health or Medco Health's designee may furnish Eligible Persons with prescription ID card to be presented at Pharmacy or may implement alternative eligibility verification methods. Pharmacy may submit prescription drug claims only for the Eligible Person for whom the prescription is written by the prescriber. Pharmacy will not be paid for Covered Services provided to persons whose eligibility to participate in a Medco Health program has not been verified and communicated to Pharmacy by the TelePAID® System or other applicable eligibility verification methods used by Medco Health or, if the claim was submitted for an Eligible Person other than the person for whom the prescription is written by the prescriber. Signature logs must conform on an ongoing basis to the requirements set forth under the Professional Audits section of this Manual for Third Party Signature Claim Logs. Pharmacy will obtain the signature of the Eligible Person or his/her authorized agent in Pharmacy's Third Party Signature Claim Log Book confirming receipt of the prescription and the required certification statement for all claims submitted through the TelePAID® System. Pharmacy will not be entitled to payment for any claims not supported by a log book signature.

Eligible Person information necessary to file a claim is contained on the prescription ID card and described as follows:

1. **Cardholder ID —** Usually nine numeric characters that often reflect the Social Security number of the primary cardholder. The National Council for Prescription Drug Programs ("NCPDP") standard for this field allows up to 20 alphanumeric characters.
2. **Group Number —** Usually a 7-character field assigned by Medco Health. This field may, however, contain up to 15 alphanumeric characters.
3. **Dependent coverage** may include spouse and/or children. The card may be coded to indicate which family members are covered. Covered family members are identified by the following:

   Relationship Codes:

   "1" Cardholder — Eligible Primary Person or Subscriber

   "2" Spouse of the Cardholder

   "3" Dependent Child

   "4" Other (requires "Clarification Eligibility Exception Code")

   Clarification Eligibility Exception Codes:

   "3" Full-time Student

   "4" Disabled Dependent

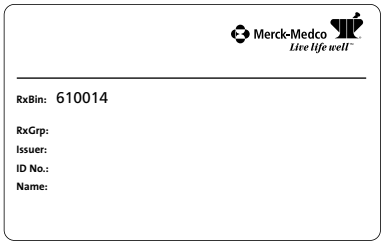
   "5" Dependent Parent

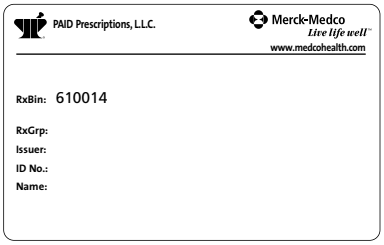
   "6" Significant Other/Dependent Adult/Domestic Partner

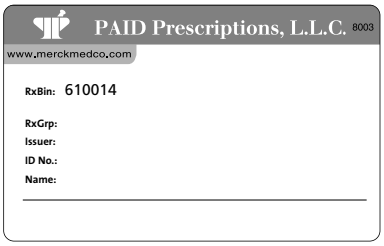
IMPORTANT NOTE: Use of the correct Relationship Code is important. Prescription claims must be submitted to Medco Health only for the Eligible Person for whom the prescription is written by the prescriber. This requirement has taken on added significance in that (1) DUR reviews are based on the claims submitted for the correct individual; (2) the change from Social Security Number (SSN) to non-unique, non-SSNs and the preponderance of many of the same cardholder ID numbers belonging to multiple persons. Claims submitted for any other Eligible Person, except for the person for whom the prescription was written, are subject to audit and recovery of paid-out funds.

Examples of Medco Health Prescription ID Cards

Eligibility of the individual patient for whom the prescription is prescribed is confirmed via the TelePAID® System. Some cards are valid for only the cardholder whose name is embossed on the prescription ID card; some cover only the member or spouse, while others cover the entire family.







Certain clients may have a custom prescription ID card containing the Medco, Medco Health, Merck-Medco and/or PAID logos shown below. Process these cards using the TelePAID® System.

medco medcohealth™ Merck-Medco

Claims Submission Protocols

TELEPAID® CLAIMS SYSTEM

The TelePAID® System sets forth pricing, eligibility, and other information that governs participation in the Network applicable to each Plan Sponsor and Eligible Person. The TelePAID® System also provides information necessary to effectively implement Medco Health's clinical and benefit management initiatives such as drug utilization review, prior authorization, and formulary management programs on behalf of Plan Sponsors. Pharmacy will submit all claims through the TelePAID® System and will comply with all information communicated via the TelePAID® System or otherwise by Medco Health.

All claims must contain complete and accurate information for each prescription dispensed. Claims must be submitted only for the Eligible Person for whom the prescription is written by the prescriber. Pharmacy will transmit claims to Medco Health with all required fields as defined by Medco Health using the most current NCPDP standard defined by the Medco Health Version 5.1 Payer Sheet. The Medco Health (formerly PAID and Merck-Medco) Version 5.1 Payer Sheet was initially communicated on March 1, 2002. The most current Payer Sheet can be obtained through any of the following channels:

- Pharmacist Resource Center website, **www.medcohealth.com/rph**: From the Tools menu, select "Contact the Help Desk."
- Pharmacy Services Help Desk: 1 800 922-1557
- Write to: Medco
  File Management (B3 MS1)
  100 Parsons Pond Drive
  Franklin Lakes, NJ 07417

All authorized refills of any prescription must bear the original prescription number. An on-site registered and licensed pharmacist experienced in third party procedures will supervise the claims submitted by Pharmacy. All claims submitted by Pharmacy will be in accordance with the metric decimal quantity guidelines established by NCPDP from time to time.

TELEPAID® CLAIMS SYSTEM

continued

Pharmacy will submit all TelePAID® System claims simultaneously with dispensing unless unusual circumstances require otherwise, in which event Pharmacy will submit TelePAID® System claims within 30 days of the date of service. Claims submitted to Medco Health after the applicable claims cut-off date will not be eligible for payment. Medco Health will endeavor to pay all valid claims payable by Medco Health in accordance with the payment rate established for the applicable plan within Medco Health's next regular billing cycle less the applicable co-payment/coinsurance, deductible or other payments, such as administrative fees for certain programs, to be paid directly by the Eligible Person. Medco Health will provide Pharmacy with a payment record of all claims paid. Medco Health may deduct from claim payments to Pharmacy, for Pharmacy's use of the TelePAID® System, a minimum of $0.10 per transaction transmitted in the most current NCPDP standard and a minimum of $0.99 for transactions in any other version. This amount will constitute a fee to Medco Health for the TelePAID® System service. This fee may be modified by Medco Health, from time to time, upon prior notice to the Pharmacy. For non-standard processing of Universal Claim Forms ("UCF") a $1.00 administration fee will be applied per payable claim.

NDC Number & Package Size

NDC number must appear on submitted claims as defined in the current Medco Health Payer Sheet.

Pharmacy must submit the complete NDC number of the package size dispensed. For example, whenever 10 or more Pergonal® vials (or similar drug products) are dispensed at one time, the NDC number of the 10 Pack, or larger, must be submitted.

Unbreakable packages such as liquid fluoride vitamins, oral contraceptives, and Accutane 10 Packs are defined as "unbreakable" by the FDA. These, and drug products similarly defined by the FDA, must be dispensed in the original packaging for all Medco Health plans covering such drug products. All other packages, including nitroglycerin patches are considered "breakable" and as such must be dispensed in the quantity prescribed.

Sales Tax

The amount of any allowable taxes will be specifically identified on each claim submitted by pharmacy as a condition of payment by Medco Health. Medco Health supports all state sales tax fields in accordance to the standards of NCPDP v5.1. For those states that require sales tax on prescriptions, Pharmacy should identify the percentage sales tax rate and tax basis amount used to determine the sales tax amount.

Partial Fills

Medco Health supports all partial fill fields in accordance to the standards of NCPDP v5.1. Dispensing fees are paid on the initial fill only. Collect only the amount transmitted through the TelePAID® System from the cardholder as co-payment/coinsurance amounts differ from plan to plan. Sales tax, if any, is

TELEPAID® CLAIMS SYSTEM

continued

payable on all claims based on amount allowed. Basis of calculations for ingredient cost, dispensing fee, sales tax, and co-payment/coinsurance will be returned to pharmacy on TelePAID® System response. Pharmacy has 30 days to complete a partial fill claim, after 30 days the claim will reject. Rejections will occur if the intended quantity, days' supply, patient, or product dispensed differs from the initial fill. The associated prescription/service reference ID and dates of service are required for subsequent fills; the fill number should be identical on each fill if the prescription/service reference number is the same. When reversing a partial fill claim, include the dispensing status.

Coordination of Benefits/Split Billing/Secondary Claims

Medco Health supports coordination of benefits ("COB"), split billing, and secondary claims in accordance with the standards of NCPDP v5.1. The COB segment is required when submitting secondary claims. COB values 1 through 7 are supported and will drive claim if secondary adjudication applies. Claims denied by primary carrier should be submitted with the NCPDP v5.1 reject code identified on the COB segment. Include "other coverage" code when reversing a claim as Medco Health can offer both primary and secondary coverage even when same cardholder ID has both benefits. If pharmacy receives a reject message indicating group does not accept secondary coverage, notify card holder. Medco Health does not accept UCF hard copy claims for purpose of billing secondary coverage from Pharmacy. Pharmacy has 90 days to submit a COB claim. Pharmacy can submit a COB claim electronically through the TelePAID® System up to 90 days from date of service.

TELEPAID® CLAIMS SYSTEM

continued

QUANTITY DISPENSED

The Quantity Dispensed transmitted via TelePAID® for all Medco Health claims must reflect the exact Quantity Dispensed, including decimal amounts. Pharmacy software must conform to the then current NCPDP standard for "Quantity Dispensed" field.

1. Tablets, Capsules, Suppositories, Needles, and Syringes:

Should be expressed as the Quantity Dispensed.

Example: 100 tablets dispensed Quantity Dispensed = 100

2. Ointments, Creams, Balms, Bulk Powders, etc.:

Should be expressed as the exact number of grams, including decimal amounts, in the Quantity Dispensed field.

3. Liquids, Suspensions, Solutions, IV Solutions, Irrigations, Nasal Sprays, Oral Inhalers, etc.:

Should be expressed as the exact number of milliliters, including decimal amounts, in the Quantity Dispensed field.

Example: Atrovent Inhalation Solution 0.02%, 2.5-mL vial, 00597-0080-62
Report Quantity Dispensed in exact mLs X number of vials dispensed.

Exception: Imitrex Nasal Spray 20 mg, 00173-0523-00
Report Quantity Dispensed as the number of containers dispensed.

4. Injectables already in solution

Should be expressed in the exact number of milliliters, including decimal amounts, in the Quantity Dispensed field.

Example: Insulin 10 mL
Quantity Dispensed = 10

5. Reconstitutable Injectables:

Lyophilized powders in vials to be reconstituted by the addition of a diluent should be expressed as the number of vials dispensed.

6. Partially Filled Containers:

If the product is in a Partially Filled Container, the package size is the amount of fill volume containing the actual drug and should be expressed in milliliters.

Example: Dextrose 5% 250 mL in a 500-mL bottle
Quantity Dispensed = 250

7. Packets:

Packet Products such as Questran or K-Lor should be expressed by the number of packets dispensed.

Example: 60 Questran Packets
Quantity Dispensed = 60

8. Disposable Enemas:

If Enemas are labeled volumetrically, the Quantity Dispensed should be expressed in milliliters.

Example: Rowasa–60 mL per Enema
Quantity Dispensed = 60
If Enema is not labeled volumetrically, then the Quantity Dispensed would be expressed as the number of units dispensed.

9. Ophthalmic Ointments and Drops:

The Quantity Dispensed should be expressed in exact decimals, grams or milliliters, depending on whether the package is labeled by weight or volume.

Example: Bacitracin Ophthalmic Ointment 3.5 g
Quantity Dispensed = 3.5

10. Reconstituted Noninjectable Liquid Dosage Forms:

Antibiotic oral suspensions, eye drops, and other noninjectable dosage forms that require reconstitution prior to dispensing and are labeled by volume should be expressed in milliliters.

Example: Amoxil Suspension 150 mL
Quantity Dispensed = 150

11. Antihemophilic Factor:

Quantity must be expressed by the number of units dispensed and not the number of ampules dispensed.

Example: Konyne HT 1000 AHF
Quantity Dispensed = 1000

12. Combination Packages:

Drug Products that are packaged with more than one drug in different dosage forms should be expressed as units of 1.

Example: Monistat Dual Pack
Quantity Dispensed = 1

COMPOUNDED PRESCRIPTIONS DEFINED

Definition of a Compounded Prescription

A compounded prescription is one which meets the following criteria: Two or more solid, semi-solid, or liquid ingredients, one of which is a "Prescription Legend Drug," that are weighed or measured, then prepared according to the prescriber's order and the Pharmacist's art.

Note: Reconstitution of an oral antibiotic or any other similar product is not considered a compounded prescription.

PROCEDURES FOR SUBMITTING COMPOUNDED PRESCRIPTION CLAIMS:

(refer to section 1.3 for definition and criteria)

Compounded Prescriptions are required to be submitted via the TelePAID® System in accordance with the following:

1. Set the "Compound Flag" to positive in accordance with the Pharmacy Software and NCPDP standards as defined by Medco's most current Payer Sheet.
2. Submit the NDC number for the highest priced Federal Legend Drug contained in the compound or the NDC that most accurately reflects the cost of the compound.
3. Enter the Quantity Dispensed as the total amount of the finished product.
4. Enter the total cost of all ingredients, the professional fee, and your "Usual and Customary" price.*
5. Enter patient and group information as you would any other Medco Health claim.
6. Collect from the Medco Health cardholder only the applicable co-payment/coinsurance as indicated through the TelePAID® System.

*Reimbursement Note: Pharmacy will be reimbursed based on the ingredients utilized to compound the prescription according to the rates set forth in the Pharmacy's Agreement with Medco Health. Additional charges for ancillary supplies, equipment, and/or labor are not eligible for reimbursement.

TELEPAID® CLAIMS SYSTEM

continued

CLAIMS ADJUSTMENTS

Pharmacy may request an adjustment to any claim for which Pharmacy's records indicate that Pharmacy received an incorrect payment. Adjustments can be made by phoning the Medco Health Pharmacy Services Help Desk or by writing to Medco Health. When requesting an adjustment, in writing, Pharmacy must submit the Statement of Claims showing the original dollar amount paid and a copy of the remittance advice. Pharmacy should include a short note and any wholesaler, manufacturer, or distributor invoices supporting the incorrect payment as appropriate. Medco Health reserves the right to charge up to $1.00 per claim for claim research fees associated with no change in reimbursement.

Medco Health may make an adjustment to any statement where it is indicated that Pharmacy received an incorrect amount for Pharmacy services provided. Claim Adjustments should be mailed to:

Medco
Pharmacy Services/Claims Adjustment
(E1-MS1)
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

REVERSAL OF CLAIMS

Pharmacy is required to submit claim reversals through the TelePAID® System within the same payment cycle or up to 30 days after the claim was adjudicated. The practical application of a reversal is in those cases where a prescription drug claim was adjudicated through the TelePAID® System but never received by an Eligible Person. All prescriptions not received by Eligible Persons must be returned to stock within 30 days of processing and the claim reversed. Failure to reverse such claims may result in an audit recovery and recapture of all costs involved in the reversal including research costs. If the Pharmacy is unable to completely process a reversal online, the Pharmacy should call the Medco Health Pharmacy Services Help Desk at 1 800 922-1557 for assistance. Prescription claims cannot be reversed, then reentered as a means of claims adjustment after the check cycle has closed. Phone the Help Desk for all claims adjustments.

Medco Health Direct® style programs must be reversed within 3 days of the date of service.

HOME HEALTH CARE AND LONG-TERM CARE BILLING REQUIREMENTS

Pharmacies providing home health care or long-term care Covered Services to Eligible Persons must submit all claims via the TelePAID® System. Each NDC number of the individual drug dispensed must be billed only once to Medco Health during any 30-day period. It is the supervising pharmacist's responsibility to ensure that Medco Health is credited for any unused medications in accordance with the claims adjustment process and all applicable pharmacy laws and regulations.

HIGH-DOLLAR PHARMACY CLAIMS

Pharmacies that are NCPDP Version 5.1 certified can submit claims up to $999,999.99 via the TelePAID® System.

Non–Version 5.1-certified pharmacies should follow the following procedure for claims greater than $9,999.99:

- Participating pharmacy submits high-dollar claim on a UCF with the full quantity and dollar amount. **(PREFERRED method)**
- Participating pharmacy submits $9,999.99 through TelePAID®, verifies eligibility and plan coverage. Claim is **REVERSED**, and a UCF for the FULL cost and quantity is submitted.
- Participating pharmacy submits $9,999.99 with appropriate quantity through TelePAID®, and then completes a UCF with the **FULL cost and quantity**. This UCF must be clearly marked as an **ADJUSTMENT**. **Note:** The adjustment will not pay until the next billing cycle at the earliest.

Please note that claims over $99,999.99 require special handling. After a claim over this amount has been entered, an adjustment will be done for the remaining dollars in the next billing cycle.

Please submit all the patient, pharmacy, and drug information as you would any other Medco Health claim. These claims will receive special attention and will be processed within 28 days. All high-dollar claims should be forwarded to:

Medco
Pharmacy Services/Claim Adjustment
(E1-MS1)
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Email address: MedcoHDPCP@medcohealth.com

CLAIMS THAT REQUIRE AN OVERRIDE THROUGH THE PHARMACY SERVICES HELP DESK

1. Days Supply ("DS") submitted incorrectly on the original claim. For example, a "90 DS" was incorrectly submitted instead of the correct "30 DS." An error code of "refill too soon" on the refill would make it impossible to submit the claim online. A Pharmacy Service Representative, however, could override the claim. For the Pharmacy records, the software system protocol should be followed. Usually the refill would be recorded as a "cash transaction" for the sake of record keeping in the pharmacy system.

2. In the case of covered twin dependents, when no "patient number" is found on the card, if the second twin was receiving the same medication as the first twin, a Pharmacy Services override would be required for the claim to adjudicate.

3. In the case of the same prescription filled for the second of two covered "significant others" or "two covered adults" the claim would reject as a "duplicate claim" without a Pharmacy Services override.

4. Pain medication dispensed for less than 5 days and consumed in 3 days or less will reject due to "refill too soon" and the "three-days-supply limit" require a Pharmacy Services override.

5. A claim with both "refill too soon" and "maximum daily dosage" edits.

6. A claim for a "nonpreferred" drug product being filled for a "co-branded" formulary plan.

Co-payment/Coinsurance

Co-payment or coinsurance is the amount to be collected by Pharmacy from the Eligible Person. Pharmacy will collect from each Eligible Person the applicable co-payment/coinsurance or other direct payment as communicated via the TelePAID® System or other method established by Medco Health. Pharmacy will not charge or collect from any Eligible Person any amount for Covered Services in excess of the applicable co-payment/coinsurance or other direct payment communicated by Medco Health. Pharmacy acknowledges that the co-payment/coinsurance or other direct payment is an integral part of the plan design selected by the Sponsor, and Pharmacy will not waive or discount the applicable co-payment/coinsurance or other direct payment under any circumstances.

PRIOR AUTHORIZATION

What Is Prior Authorization?

At the request of some Sponsors, certain medications or classes of medications will require additional information to be obtained to determine whether the use or the quantity above-stated plan limits are covered. Prior Authorization is a feature or a program that provides prescription benefit coverage if certain circumstances are met.

Claim Message on Prior Authorization

The following components on the claim message indicate that a Prior Authorization is needed: A reject code of "70" with message "drug not covered" or reject code "75" with message "prior authorization required." After the above claim information has been received, communicate to the Eligible Person the information outlined above in "What is Prior Authorization?"

Initiating Prior Authorization

At times, a telephone number will be displayed along with the Prior Authorization claim message. The telephone number displayed may lead to Medco Health's Prior Authorization unit or a Prior Authorization unit arranged by the Sponsor.

- Contact the Prescriber and review the reason for the Prior Authorization. If required, the Prescriber can initiate a coverage review by contacting the toll-free number displayed on your screen. The Pharmacist and Patient may also initiate the coverage review process by calling the toll-free number. When requested Medco Health Managed Care will fax the Prescriber a questionnaire.
- If no telephone number is displayed on the claim reply, for a Prior Authorization you may refer the Eligible Person to the toll-free number for Member Service for further assistance. The Eligible Person's Member Service number can be found on the prescription benefit card.

Communication of Benefit Decision

Generally the Eligible Person and Prescriber receive written confirmation of benefit decisions.

Managing Clinical Messages & Opportunities

CLINICAL MESSAGES

Pharmacy is required to dispense prescriptions to Eligible Persons in accordance with its pharmacist's professional judgment, quality practice standards, generic drug programs, formulary compliance, disease state management, and other clinical management programs implemented by Medco Health as communicated to Pharmacy via the TelePAID® System and all applicable laws and regulations in accordance with Sponsor plan designs. These programs and initiatives are communicated to Pharmacy via the TelePAID® System. The following are descriptions of the various clinical messages and opportunities communicated via the TelePAID® System:

- Drug Utilization Review Messaging
- Clinical Management Programs
- Maximum Daily Dosage ("MDD")
- Drug-To-Drug Interaction
- Refill Too Soon Edits
- DUR Conflict, Intervention, and Outcomes Codes and Descriptions

DRUG UTILIZATION REVIEW ("DUR")

1. Pharmacy is required to operate a computer system that provides for the recording of patient drug and medical history, as allowed by law and sound pharmacy practice. Medco Health may require that Pharmacy send to Medco Health via the TelePAID® System other patient information as might be collected by the Pharmacy, under applicable state law, such as diseases, medical conditions, non-reimbursable medications (e.g., OTCs), and allergies. This information should be compatible with DUR messaging received via the TelePAID® System when a claim is being adjudicated. Messaging includes DUR, formulary, and intervention messages transmitted via the TelePAID® System.

2. Pharmacy is required, subject to professional judgment, to act upon DUR information provided by message alerts transmitted to Pharmacy via the TelePAID® System. The DUR messaging may not be complete; therefore, the Pharmacy should perform its own individual utilization review. Pharmacy's claims transmission system must comply fully with the current standard recognized by the NCPDP (see Glossary) Version 5.1. Pharmacy is required to provide intervention resolution and outcome codes to Medco Health informing Medco Health of the resolution of DUR alerts and messages transmitted via the TelePAID® System. The DUR Reason for Service, Professional Service, and Result of Service codes follow at the end of this section. These codes are also available from NCPDP and systems software vendors.

Temporary Coverage Policy

- Temporary Coverage is allowed for certain drugs that require prior authorization.
- Pharmacists receiving a Primary Reject Error Code of "Drug Not Covered" or "Prior Authorization" (NCPDP Reject Error Codes 70, 75 or 76) may be able to obtain Temporary Coverage for Eligible Persons for a limited supply of certain medications while awaiting the benefit decision by going through the following steps.
- If the drug qualifies for Temporary Coverage, a Secondary Reject Error Code message will be attached to the Primary Reject Error Code (see above). The Secondary Reject Error Code of "Temp Fill of XX D/S Allowable with PA/MC Override of 11111." Translated: "Temporary Fill of XX Days Supply (Override Days Supply Value) Allowable with Prior Authorization/ Managed Care Override of '11111.'"
- Important Note: If a possible DUR safety issue exists, contact the Prescriber to discuss the alert prior to processing the prescription using the Temporary Coverage Override.
- If there is no safety issue, resubmit the prescription claim for the days supply (D/S) provided in the reject message with the value of "01" in the NCPDP prior auth type code field and "9999" in the PA/MC field.
- Collect from the Eligible Person the indicated co-payment/coinsurance amount, if any. You will be reimbursed for the Temporary Supply of medication provided to your patient.

DUR Specification Codes

General DUR Specification Codes

DUR Reason for Service Codes and Descriptions:
Represents the NCPDP code that identifies the reason for generating a DUR conflict.

DUR Professional Service Codes and Descriptions:
Represents the NCPDP code that identifies the intervention or action taken by a pharmacist to resolve a DUR conflict.

DUR Result of Service Codes and Descriptions:
Represents the NCPDP code that identifies the resolution (or outcome) associated with a DUR conflict.

DUR Reason for Service Codes and Descriptions

AD	Additional Drug Needed — Optimal treatment of the patient's condition requires the addition of a new drug to the existing therapy.
AN	Prescription Authentication — Circumstances require that the pharmacist verify the validity and/or authenticity of the prescription. The principal use is for suspected fraud.
AR	Adverse Drug Reaction — First occurrence of an adverse reaction by a patient to a drug.
AT	Additive Toxicity — Detects drugs with similar side effects that could exhibit additive toxic potential.
CD	Chronic Disease.
CH	Call Help Desk — Processor message to call help desk.
CS	Patient Complaint/Symptom — Patient presents to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.
DA	Drug Allergy — Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.
DC	Drug Disease (Inferred) — Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of specific medical condition may be inferred from drugs in the patient's medication history.
DD	Drug-to-Drug Interaction — Detects drug combinations in which the net pharmacological response may be different from the result expected when each drug is given separately.

DUR Reason for Service Codes and Descriptions *continued*

DF	Drug Food Interaction — Detects interactions between a drug and certain foods.
DI	Drug Incompatibility — Identifies physical and chemical incompatibilities between two or more drugs.
DL	Drug Lab Conflict — Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value.
DM	Apparent Drug Misuse — Pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber.
DS	Tobacco Use — Conflict detects when a prescribed drug is contraindicated or might conflict with the use of tobacco products.
ED	Patient Education.
ER	Overuse (Early Refill or Refill Too Soon) — Detects prescription refills that occur before the days supply of the previous filling should have been exhausted.
EX	Excessive Quantity — The quantity of dosage units prescribed is excessive for dispensing at a single time.
HD	High Dose (Exceeds Maximum Daily Dose) — Detects drug doses that fall above the standard dosing range.
IC	Iatrogenic Condition — Detects possibly inappropriate use of drugs that are designed to ameliorate complications caused by another medication.
ID	Ingredient Duplication — Detects simultaneous use of drug products containing one or more identical generic chemical entities.
LD	Low Dose (Under Minimum Daily Dose) — Detects drug doses that fall below the standard dosing range.
LK	Lock in recipient.
LR	Under Use — Detects prescription refills that occur after the days' supply of the previous filling should have been exhausted.
MC	Drug Disease (Reported/Actual) — Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient, or pharmacist.
MN	Insufficient Duration — Detects regimens that are shorter than the minimal limit of therapy for the drug product based on the product's common uses.

DUR Reason for Service Codes and Descriptions *continued*

MS	Missing Information/Clarification — The prescription order is unclear, incomplete, or illegible with respect to essential information.
MX	Excessive Duration — Detects regimens that are longer than the maximal limit of therapy for the drug product based on the product's common uses.
NA	Drug Not Available — Drug is not currently available from any source.
NC	Non-covered drug purchase.
ND	New Disease/Diagnosis — Patient has a newly diagnosed condition or disease that necessitates a professional pharmacy service.
NF	Non-Formulary Drug — Drug is not included on the formulary of the patient's pharmacy benefit plan. This code is intended to support mandatory formulary enforcement activities by pharmacists.
NN	Unnecessary Drug — Drug is no longer needed by the patient. This code is intended to support ongoing monitoring of established drug therapy by the pharmacist, as distinguished from "Inappropriate drug/indication," which is intended to support prospective drug utilization review of new therapy.
NP	New Patient Processing — Initial interview and medication history of a new patient.
NR	Lactation/Nursing Indication — Drug is excreted in breast milk and may represent a danger to a nursing infant.
NS	Insufficient Quantity — Quantity of dosage units prescribed is insufficient.
OH	Alcohol Conflict — Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.
PA	Drug Age — Detects when a prescribed drug is contraindicated based on the patient's age.
PC	Patient Question/Concern — Request for information or concern expressed by the patient with respect to his or her care.
PG	Drug Pregnancy — Detects when a prescribed drug is contraindicated for use by a pregnant woman. This information is intended to assist in weighing the therapeutic value of a drug against possible adverse effects on the fetus.
PH	Preventive healthcare.
PN	Prescriber Consultation — Request by a prescriber for information or a recommendation related to the care of a patient.

DUR Reason for Service Codes and Descriptions *continued*

PP	Plan Protocol.
PR	Prior Adverse Reaction — Identifies those drugs that the patient has previously reacted in an atypical manner.
PS	Product Selection Opportunity — An acceptable generic substitute or therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.
RE	Suspected environmental risk.
RF	Health Provider Referral — Patient referred to the pharmacist by another health care provider.
SC	Suboptimal Compliance.
SD	Suboptimal Drug/Indication — Incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition (should not be used when a more precise code exists to describe the problem, such as Drug Interactions, Drug Allergy, Drug Disease, etc.)
SE	Side Effect — Reports possible major side effects of the prescribed drug.
SF	Suboptimal Dosage Form — Incorrect, inappropriate, or less than optimal dosage form prescribed for the patient's condition.
SR	Suboptimal Regimen — Incorrect, inappropriate, or less than optimal dosing regimen prescribed for the patient's condition.
SX	Drug Gender — Detects when a prescribed drug is contraindicated or inappropriate for use based on the patient's sex.
TD	Therapeutic Duplication — Detects simultaneous use of different primary generic chemical entities that have the same therapeutic effect.
TN	Laboratory Test Needed — Assessment of the patient by the pharmacist suggested that a laboratory test is needed to optimally manage therapy.
TP	Payer/Processor Question — Request by a payer or processor for information related to the care of a patient.

DUR Specification Codes

continued

DUR Professional Service Codes and Descriptions

AS	Patient Assessment — Initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.
CC	Coordination of Care — Case management activities of a pharmacist related to the coordination of care being delivered by multiple providers.
DE	Dosing evaluation/determination.
FE	Formulary Enforcement — Activities including interventions with prescriber and patients related to the enforcement of a pharmacy benefit plan formulary.
GP	Generic Product Selection — The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer.
MA	Medication Administration.
MO	Prescriber Consulted — Prescriber communication related to collection of information or clarification of a specific limited problem.
MR	Medication Review — Comprehensive review and evaluation of a patient's entire medication regimen.
PO	Patient Consulted — Patient communication related to collection of information or clarification of a specific limited problem.
PE	Patient Education/Instruction — Verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.
PH	Patient Medication History — Establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.
PM	Patient Monitoring — Evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.
PR	Patient Referral — Referral of a patient to another healthcare provider following evaluation by the pharmacist.
PT	Perform Laboratory Test — Pharmacist performs a clinical laboratory test on a patient.
RO	Pharmacist Consulted Other Source — Communication related to collection of information or clarification of a specific limited problem via professional judgment.
RT	Recommend Laboratory Test — Pharmacist recommends the performance of a

DUR Professional Service Codes and Descriptions *continued*

	clinical laboratory test on a patient.
SC	Self-Care Consultation — Activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. Counseling a patient about the selection and use of an over-the-counter medication is probably the most common example of this type of service.
SW	Literature Search/Review — Pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.
TC	Payer/Processor Consulted — Communication by a pharmacist to a processor or payer related to the care of a patient.
TH	Therapeutic Product Interchange — The selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer.

DUR Specification Codes

continued

DUR Result of Service Codes and Descriptions

1A	Filled As Is, False Positive — Identified conflict determined not to be valid.
1B	Filled Prescription As Is — Identified conflict determined to be insignificant without contacting the prescriber.
1C	Filled with Different Dose.
1D	Filled with Different Directions.
1E	Filled with Different Drug.
1F	Filled with Different Quantity.
1G	Filled with Prescriber Approval — Conflict identified was valid and potentially significant. Resolution required consultation with the prescriber.
1H	Brand to Generic Change — Generic drug product was substituted for the prescribed branded product.
1J	Rx to OTC Change — An equally efficacious nonprescription drug product was dispensed in place of the prescribed product.
1K	Filled with different dosage.
2A	Prescription Not Filled.
2B	Prescription Not Filled, Directions Clarified.
3A	Recommendation Accepted — Prescriber accepted the recommendation made by the pharmacist.
3B	Recommendation Not Accepted — Prescriber did not accept the recommendation made by the pharmacist.
3C	Discontinued Drug — Prescriber authorized the discontinuance of a drug.
3D	Regimen Changed — Prescriber authorized a change in dose or dosage regimen.
3E	Therapy Changed — Prescriber authorized a change in medication therapy.
3F	Therapy Changed, Cost Increase Acknowledged — Prescriber authorized a change in medication therapy recommended by the pharmacist that will increase the current cost of therapy with the goal of improving the overall healthcare outcome.

DUR Result of Service Codes and Descriptions

3G	Drug Therapy Unchanged — Prescriber did not authorize a change in medication therapy.
3H	Follow-up/Report — Verbal and/or written follow-up information was communicated from the pharmacist to the prescriber.
3J	Patient Referral.
3K	Instructions Understood.
3M	Compliance aid provided.
3N	Medication Administered.

Maximum Daily Dosage

If Pharmacy receives a Maximum Daily Dosage Rejection Code message via the TelePAID® System when submitting a claim of "76 - Max. Dose/Day = #," the following steps need to be taken:

1. Verify that the days supply and quantity dispensed is correct.
2. Contact the prescriber to confirm the dosage. Document the conversation on the original prescription.
3. Document on the hard copy prescription: a) the reason for the override; b) the authorization code, if applicable; c) the name of the Medco Health representative, if applicable.

Once the steps are completed, enter "02" in the Submission Clarification Code Field (Submission Clarification Code), field number 420-Dk and retransmit.

Follow your Pharmacy System's Software Protocols.

Note: *No default override codes are permitted on an initial inbound claims transaction.*

Drug-to-Drug Interaction

If Pharmacy receives a DUR Reason for Service message, via the TelePAID® System for Drug-to-Drug interactions, the following steps need to be taken:

1. Contact the prescriber to discuss the potential "Drug-to-Drug" interaction.
2. If the prescriber approves the prescription to be dispensed with no change after the alert, resubmit the claim using all three of the following Codes:

   DUR Reason for Service Code = DD (Drug-to-Drug interaction)

   DUR Professional Service Code = M0 (Prescriber Consulted)

   DUR Result of Service Code = 1G (Filled, with Prescriber's Approval)

Note: *No default override code permitted on an initial inbound claims transaction, unless the Pharmacy has detected the Drug-to-Drug interaction and contacted the prescriber.*

Submission Clarification Codes

If Pharmacy receives a "refill too soon" rejection message the following responses are appropriate:

If the Eligible Person requests an "early refill" for no apparent reason, inform the Eligible Person of the plan limitations and let that Eligible Person know when the prescription can be refilled without a rejection.

Use the Standard NCPDP override Codes as follows:

Submission Clarification Codes	Definition
Value of "03" in Rx Clarification Field	Vacation supply refill
Value of "04" in Rx Clarification Field	Lost or spilled prescription
Value of "05" in Rx Clarification Field	Daily dosage, therapy changed by prescriber

Note:

- *If the Submission Clarification Code is entered into the Pharmacy Software system and the claim rejects a second time, inform the Eligible Person that the plan has not approved an override for one of the three conditions indicated above.*
- *No default override codes are permitted on an initial inbound claim transaction.*
- *The reason for the override must be recorded on the original prescription.*
- *Document on the hard copy prescription: a) the reason for the override; b) the Authorization Code, if applicable; c) the name of the Medco Health representative, if applicable.*
- *Utilization of any Submission Clarification Codes for reasons other than the intended purpose will result in the identification of audit discrepancies and charge backs.*

TelePAID® Submission Reject Codes

Consult the NCPDP Data Dictionary Version 5.1 for a complete list of NCPDP reject codes for the telecommunication standard.

PRESCRIPTION SUBSTITUTION STANDARDS

Generic Drug Standards

As part of Medco Health's managed care initiatives, Pharmacy is required to use its best efforts in supporting Medco Health and its Sponsors in managing the cost and quality of Covered Services by cooperating in administering mandatory generic programs as they may from time to time be contained in Sponsor benefit or Medco Health programs. In practice, what this means is that Pharmacy will dispense generic drug products in all cases for multisource brand drugs, except where prohibited by applicable laws, rules, or regulations. Where the prescription does not authorize substitution, contact the prescriber to reinforce plan guidelines and request authorization to change to an approved generic.

DISPENSE AS WRITTEN ("DAW") CODES

The following NCPDP Standard DAW Codes are supported by Medco Health. These Codes should be part of the claim record whenever a multisource brand drug product is dispensed. Proper use of the correct DAW Code is important for payment and co-payment processing. Follow the TelePAID® System for reimbursement and co-payment/coinsurance information.

Substitution with a generic product must always be in a manner consistent with applicable laws, rules, and regulations.

DAW-0 NO PRODUCT SELECTION INDICATED

This is a field default value that is appropriately used for prescriptions where selection is not an issue. Examples include prescriptions written for single-source brand products and prescriptions written using the generic name and a generic product is dispensed. Plans mandate that generic pricing be applied when **DAW-0** is submitted for multisource brand medications.

DAW-1 SUBSTITUTION NOT ALLOWED BY PRESCRIBER

This value is used when the prescriber indicates, in a manner specified by applicable laws, rules, and regulations, that the product is to be Dispensed as Written. This is subject to verification by Medco Health at any time.

DAW-2 SUBSTITUTION ALLOWED — PATIENT REQUESTED PRODUCT DISPENSED

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. Patient requested brand must be documented on the prescription and may affect patient co-payment.

DAW-3 SUBSTITUTION ALLOWED — PHARMACIST SELECTED PRODUCT DISPENSED

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. Plans mandate that generic pricing be applied when **DAW-3** is submitted for multisource brand medications.

DISPENSE AS WRITTEN ("DAW") CODES

continued

DAW-4 SUBSTITUTION ALLOWED — GENERIC NOT IN STOCK

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the availability of the generic product in the marketplace. Plans mandate that generic pricing be applied when **DAW-4** is submitted for multisource brand medications.

DAW-5 SUBSTITUTION ALLOWED — BRAND DRUG DISPENSED AS GENERIC

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity. Plans mandate that generic pricing be applied when **DAW-5** is submitted.

DAW-6 OVERRIDE

NCPDP – Override Code with no meaningful application by Medco Health. Plans mandate that generic pricing be applied when **DAW-6** is submitted.

DAW-7 SUBSTITUTION NOT ALLOWED — BRAND DRUG MANDATED BY LAW

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

DAW-8 SUBSTITUTION ALLOWED — GENERIC DRUG NOT AVAILABLE IN MARKETPLACE

This value is used when the prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. Plans mandate that brand pricing be applied when **DAW-8** is submitted for multisource brand medications.

DAW-9 OTHER

Reserved with no meaningful application by Medco Health. Plans mandate that generic pricing be applied when **DAW-9** is submitted.

Formulary Drug Standards

Sponsors often adopt a formulary as part of their overall cost containment programs, attempting to deliver a balance between cost management and quality of care. Medco Health implements a variety of formulary programs for Sponsors. The most common formulary programs administered are **Preferred Prescriptions**® and **Rx Selections**®, which are supported by Medco Health's independent Pharmacy & Therapeutics Committee. In addition, Medco Health implements Sponsors' proprietary formulary programs. Pharmacy is required to support *all* formulary programs by dispensing formulary drugs to the maximum extent possible. Pharmacy must use best efforts to contact the prescriber to encourage formulary compliance.

Point-of-sale messaging is the primary vehicle for communicating formulary information to pharmacists and, thereby, to Eligible Persons. Messaging is supplemented with other communications at the discretion and direction of the Sponsor. When a Pharmacy transmits a claim consistent with the formulary the claim adjudicates with the message, "Formulary Rx." When a prescription is transmitted for a nonformulary drug product the claim will either (i) reject, with the message "Non-Formulary Rx," for Plans utilizing a "Closed Formulary"; or, (ii) will adjudicate with the message "Non-Formulary Rx," in the approved message fields, for Plans utilizing an "Incentive or Open Formulary." Where appropriate, up to five formulary alternatives are displayed in the preferred product fields.

If a prescription is submitted for a nonformulary drug, and the prescriber has not authorized a formulary drug alternative, the Pharmacy will inform the cardholder that the prescription is for a nonformulary drug and apply the co-payment/coinsurance, deductible, or other benefit requirement rules as transmitted via TelePAID®. In some cases the co-payment/coinsurance for a nonformulary drug may be higher if the Plan is utilizing an "Incentive or Open Formulary" program.

The Pharmacy is expected to cooperate with, administer and dispense in accordance with, subject to the Pharmacist's professional judgment, formulary compliance programs implemented by Medco Health. It is inconsistent with Medco Health Network standards if Pharmacy does not attempt to dispense in accordance with the formulary. Pharmacy is required to keep a record on the original prescriptions of its attempt at achieving formulary compliance. Medco Health may recover from Pharmacy the full amount of Pharmacy's dispensing fees when Pharmacy (i) fails to attempt formulary compliance or note formulary compliance efforts on the original prescription; (ii) acts contrary to formulary compliance; or (iii) causes the prescription to result in a higher cost to the Sponsor and/or the Eligible Person.

PHARMACY CREDENTIALING

Pharmacy will comply with all applicable laws and regulations (including but not limited to generic substitution laws) and will provide all services and products in a professional manner and in compliance with the highest industry standards with care, skill, and diligence. Pharmacy will at all times maintain in good standing, all federal, state and local licenses, permits, and certificates as required by law. Pharmacy represents that all personnel employed by or contracted with Pharmacy shall be licensed and qualified to perform their professional duties, shall act within the scope of their licensure, and shall not have been excluded from any federal healthcare programs. Pharmacy also will give notice to Medco Health of the restriction, suspension, revocation, or any other disciplinary action taken against Pharmacy, or any pharmacist or individual employed by Pharmacy. Failure to maintain the appropriate licenses and certificates and/or failure to notify Medco Health of disciplinary action will result in the immediate termination of Pharmacy's Agreement with Medco Health. Medco Health, in its sole discretion, will determine if Pharmacy meets and maintains the acceptable criteria required of a Medco Health participating pharmacy. Upon request by Medco Health, Pharmacy will furnish Medco Health copies of currently effective licenses, permits, certificates, or registrations held by Pharmacy or by any pharmacist. Pharmacy will comply with Medco Health's credentialing and quality assurance programs.

Pharmacy, at its cost and expense, will procure and maintain at all times while Pharmacy's Agreement with Medco Health is in effect such policies of general and professional liability insurance, including malpractice, and other insurance as will be necessary to insure Pharmacy and its employees against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the rendering of Covered Services and all other activities by Pharmacy in connection with or as required by Pharmacy's agreement with Medco Health. Each such policy will be in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per policy year. Pharmacy will provide evidence of such insurance to Medco Health upon request at any time, including after termination of Pharmacy's Agreement with Medco Health.

Pharmacy must immediately give notice to Medco Health should it be in jeopardy (e.g., receives notice of any proceeding and/or investigation which may lead to loss and/or suspension of license) of, or actually lose its license(s); or, should its insurance be in jeopardy (e.g., Pharmacy fails to pay premium when due or received notice of cancellation) of being or be canceled, lapsed, or terminated. In the event Pharmacy loses its license or its license is suspended or revoked; or, its insurance, as required herein, is canceled, lapses, or terminates, Pharmacy's Agreement with Medco Health will immediately terminate and Pharmacy will no longer attempt to provide covered services to any Eligible Person under Pharmacy's Agreement with Medco Health.

Medco Health credentials/recredentials pharmacies as part of Medco Health's specific network initiatives. These network initiatives include patient health programs, point-of-sale requirements, and pharmacy

compliance and audit programs. Pharmacy will comply with any such programs, initiatives, and requirements.

Medco Health's *Performance Based Network* pharmacies are selected based on criteria designed to maximize managed care compliance, and to control drug program expenditures. The criteria for participating in Medco Health's *Performance Based Networks* is focused on administrative, professional, and financial elements which provide the framework for participating pharmacies to deliver managed care programs to those Sponsors willing to pay for performance. From time to time Medco Health may provide quarterly updates as well as performance enhancement support to ensure pharmacy's success. Initial credentialing/recredentialing consists of a signed Medco Health Network Agreement.

Pharmacy will comply with any special Quality Management requirements and programs established by Medco Health or Sponsors for providers participating in Networks. Pharmacy will participate, as requested, in the activities and programs of and abide by the decisions of Sponsors' Quality Management and Utilization Review Committees. Pharmacy must maintain an internal quality assurance program and will report on same to Medco Health upon Medco Health's request along with remedial action plans.

Pharmacy will cooperate with Medco Health and Sponsors to resolve complaints from Eligible Persons, and Pharmacy will comply with the complaint procedures and programs established by Medco Health and Sponsors.

Pharmacy is required to participate in a variety of plan designs including those which permit access to a negotiated discount when producing an identification card and paying for the prescription at the point of sale.

Criteria required in order for pharmacy to be eligible for participation include:

CLINICAL CRITERIA

- Pharmacy must participate in Health Management Programs offered through the Network.
- Pharmacy must evaluate and act on DUR messages received through the TelePAID® System.

DISPENSING CRITERIA

- ☐ Pharmacy must agree to dispense generic drugs whenever possible and abide by any Maximum Allowable Cost ("MAC") program pricing arrangements.
- ☐ Pharmacy must support Medco Health's formulary programs by informing patients when a nonformulary drug has been prescribed and Pharmacy must use best efforts to contact the prescriber to encourage formulary compliance.

POINT-OF-SALE CRITERIA

- ☐ Pharmacy must support the current NCPDP Version 5.1 software in the claims adjudication process and agree to use NCPDP updates as required from time to time by Medco Health.
- ☐ Pharmacy must submit a Prescriber Identifier for all prescriptions dispensed. The Prescriber Identifier can be a DEA, State License, and/or Plan Specific Number along with their associated qualifier "12," "08," "14," respectively.
- ☐ Pharmacy must agree to submit all claims, including compounded prescriptions, online to Medco Health via the TelePAID® System.
- ☐ Pharmacy must support Coordination of Benefits ("COB") segment in order to submit secondary claims on-line.

PRICING CRITERIA

- ☐ Pharmacy must accept "lesser of" pricing, that is; the lower of usual and customary, MAC, or network reimbursement rate pricing.
- ☐ Pharmacy must submit at the point of sale the NDC representing the actual package size from which the drug or item was dispensed.

ADMINISTRATIVE CRITERIA

- ☐ Pharmacy must maintain an adequate inventory of Brand Name Prescription medications and a sufficient quantity of quality; generic drugs as rated "A" by the Federal Orange Book.
- ☐ Pharmacy must be available for periodic audits, and abide by the Pharmacy Services Manual and online communications of plan designs via the TelePAID® System.
- ☐ Pharmacy is required to participate in a variety of plan designs including those which permit access to a negotiated discount when producing an identification card and paying for the prescription at the point of sale.
- ☐ Pharmacy must agree to hold harmless and indemnify Medco Health and its Plan Sponsors and Eligible Persons for all activities in connection with its participation in the Medco Health Networks.
- ☐ Pharmacy must hold a valid Pharmacy license or permit as issued by the appropriate State agency in which it operates to dispense medications. Additionally, the Pharmacy must meet all standards of operation as described in Federal, State, and local laws.

- Pharmacy will be ineligible to participate in the Medco Health Participating Pharmacy Network if Pharmacy has been excluded by the Office of the Inspector General under any federal healthcare program. In addition, no compensation shall be made to Pharmacy for services or items furnished by Pharmacy or excluded employee of Pharmacy.
- Pharmacy must maintain professional liability coverage (in the amount of $1,000,000/$3,000,000) to cover all risks including those associated with dispensing errors, patient counseling, and quality assurance activities.
- Pharmacy must dispense prescriptions to Eligible Persons in a practice setting approved by Medco Health. Shipping prescriptions to Eligible Persons by mail or other remote delivery carrier as a routine business practice is unapproved without the express written permission of Medco Health.
- Pharmacy is required to submit a completed and signed Pharmacy Verification Form on an annual basis within 30 days of receipt.

Non-Liability

All liability arising from the provision of drugs, products, and services by Pharmacy will be the sole responsibility of Pharmacy. Medco Health and Sponsors will not be liable for and Pharmacy will indemnify, defend, and hold Medco Health and Sponsors harmless from and against any claim, injury, damage, loss, expense (including reasonable attorney's fees), demand, or judgment in any way resulting from any acts or omissions by Pharmacy in the sale, compounding, dispensing, or use of any prescription drug dispensed by Pharmacy or the providing of any other services or products by Pharmacy. In no event and under no circumstances will Medco Health or Sponsors be liable to Pharmacy for indirect or consequential damages of any nature, loss of profit, punitive damages, injury to reputation, or loss of customers or business.

Professional Judgment

Pharmacy is obligated to provide the patients and prescriber whom it serves with an adequate inventory of quality drugs. The pharmacist is by profession uniquely qualified to judge the integrity and the quality of manufactured sources. Where a prescription is written in such a manner that the Pharmacy is provided with an option with respect to brand name, manufacturing source, or package size of the drug to be supplied, Pharmacy will supply and charge for that drug which meets official compendium specifications, if listed therein; which has the lowest ingredient cost; which in the pharmacist's professional judgment fulfills the prescriber's requirements; and, meets formulary requirements. Subject to the pharmacist's professional judgment and availability, Pharmacy will dispense an "A"-rated generic when dispensing a generic drug. Pharmacy will (i) stock a sufficient number of drugs distributed under their generic names consistent with the prescribing habits of the prescriber in Pharmacy's community, communications via the TelePAID® System, or the generic formulary of the state in which Pharmacy is located, subject to the pharmacist's professional judgment as to the integrity and quality of the manufacturing source, and (ii) dispense a generic drug wherever possible in accordance with applicable law or regulations. Pharmacy must clarify ambiguous dosage directions regarding utilization prior to dispensing and will not combine prescriber-authorized refills. Pharmacy will at all times exercise good professional judgment in the dispensing of medications and may refuse to dispense any prescription based on the dispensing pharmacist's own professional judgment.

Independent Contractors

Medco Health and Pharmacy are independent contractors engaged in the operation of their own respective businesses and Pharmacy will not represent to anyone anything to the contrary. Neither party will be deemed or construed to be an agent or representative of the other party for any purpose whatsoever.

Information Management

Confidentiality

All information pertaining to programs, Sponsors, networks, marketing, Eligible Persons, procedures, methods, business practices, managed care initiatives, and solicitations by Medco Health, and the contents of Pharmacy's Agreement with Medco Health ("Confidential Information") are confidential and/or proprietary to Medco Health. Pharmacy will use such Confidential Information only to the extent necessary for the purposes set forth in Pharmacy's agreement with Medco Health, will restrict disclosure of such Confidential Information to its employees with a need to know (and advise such employees of the obligations set forth herein), and will not disclose Confidential Information to any third party without the prior written approval of Medco Health. Pharmacy will maintain the confidentiality of Eligible Persons' records and personal information as required by applicable laws, rules, and regulations. All Confidential Information will remain the exclusive property of Medco Health. No right, title, or interest in the Confidential Information is conveyed to Pharmacy by release of Confidential Information to it. Pharmacy will promptly notify Medco Health if it becomes aware of any use of the Confidential Information that is not authorized by Pharmacy's agreement with Medco Health. Pharmacy understands that, in the event this provision is not adhered to by Pharmacy or any of its employees, Medco Health will suffer irreparable damages that cannot be fully remedied by monetary damages. Accordingly, Medco Health will be entitled to seek and obtain injunctive relief against any such nonadherence in any court of competent jurisdiction. Medco Health's rights under these confidentiality requirements will not in any way be construed to limit or restrict Medco Health's rights to seek or obtain other damages or relief available under Pharmacy's agreement with Medco Health or applicable law.

Dispensing Pharmacy Identification

Prescriptions dispensed to Eligible Persons must be from the pharmacy location approved by Medco Health's agreement with Provider Pharmacy. The NCPDP number (qualifier code "07") and Medco Health Provider (Pharmacy Identification number "99") under which the claim was submitted to and adjudicated by Medco Health must be the pharmacy where the pharmacist supervised dispensing of the prescription.

Prescriber Identification

Pharmacy is required to submit accurate information identifying the prescriber for each claim submitted. A valid DEA number ("12"), State License number ("08"), and/or plan specific ("14") number specified by Medco Health is to be submitted with all claims *in the* ***Prescriber ID*** *field*.

PROFESSIONAL AUDITS

PROFESSIONAL RESPONSIBILITY

All professional services provided by Pharmacy must be rendered only under the direct supervision of a licensed pharmacist and each prescription must be dispensed in accordance with a lawful prescriber's directions, the terms and conditions contained in Pharmacy's Agreement with Medco Health and/or communicated via the TelePAID® System, and applicable state and federal laws.

Pharmacy will abide by all applicable Federal, State, and local governmental patient disclosure requirements concerning payment for services including cognitive services, fees, and rebate programs. Pharmacy will provide Covered Services in compliance with Pharmacy's Agreement with Medco Health for all Eligible Persons of all Sponsors to which Pharmacy's Agreement with Medco Health applies; and will not discriminate in the provision of services, including compounded prescriptions, with respect to any Sponsor(s) or Eligible Person(s) regardless of the Eligible Person's right to reimbursement, amount of co-payment/coinsurance, or other plan or program terms.

PROFESSIONAL AUDITS

Medco Health maintains a pharmacy audit program on behalf of, and as a service to, Sponsors in order to ensure compliance with program guidelines and to protect against abuses of the prescription programs. The review of claim reimbursements to participating pharmacies by the plan administrator is a part of all third-party prescription drug benefit programs. This Professional Audits section details the following information.

- **Audit Overview**
- **On-Site Audits**
- **Auditable Records**
- **Record Access**
- **Audit Resolution**
- **Potentially Fraudulent Prescription Referrals**

AUDIT OVERVIEW

Audits may take the form of a phone call, letter, an on-site visit, or internal claims review. For example, if there is a question and clarification is possible over the phone, then the question will be resolved as necessary based on the information provided and no on-site visit would be necessary. Every effort will be made to minimize the burden on the Pharmacy while balancing the need for further information. Auditing of Pharmacy's records may also be conducted through the mail. Pharmacies are frequently requested to furnish photocopies of specific documents in such cases. Any potential discrepancies identified through an on-site audit will be forwarded to Pharmacy for review and response. In addition, Medco Health performs routine on-site audits of its participating pharmacies. Pharmacy acknowledges that HIPAA specifically permits a covered entity (i.e., a pharmacy) to disclose protected health information to another covered entity for audit purposes. Specifically, as indicated in section 506(c)(4)(ii) of HIPAA, a pharmacy may disclose protected health information to Medco "for the purpose of health care fraud and abuse detection or compliance."

ON-SITE AUDITS

1. Notice of Audit

Although advance notice is generally given to a pharmacy prior to an on-site audit, Medco Health is not required to provide Pharmacy with prior notice of a planned audit. Upon receiving notification of a scheduled audit, if any of the dates are inconvenient, Pharmacy should contact Medco Health as soon as possible at 1 800 523-6389, extension 7292 to request a specific appointment. Although we will make every effort to accommodate reasonable scheduling requests, the sooner that we are contacted, the more likely we will be able to accommodate Pharmacy's request. Medco Health reserves the right to recover the full amount paid or due to Pharmacy for all claims should Pharmacy refuse to allow Medco Health's auditor to have access to Pharmacy or auditable prescription records. Medco Health's auditor will generally review prescription records associated with claims paid to the Pharmacy during the previous 12 to 18 months.

Pharmacy will provide Medco Health, Sponsors, governmental agencies and departments and/or their representatives or agents, during normal business hours, access to examine, audit, and copy any and all records deemed by Medco Health, in Medco Health's sole discretion, necessary to determine compliance with the terms of Pharmacy's Agreement with Medco Health, the TelePAID® System and other Medco Health guidelines and requirements. Pharmacy will, in addition to the above, provide Medco Health within 14 calendar days of a request, any information requested or necessary for Medco Health to verify and/or substantiate Pharmacy's compliance with Pharmacy's Agreement with Medco Health.

2. Audit Location

In most cases the field auditor can work independently with minimal interaction with Pharmacy until the conclusion of the on-site audit. First, the field auditor does not need a large area to work; however, an uncluttered area with a hard writing surface will allow the field auditor to work more effectively. Ideally, this area will not be located in the middle of the busiest area of the pharmacy but will be located so as to allow the field auditor to have easy access to the prescription records that the auditor is required to review. Second, if Pharmacy is going to work with the field auditor, Pharmacy should ensure that proper staffing is available on the day of the audit so that the auditor can work effectively without waiting for information as the staff attends to the operation of Pharmacy.

AUDITABLE RECORDS

All prescriptions, including oral, telephone, and/or computer-generated prescriptions, must include, but not be limited to, the following information:

- First and last name of the patient for whom the prescription was written by the prescriber
- Current address of the patient for whom the prescription was written by the prescriber
- The prescriber's complete name, address, and telephone number
- Name and strength of the medication prescribed
- Quantity of medication prescribed
- Prescriber's generic substitution instructions
- Documentation when the patient requests a multisource brand medication to be dispensed. Prescriptions without such notation will be determined to allow generic substitution
- Documentation why a prescription is refilled early (e.g., lost prescription, therapy change, vacation supply, etc.)
- Refill instructions
- Specific dosage directions
- Medication pricing brochures for cash customers (paper, internet or other format)
- The name and metric quantity of each component utilized to prepare a compounded prescription
- Documentation of any changes or additions to the prescription including, but not limited to, revisions to the medication's strength, daily dosage, quantity of medication prescribed, refill authorization, or generic substitution instructions; along with the date and name of the person at the prescriber's office who authorized the change

Pharmacy will maintain in accordance with industry and Sponsor standards and applicable laws, rules, and regulations (or 6 years, whichever is greater) in a readily retrievable manner during Medco Health's audit the records necessary to determine compliance with the terms of Pharmacy's Agreement with Medco Health, Medco Health and Sponsor Quality Assurance and/or Utilization Review Committee standards, and/or other Medco Health guidelines and requirements. Such records will include, but not be limited to:

- Paper prescription records
- Signature Logs
- Quality assurance plans or dispensing procedures
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices
- Refill data
- Prescriber information
- Patient information
- Transfer of prescription stock between pharmacies
- Pharmacy records stored electronically
- Compounded prescriptions (quantities and components) dispensed by Pharmacy
- Medication pricing brochures for cash customers (paper, internet or other format).

AUDITABLE RECORDS *continued*

Helpful Explanations

1. DAW Code Submission

In order to prevent audit discrepancies and to ensure proper payment to Pharmacy and identification of co-payment/coinsurance amounts, all claims must be submitted with the accurate DAW indicator in accordance with NCPDP standards. Claims should be processed with DAW 2 (patient requests the brand to be dispensed) when the prescription as originally written by the prescriber and following state generic substitution laws allows for, or does not prohibit, generic substitution, even though the prescriber subsequently agrees to change the prescription to require the brand drug be dispensed at the Eligible Person's request. In all cases Pharmacy must document on the original prescription the Eligible Person's request for brand. Computer systems that default to DAW 1 or that cannot handle all DAW codes will result in discrepancies.

2. Coverage Exclusions

Although some Medco Health plans cover the categories listed below, they are typically excluded from Medco Health plans. In all cases, Pharmacy should follow the messages received from the TelePAID® System when submitting claims for these categories.

- Investigational
- Therapeutic devices
- Refills dispensed more than one year from the date of the prescriber's original order date

3. Signature Logs

A Third-Party Signature Claim Log maintained in an organized and chronological manner will facilitate the location and retrieval process for the field auditor.

4. Paper Prescription

The Pharmacy should document as much information as possible on the paper prescription itself regarding the filling of the prescription when the prescription is dispensed. During the audit it will be difficult to remember the circumstances regarding a particular prescription. In addition, the notation on the prescription may eliminate a question or may even identify the audit discrepancy.

RECORD ACCESS

1. Documents

Medco Health may determine the information required to address audit discrepancies, including, but not limited to, Pharmacy's records not directly related to Medco Health claims that may have a bearing on determining potential discrepancies, for example, Usual and Customary Prices and dispensing patterns. In addition, when a Medco Health Auditor calls upon a Medco Health Pharmacy Provider who has an inordinately large quantity of high-priced prescription drugs, the Auditor will ask to see invoices substantiating the purchase of those drugs. Medco Health Auditors are instructed to be fully aware of patient confidentiality practices in the profession of Pharmacy. Pharmacy authorizes appropriate agencies (including, but not limited to, governmental authorities, third party payers, professional review organizations, and other such entities) to release to Medco Health, information deemed by Medco Health to be necessary to determine Pharmacy's compliance with Pharmacy's Agreement with Medco Health and other Medco Health guidelines and requirements.

2. Provider Number

Pharmacy agrees to process all claims with the unique Medco Health provider identification number of the dispensing pharmacy. Prescription claims submitted with a Medco Health provider number other than the dispensing pharmacy's Medco Health provider number are subject to full charge back. Pharmacy will maintain the confidentiality of all records relating to services provided by Pharmacy to Eligible Persons.

3. Termination and Reporting

Medco Health's right to audit Pharmacy records relating to services provided and the reporting of findings will survive termination of Pharmacy's Agreement with Medco Health. Medco Health may report its examination/audit findings to appropriate governmental bodies, claims processors and payers, regulatory agencies, professional review and audit reporting organizations, and other such entities.

AUDIT RESOLUTION

1. Discrepancy Examples

Prescription splitting is a common discrepancy identified during the audit process. For this discrepancy the pharmacy reduces the amount dispensed from the quantity authorized by the prescriber and allowed under the applicable plan. As a result, the Eligible Person is caused to pay extra co-payments and the pharmacy receives additional dispensing fees.

Prescription Example:

90 Procardia XL 90 mg
1 tablet daily
2 refills authorized
Applicable Plan maximum is a 90-day supply

Under this example, the proper quantity to dispense is 90 tablets. The pharmacy would be splitting the prescription if the quantity dispensed was reduced to a 30-day supply. Improper dispensing such as this would result in the Eligible Person paying two additional co-payments and the pharmacy receiving two extra dispensing fees.

Authorized refills cannot be combined with the initial quantity written by the prescriber in order to increase the quantity of medication dispensed.

Prescription Example:

30 Procardia XL 90 mg
1 tablet daily
2 refills authorized
Applicable Plan maximum is a 90-day supply

The proper quantity to dispense in this example is 30 tablets.

2. Discrepancy Determination

Audit discrepancies (including those resulting from mailed prescriptions as specified below) will result in full or partial charge backs to Pharmacy including charge backs to monies due to Pharmacy and may result in Pharmacy being terminated as a Medco Health Pharmacy. In the event of discrepancy amounts exceeding five hundred dollars ($500.00), Medco Health may apply statistically valid sampling and extrapolation methods to calculate the actual discrepancy amounts. The specific methodologies are reviewed by external audit consultants before application.

3. Audit Charges

In the event any examination or on-site audit of Pharmacy's records evidences any payments to Pharmacy to which Pharmacy was not entitled under Pharmacy's Agreement with Medco Health, Medco Health may, in addition to any other remedies available to it or the Sponsors, withhold such amount from future payments to Pharmacy under Pharmacy's Agreement with Medco Health, and should unentitled payments exceed two thousand dollars ($2,000.00), then Pharmacy will reimburse Medco Health the reasonable costs of Medco Health's Audit. Pharmacy is responsible for collection and attorney costs incurred by Medco Health to recover funds paid to the Pharmacy which the Pharmacy was not entitled to. Any Pharmacy placed on probationary status or reinstated into the Medco Health Participating Pharmacy Network shall be required to pay Medco Health's reasonable audit costs related to such Pharmacy's probation or

AUDIT RESOLUTION *continued*

reinstatement; and, a reinstatement fee as applicable.

4. Dispute Resolution

Inquiries regarding audits may be submitted in writing to:

Medco
Director, Pharmacy Audit Department
(Mail Stop E2-12)
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

or, by phone to:

Medco Health's Audit Department at 1 800 523-6389, extension 7292.

Each field-audited Pharmacy has the opportunity to review and respond to noted discrepancies.

Explanations of discrepancies, recovery amounts, and documentation required to address certain discrepancies may be found on the back of or included with each Discrepancy Evaluation Report.

Prescription claims cited by the auditor for inaccurate or missing DAW will be recovered by Medco Health without recourse by Pharmacy. Pharmacy must document on all paper prescriptions (original, telephone, fax, or electronic) submitted for payment with DAW 1 (prescriber DAW) at the time of dispensing that the prescriber prevented substitution.

5. Discrepancy Resolution Information

Discrepancy Type	*Recovery Amount*	*Documentation Required to Address Discrepancy*
No Record of Refill (noncomputerized pharmacy)	Net Amount Paid	Patient Statement*
No Record of Refill (computerized pharmacy)	Net Amount Paid	Not Addressable
Rx not on File	Net Amount Paid	Covering Original Prescription or Physician Statement†
Cut Quantity	Extra Dispensing Fees	Not Addressable
Overqualified Dispensing Generic/Less Expensive Product should be Billed	Difference Between the Billed and Correct Costs	Not Addressable
Dispensed Generic Billed Brand	Difference Between the Billed and Correct Costs	Not Addressable

continued

5. Discrepancy Resolution Information *continued*

Discrepancy Type	*Recovery Amount*	*Documentation Required to Address Discrepancy*
Unauthorized Refill	Net Amount Paid	Covering Original Prescription or Prescriber Statement†
Over-billed Quantity	Difference Between the Billed and Correct Costs	Not Addressable
Incorrect Drug Billed	Difference Between the Billed and Correct Costs	Not Addressable
Exceeds Plan Limits	Difference in Costs	Not Addressable
Missing Signature Log	Net Amount Paid	Patient Statement*
Prescriber Cannot be Identified	Net Amount Paid	Covering Original Prescription or Prescriber Statement†
Ineligible Member Dependent	Net Amount Paid	Not Addressable
Refill Too Soon	Net Amount Paid	Not Addressable
Patient Contests Receipt	Net Amount Paid	Patient Statement*
Prescriber Contests Authorizing Rx	Net Amount Paid	Covering Original Prescription or Prescriber Statement†
Dispensed Greater than Rx	Difference in Costs	Not Addressable
Overpriced Compound	Difference in Costs	Not Addressable
Patient Name Different	Net Amount Paid	Not Addressable
Unauthorized Mail Rx	Net Amount Paid	Not Addressable
Package Size Overqualified Dispensing	Difference In Costs	Not Addressable
Other	See Remarks on the Discrepancy Evaluation Report	

Photocopies of documentation are not acceptable. All information should be submitted via Certified Mail, Federal Express, UPS, or other certified carrier. Documentation submitted for review should be received by the finalization date indicated on the accompanying letter.

*All patient and prescriber statements must: (1) include the address and telephone number of the patient or prescriber, respectively, (2) clearly reference the medication(s), date(s) of service, and patient(s) in question, and (3) explain why the initial contact was contested. Statements from prescriber must be on the prescriber's own letterhead or covering prescription.

†Covering Original Prescription is obtained from the prescriber to document certain types of discrepancies and is not the prescription on file at the pharmacy.

continued

6. Discrepancy Type Legend

CF	Prescription Not on File — There was no hard copy prescription on file at the pharmacy which corresponded to the claim billed.
NRR	The pharmacy had no record of a refill being dispensed on the date billed.
CQ/R	The quantity dispensed by the pharmacy was reduced from the amount authorized by the prescriber and allowed under the applicable Medco Health Plan.
OD	Overqualified Dispensing — The prescription as written by the prescriber allowed for generic substitution, however, the pharmacy dispensed and billed for the brand-name medication.
DG	Dispensed Generic, Billed Brand — The pharmacy dispensed the generic medication to the patient while billing for the more expensive brand-name product.
UR	Unauthorized Refill — The pharmacy exceeded the prescriber's refill authorization.
OBQ	Over-billed Quantity — The pharmacy submitted the claim with a metric quantity in excess of the quantity actually dispensed.
XDB	Incorrect Drug Billed — The medication billed by the pharmacy differs entirely from the medication identified on the prescriber's prescription order.
EPL	Exceeds Plan Limits — The quantity of medication dispensed by the pharmacy exceeded the amount allowed under the applicable Medco Health plan.
DISP > RX	The quantity dispensed exceeded the amount authorized by the prescriber.
No Sig Log On File	There was no signature log on file at the pharmacy corresponding to the claim billed.
Pack Size	The pharmacy submitted the claim with the NDC of a smaller package size than should have been dispensed.
Comp RX	Overpriced compounded prescription.
Mail RX	The prescription was not personally picked up, nor received through a local delivery service. This definition encompasses mail and other remote delivery carriers. Claim was not authorized as a mail service prescription.
MD Not ID	Based on the information provided by the pharmacy the prescriber could not be identified.
Patient Contests Receipt	The patient contests receiving the prescription claim reimbursed under his Member ID number.
Prescriber Contests	The prescriber contests authorizing the prescription.
PND	Patient name different — The last name of the patient identified on the prescription differs from the name under which the claim was billed.
Return to Stock	The claim in question was not picked up by the patient and returned to the pharmacy's stock.
Refill > Than 1 Year	The pharmacy dispensed a refill more than one year from the date that the particular prescription was originally written.

POTENTIALLY FRAUDULENT PRESCRIPTION REFERRALS

According to government estimates, healthcare fraud may represent 5% of the healthcare dollar. Together, Medco Health and Pharmacy can coordinate efforts to provide an effective prescription benefit while also helping to deter fraudulent claims. Pharmacy will notify Medco Health if Pharmacy has reason to believe potentially fraudulent prescriptions or inappropriate claims activity such as the following is occurring.

- An Eligible Person is presenting a prescription not written by the prescriber identified.
- An Eligible Person is presenting a forged or altered prescription, calling in their own prescriptions, or may be overutilizing prescriptions.
- Claim rejects based on a claim submitted by another pharmacy without explanation by Eligible Person.
- Medication inconsistent with practice or specialty of prescriber.

Fraudulent "original" prescriptions involve many types of medications (antibiotics, antifungals, antivirals, cardiac, cholesterol lowering, etc.), not just controlled substances. Medco Health has also seen an increase in the number of prescriptions (e.g., Stadol) inappropriately telephoned to pharmacies by patients posing to be prescribers. Pharmacy must know their patient and prescriber. Pharmacy should verify the prescription with the prescriber and the identity of the patient before dispensing. Prescriptions not authorized by a prescriber are not valid prescriptions and are subject to recovery from the Pharmacy.

When information is identified, the information and associated documentation should be forwarded to the address below. Each referral should identify the Eligible Person (Member ID number), prescriber (DEA or PIN number, if possible), pharmacy (National Association Boards of Pharmacy ("NABP")/Medco Health provider number) and the fraudulent prescriptions or inappropriate claims activity. Information regarding Eligible Persons, pharmacies, and/or prescribers can be forwarded to the Audit Department by telephone at 1 800 523-6389, extension 7292, or by letter to:

Medco Health Solutions, Inc.
Director, Pharmacy Audit Department
100 Parsons Pond Drive (Mail Stop RD2-1)
Franklin Lakes, NJ 07417

Third-Party Signature Claim Log

Each Pharmacy must maintain a Third-Party Signature Claim Log, in the then current format. A paper form of Third-Party Signature Claim Log is attached to this Manual, along with the requirements of an electronic signature log record. Pharmacy will maintain a signature in the Third-Party Signature Claim Log, either electronically or on paper, for each prescription for which a claim is submitted via the TelePAID® System, including but not limited to delivered prescriptions and Medco Health Direct℠ and unfunded programs. In addition, when an authorized override has been obtained, Pharmacy must note the override on the original prescription. The notations must contain the reason for the override, and, where applicable, the name of the Medco Health representative that authorized the override and the authorization claim number. If Pharmacy has not documented an appropriate reason for the override, the claim is subject to audit review. Pharmacy is required to maintain the Third-Party Signature Claim Log in a retrievable manner by date of service at the Pharmacy for a period of 6 years from the date the prescription was dispensed. The Third-Party Signature Claim Log shall be subject to audit by Medco Health. Pharmacy is not entitled to payment for any claim for which there is no signature of the Eligible Person or authorized representative on the Third-Party Signature Claim Log. Providers that are approved to dispense prescriptions by mail or other remote carrier shall maintain either a signature log or a record of shipment, including tracking numbers where applicable, at the prescription level. When requested, Pharmacy agrees to provide copies of signature log records to Medco Health.

PAPER THIRD-PARTY SIGNATURE CLAIM LOG

PHARMACY:
Please have the patient, guardian, or legal representative who has received this prescription listed below read this statement and sign for the appropriate prescription.

PATIENT:
Your signature certifies that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified below and authorize release of all the information contained on this log and the prescription to which it corresponds to the plan administrator, the underwriter, the sponsor, the policy holder, the insurer, the employer, and their authorized agents. You further certify that this medication is not for treatment of an on-the-job injury, and you hereby assign to this provider pharmacy any payment due pursuant to this transaction, and authorize payment directly to this provider pharmacy.

FOR MEDICAID RECIPIENTS ONLY:
Your signature certifies that you received a service or item dispensed on the date listed below. You understand that payment for this service or item will be from Federal and State funds and that any false claims, statements, or documents or concealment of material facts may be prosecuted under applicable Federal and State Laws.

Date	Rx Number	Signature of Patient, Guardian or Legal Representative, acknowledging you have read and agree to the above statements.	Third-Party Program	Counseling R=Refused A=Accepted

I certify that the prescriptions referred to hereon were lawfully dispensed to the person whose signature appears above and the prescriptions comply with the conditions and applicable instructions of the third party program identified. I also certify that the information covering each transaction is, to the best of my knowledge, correct and that all documentation is available for audit.

Pharmacist's Signature _____ Pharmacy Number _____

Pharmacy Name _____

Pharmacy Address _____ City _____ State _____ Zip Code _____

Requirements of an Electronic Third-Party Signature Claim Log

An Electronic Signature Log, in the format outlined in this section, is acceptable to Medco Health as a replacement to the traditional paper signature log. The Electronic Signature Log must meet the following requirements:

1. Minimum Data Elements: The following data elements must be retained for each Electronic Third-Party Signature Claim Log record:

- Prescription number (7 position numeric field — left justified with zeros)
- Date of service (date field — mm/dd/yyyy)
- Co-payment charged (9 position numeric field — two positions to the right of the decimal)
- Identification of the third-party program providing prescription coverage to this patient
- Patient's first and last name (30 positions)
- Date and time the prescription was dispensed to the patient (date field mm/dd/yyyy — Time hh:mm — 24-hour time)
- The certification statement text in its entirety (text)
- Dispensing Pharmacy's NCPDP number (7 position numeric field)
- The unique signature of the Eligible Person or authorized agent captured at the time of dispensing that particular prescription (image format — .bmp, .gif, .tif, .jpg)
- Counseling (1 position "R" — Refused, "A" – Accepted)

2. Certification Statement:

For each prescription transaction the following text must be displayed, and be visible to the Eligible Person or Authorized Representative, directly above the area where the Eligible Person or Authorized Representative signs their name when the applicable prescription is dispensed by Pharmacy.

Text to be displayed:

***PHARMACY*:**

Please have the patient, guardian, or legal representative who has received this prescription listed below read this statement and sign for the appropriate prescription.

***PATIENT*:**

Your signature certifies that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified below and authorize release of all the information contained on this log and the prescription to which it corresponds to the plan administrator, the underwriter, the sponsor, the policy holder, the insurer, the employer, and their authorized agents. You further certify that this medication is not for treatment of an on-the-job injury, and you hereby assign to this provider pharmacy any payment due pursuant to this transaction and authorize payment directly to this provider pharmacy.

FOR MEDICAID RECIPIENTS ONLY:

Your signature certifies that you received a service or item dispensed on the date listed below. You understand that payment for this service or item will be from Federal and State funds and that any false claims, statements, or documents or concealment of material facts may be prosecuted under applicable Federal and State Laws.

1) Prescription Number: 1234567	*Date of Service: mm/dd/yyyy*	*Co-payment: $,$$$.$$*
Counseling – "A"	*Third-Party Program: Medco Health*	*Patient First & Last Name:XXXXX*
2) Prescription Number: 1234568	*Date of Service: mm/dd/yyyy*	*Co-payment: $,$$$.$$*
Counseling –"A"	*Third-Party Program: Medco Health*	*Patient First & Last Name:XXXXX*
3) Prescription Number: 1234563	*Date of Service: mm/dd/yyyy*	*Co-payment: $,$$$.$$*
Counseling – "A"	*Third-Party Program: Medco Health*	*Patient First & Last Name:XXXXX*
4) Prescription Number: 1234564	*Date of Service: mm/dd/yyyy*	*Co-payment: $,$$$.$$*
Counseling – "A"	*Third-Party Program: Medco Health*	*Patient First & Last Name:XXXXX*

Signature of Patient, Guardian, or Legal Representative, acknowledging you have read and agree to the above statements.

Signature _____

3. Retrievability:

Pharmacy agrees to maintain, in a retrievable manner, the Electronic Third-Party Signature Claim Log for a period of not less than 6 years from the date the prescription was dispensed. Subject to a request from Medco Health, either in writing, during an on-site claims review, by telephone, or as otherwise required by Medco Health, Pharmacy agrees to retrieve, display, print, electronically transmit, and/or provide copies of Electronic Third-Party Signature Claim Logs to Medco Health. The information displayed, transmitted, or printed must be in a format that includes at least the Data Elements as outlined earlier in this section, including the unique signature of the Eligible Person or Authorized Representative, in an image format, obtained by Pharmacy at the time of dispensing.

Pharmacy is not entitled to payment for any prescription claim for which the Pharmacy is unable to produce an Electronic Third-Party Signature Claim Log or for any claim in which the Electronic Third-Party Signature Log is not maintained in the required format as outlined above. Pharmacy certifies that the prescriptions referred to in the Electronic Third-Party Signature Claim Logs were lawfully dispensed to the person whose signature appears in the electronic record and the prescriptions comply with the conditions and applicable instructions of the third party program identified. Pharmacy also certifies that the information covering each transaction, is, to the best of Pharmacy's knowledge, correct and that all documentation is available for audit.

The Electronic Third-Party Signature Claim Log as detailed in this section provides an alternative to participating pharmacies that keeps pace with advancing technology. Pharmacy has the opportunity to replace their current Paper Third-Party Signature Claim Log with a computer-based Electronic Third-Party Signature Claim Log that meets the requirements of Medco Health's plan sponsors as outlined above.

Miscellaneous Provider Issues

MISCELLANEOUS PROVIDER ISSUES

Pharmacy's providing of Covered Services to any Eligible Person is a reaffirmation of the terms and provisions of the Pharmacy's Agreement with Medco Health as of the time the Covered Services are provided.

Pharmacy is required to support the objectives of Sponsors whose Eligible Persons obtain Covered Services from Pharmacy, to advance Medco Health programs, to not take actions against the best interest of the Networks, plans, programs, and Sponsors, and to comply with disease management and other clinical drug benefit management programs implemented by Medco Health. Medco Health may, from time to time in its discretion, make available to Pharmacy the opportunity to participate in Exclusive Provider Organizations ("EPO"), Preferred Provider Organizations ("PPO"), or other alternative pharmacy networks. Such pharmacy networks may be limited by geographic region or other basis determined by Medco Health, and may involve different payment rates. Pharmacy's Agreement with Medco Health does not constitute an agreement for Pharmacy to participate in any such alternative pharmacy network(s). If Pharmacy desires to participate in any such network(s), and Medco Health agrees to such participating Pharmacy's commitment to do so, the applicable payment for such network(s) will be set forth in Schedule A to Pharmacy's Agreement with Medco Health and Schedule A will also set forth the geographic area, pricing, and other terms and provisions applicable to such network(s). If the Pharmacy is considered a chain pharmacy by Medco Health, that is having four locations or more and a common billing address, Pharmacy's Agreement with Medco Health will be applicable to all pharmacy locations regardless of the pharmacy location and when the affiliated pharmacy is opened. The term "Pharmacy" as used in Pharmacy's Agreement with Medco Health will be deemed to include all of the locations of Pharmacy's chain. Notwithstanding the foregoing, Medco Health may limit participation of any particular location of the chain pharmacy in the Pharmacy's Agreement with Medco Health or any Network.

Subject to the assignment requirements of this Manual, the provisions of Pharmacy's Agreement with Medco Health will bind and inure to the benefit of the parties thereto and their heirs, representatives, and successors. Failure to exercise any rights arising in respect of any breach or violation of Pharmacy's Agreement with Medco Health will not be a waiver of the right to exercise any rights arising in respect of any subsequent breach or violation. In the event any term or provision contained in Pharmacy's Agreement with Medco Health is determined to be invalid or unenforceable, such invalidity or unenforceability will not affect the validity or enforceability of any other term, provision or requirement contained in Pharmacy's Agreement with Medco Health. Medco Health is the owner of the information obtained by and through the administration and processing of any prescription claim by Pharmacy through Medco Health.

Checks and other payments processed by Medco Health that go unclaimed by the Pharmacy for more than 1 year from the date of issuance will become the property of Medco Health.

Miscellaneous Provider Issues

continued

Pharmacy will in no event, including but not limited to nonpayment by Medco Health or any Sponsors, Medco Health or Sponsors' insolvency, or breach of Pharmacy's Agreement with Medco Health, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or persons other than Medco Health or the Sponsor acting on their behalf for covered services provided to Eligible Persons. This provision does not prohibit the collection of deductibles, co-payments/coinsurance or charges for noncovered services. This provision will survive the termination of Pharmacy's Agreement with Medco Health regardless of the cause giving rise to termination and will be construed to be for the benefit of the Eligible Person, and this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Pharmacy and Eligible Person or persons acting on their behalf. Pharmacy will provide Covered Services to all Eligible Persons at the applicable Network rate whether or not the Eligible Person has identified himself/herself as such. Further, if Medco Health determines that Pharmacy has overcharged an Eligible Person, Pharmacy will promptly pay such overpayment to Medco Health or such Eligible Person, as directed upon notification by Medco Health. Pharmacy will not discriminate against Eligible Persons on the basis of race, color, national origin, gender, age, religion, marital status, health status, or prescription benefit coverage. Pharmacy shall not charge a fee to Eligible Persons as a condition to be a participating Pharmacy.

Should Pharmacy be notified by Medco Health that Medco Health has been selected as an administrator of a drug benefit plan for a CHAMPUS Pharmacy benefit plan or a benefit plan of another Sponsor, Pharmacy will process all claims for the Eligible Persons under such plan through Medco Health. Pharmacy's failure to process claims through Medco Health in accordance with this paragraph will, notwithstanding any other rights Medco Health may have, subject Pharmacy to being charged by Medco Health liquidated damages of $2.00 per prescription not processed in accordance with this paragraph. Terms and conditions of Pharmacy's Agreement with Medco Health, which by their nature should continue beyond the termination of Pharmacy's Agreement with Medco Health, will survive the termination.

Pharmacy must abide by this Pharmacy Services Manual. This Pharmacy Services Manual will be deemed a part of and incorporated into the Pharmacy's Agreement with Medco Health as if fully set forth therein and this Pharmacy Services Manual will be deemed included in any reference to Pharmacy's Agreement with Medco Health. Any capitalized term set forth in this Manual, in the Regulatory Appendix or in the Pharmacy's Agreement with Medco Health will have the same meaning regardless of where the term is defined. Modifications by Pharmacy to any terms of this Manual shall not be binding upon the parties without the express written consent by Medco Health. Pharmacy shall maintain copies of this Pharmacy Services Manual and the Agreement with Medco Health in order to ensure compliance.

MISCELLANEOUS PROVIDER ISSUES

continued

Medco Health may limit or withdraw Pharmacy's providing of Covered Services to any Eligible Person, group, or Sponsor's Plans regardless of the Network(s) Pharmacy participates in. Medco Health may at any time terminate Pharmacy's Agreement with Medco Health without cause upon 30 days' prior written notice to Pharmacy and with cause immediately.

OFFICIAL NOTICES

All notices to Medco Health or Pharmacy pursuant to Pharmacy's Agreement with Medco Health must be in writing and be hand delivered or sent by first class mail, postage prepaid, or overnight courier addressed to Medco Health at the address set forth below; and, addressed to Pharmacy at the street, mailing, or check mailing address set forth in Pharmacy's application or verification form, or such other address as may be provided by the other party in the same manner as provided for the giving of any notice. Notwithstanding the foregoing, Medco Health may give notice to Pharmacy by communication via the TelePAID® System or by facsimile at the facsimile number set forth in the Pharmacy's application or verification. All written notices will be deemed to have been received when delivered if by hand or overnight courier, or if sent by mail then on the 3rd business day after the date such notice was mailed. Notices may be included in check cycle mailings. All TelePAID® System or facsimile notices will be deemed received by Pharmacy when sent by Medco Health. All notices to Medco Health will be sent to:

Medco
Provider Network Relations Department
100 Parsons Pond Drive
(Mail Stop E2-6)
Franklin Lakes, NJ 07417

AMENDMENTS

If Pharmacy continues to submit claims after the effective date of any notice, revision, amendment, or modification by Medco Health to Pharmacy, the notice, revision, amendment, or modification will be deemed accepted by Pharmacy and will become part of Pharmacy's Agreement with Medco Health as if Pharmacy had given its express written consent thereto. If Pharmacy objects to any such notice, revision, amendment, or modification, Medco Health reserves the right to immediately terminate Pharmacy's Agreement with Medco Health.

Revisions, amendments, or modifications to Pharmacy's Agreement with Medco Health will be provided by Medco Health from time to time. Pharmacy will abide by the terms of Pharmacy's Agreement with Medco Health, and all notices, revisions, amendments, and modifications thereto.

Breach of Agreement

It is understood that the breach by Pharmacy of any of the terms of Pharmacy's Agreement with Medco Health will constitute sufficient grounds for Medco Health to immediately terminate Pharmacy's agreement with Medco Health.

Arbitration

Any controversy or claim arising out of or relating to payments to Pharmacy by Medco Health or audit issues but not relating to termination of Pharmacy's Agreement with Medco Health or Pharmacy's Termination from Medco Health's Networks, which are not settled by the parties will be determined by arbitration involving three arbitrators, venued in Bergen County, New Jersey, in accordance with the Rules of the American Arbitration Association, and judgment upon the award rendered by the Arbitrators may be entered in any court having jurisdiction thereof. Any award of the Arbitrators will include reasonable costs and reasonable attorney's fees of the prevailing party. No award of the Arbitrators will prohibit Medco Health from exercising any rights Medco Health may have pursuant to its Agreement with Pharmacy or pursuant to law. No party will have a claim in arbitration or otherwise against the other for punitive or consequential damages or for loss of profits.

Assignment

Pharmacy will immediately notify Medco Health in the event of a change of ownership or control of the operations of Pharmacy. Upon change of ownership the new owner must apply for participation as a Medco Health provider. Any successor to ownership or control will be responsible for all liabilities and obligations of its predecessor under Pharmacy's Agreement with Medco Health.

Medco Health will not be bound to any of its obligations under Pharmacy's Agreement with Medco Health where Pharmacy has assigned its Agreement with Medco Health or ownership or control of the operation of Pharmacy has changed without Medco Health's prior written consent and under such circumstances Medco Health will have the right to terminate Pharmacy's Agreement with Medco Health.

ADVERTISING

Pharmacy will conspicuously display the appropriate Medco Health decal(s) or other identifying information provided by Medco Health indicating Pharmacy's participation as a Medco Health provider or in specific pharmacy networks established by Medco Health, as applicable. Medco Health, however, retains the exclusive right to and in the names "Medco Health Solutions, Inc.," "TelePAID®," "Coordinated Care Network®" and "Medco Health Direct℠" together with all other distinctive trademarks and/or service marks of Medco Health. Upon termination of Pharmacy's Agreement with Medco Health, Pharmacy will immediately discontinue any references to being a Medco Health provider and discontinue the use of the name or service marks of any Sponsors.

Certain Medco Health Plans require a Medco Health Plan decal to be placed in a conspicuous place identifying the Pharmacy as an In Network Pharmacy their cardholders can use. Pharmacy will place such decals as Medco Health directs Pharmacy to do.

Pharmacy will not use the name or service marks of Medco Health or any Sponsors except as authorized by Medco Health or the Sponsors.

Pharmacy will permit Medco Health to list Pharmacy in applicable provider directories and data bases as determined by Medco Health for use by Eligible Persons, Sponsors, and others to locate Medco Health providers.

QUESTIONS & ANSWERS

FREQUENTLY ASKED QUESTIONS

Q Can medications that require Prior Authorization be dispensed when Medco Health's Prior Auth Desk is unavailable?

A Medco Health does have a Temporary Coverage Policy. For such a circumstance see page 2.1 of this manual for details.

Q When I enroll in a specific Medco Health Network, am I obligated to accept all programs for all cardholders using that Network?

A When you enroll as a Medco Health provider it does not obligate you to accept any specific network terms. When you sign a network contract you *are obligated* to accept all programs for all cardholders using the Network you are enrolled in. Termination from a Network can be accomplished by writing to the Network Management Department, Medco Health Solutions, Inc., 100 Parsons Pond Drive, Franklin Lakes, NJ 07417.

Q Does the TelePAID® System support fractional quantities of ophthalmic products and metered dose inhalers?

A Yes. Fractional quantities of medications must be sent through the TelePAID® System for proper claims adjudication. For example the 3.5-g tube of Bacitracin Ophthalmic Ointment must be reported in the "quantity dispensed" field as 3.5, not 4.

Q How does Medco Health calculate the MDD for ointments, creams, and lotions?

A Medco Health calculates the MDD of ointments, creams and lotions based on the use of 10 g of these external preparations per day.

Q What is the MDD for Imitrex 50-mg oral tablets?

A The MDD for Imitrex 50 mg oral tablets is considered as 1.07 tablets per day. Stated another way, 32 tablets per 30 days; 96 tablets per 90 days.

Q What number of days supply should be used for Premarin 0.625 mg, # 75, Sig: One tablet daily for days 1- 25?

A The proper days supply in this case is 90, and not 75.

Q How does Medco Health determine whether a drug product is a single-source, multisource brand, or generic?

A Medco Health utilizes the definition of these categories based on an outside vendor's pricing data.

Q What should I do if I did not receive my bi-weekly check from Medco Health? Where can I obtain a schedule of payment dates?

A Call the Medco Health Pharmacy Services Help Desk at 1 800 922-1557.

Q Who do I call if I have a compounding or DUR question that only a pharmacist can answer?

A Call the Medco Health Pharmacy Services Help Desk at 1 800 922-1557.

Q How do I report the correct days' supply (DS) on a prescription for 4 tablets of a drug with the directions of 1 tablet per week?

A The DS should be reported as 28 days.

Glossary

Average Wholesale Price:

"AWP" as used herein means the current Average Wholesale Price as listed in print or electronically by First Data Bank Medispan, Red Book, or other nationally recognized pricing source determined by Medco Health based on the package size dispensed.

Compounded Prescription:

A compounded prescription is an extemporaneous preparation which contains two or more solid, semi-solid, or liquid ingredients, one of which is a Federal Legend Drug, that are weighed or measured, then prepared according to the prescriber's order and the pharmacist's art.

Note: Reconstitution of an oral antibiotic is not considered a compounded prescription.

Covered Services:

The providing of prescription drugs, and services and other medical products and services covered by Sponsors' plans.

Eligible Person:

An Eligible Person refers to a person who is enrolled with a Sponsor.

NCPDP Standard:

TelePAID® claims are submitted to Medco Health in accord with the standard Version 5.1 or the then current standard version as established by the National Council for Prescription Drug Programs Inc., 9240 East Raintree Drive, Scottsdale, Arizona 85260
Phone Number: 1 480 477-1000
Fax Number: 1 480 767-1042
Provider Services Number: 1 480 767-1043.

Prescriber:

A licensed practitioner with the legal authority to initiate a prescription drug order in the course of professional practice for an Eligible Person. Prescribers generally refer to: licensed physician, podiatrist, and physician extenders but may include other practitioners as well. Coverage of prescription drugs and other medical product and services may vary by type of prescriber, plan sponsors' plan designs, and applicable state law.

Secure Fax Number:

A Secure Fax Number is defined as a pharmacy fax number that is secure enough to receive confidential patient information and is not available to the general public nor to any nonprofessional pharmacy staff.

Sponsor:

An entity that has contracted with Medco Health with respect to pharmacy benefit management services.

TelePAID® System:

TelePAID® is the online claims submission and processing system used for the adjudication of all Medco Health claims for Eligible Persons. TelePAID® System claims are submitted only for the Eligible Person for whom the prescription is intended.

Usual and Customary Price ("U&C"):

The lowest net price a cash patient would have paid the day the prescription was dispensed inclusive of all applicable discounts. These discounts include, but are not limited to, senior citizen discounts, "loss leaders" frequent shopper or special customer discounts, competitor's matched price, or other discounts offered customers.

MEDCO HEALTH SOLUTIONS, INC.
CHECK CYCLE MAILING SCHEDULE – 2005

Cycle #	POS Cut-Off Date		Check Date	
1	Friday	12/31/04	Thursday	1/13/05
2	Friday	1/14/05	Thursday	1/27/05
3	Friday	1/28/05	Thursday	2/10/05
4	Friday	2/11/05	Thursday	2/24/05
5	Friday	2/25/05	Thursday	3/10/05
6	Friday	3/11/05	Thursday	3/24/05
7	Friday	3/25/05	Thursday	4/7/05
8	Friday	4/8/05	Thursday	4/21/05
9	Friday	4/22/05	Thursday	5/5/05
10	Friday	5/6/05	Thursday	5/19/05
11	Friday	5/20/05	Thursday	6/2/05
12	Friday	6/3/05	Thursday	6/16/05
13	Friday	6/17/05	Thursday	6/30/05
14	Friday	7/1/05	Thursday	7/14/05
15	Friday	7/15/05	Thursday	7/28/05
16	Friday	7/29/05	Thursday	8/11/05
17	Friday	8/12/05	Thursday	8/25/05
18	Friday	8/26/05	Thursday	9/8/05
19	Friday	9/9/05	Thursday	9/22/05
20	Friday	9/23/05	Thursday	10/6/05
21	Friday	10/7/05	Thursday	10/20/05
22	Friday	10/21/05	Thursday	11/3/05
23	Friday	11/4/05	Thursday	11/17/05
24	Friday	11/18/05	Thursday	12/1/05
25	Friday	12/2/05	Thursday	12/15/05
26	Friday	12/16/05	Thursday	12/29/05

In order to comply with applicable state laws there may be additional check cycles. Pharmacy will be notified.

Regulatory Appendix

REGULATORY APPENDIX

A Medco Health Regulatory Appendix is attached hereto and made a part hereof. The Regulatory Appendix contains various regulations, requirements, and laws ("Requirements") that are sometimes applicable to the arrangement between Medco Health, Pharmacy, and/or Sponsor and the providing of applicable Covered Services by Pharmacy.

By way of example and not by way of limitation, the Centers for Medicare & Medicaid Services ("CMS") Requirements would be applicable to CMS affiliated Covered Services (e.g., Medicare recipients) and the Maryland Requirements would relate to applicable Covered Services performed in Maryland. Generally, the Requirements are applicable to Covered Services for Sponsors that are insurance companies, HMO(s), and governmental agencies and are usually not applicable to Sponsors that have self-funded plans. Pharmacy is required to comply with all applicable Requirements and Pharmacy, by the providing of Covered Services, does acknowledge it will comply with such applicable Requirements.

CMS REQUIREMENTS

1. Pharmacy will provide Covered Services to Eligible Persons for 1-year periods commencing from the most recent anniversary date of Pharmacy's Agreement with Medco Health, and continuing thereafter for 1-year periods.

2. Pharmacy will provide Covered Services to all Eligible Persons, and included in the definition of Eligible Persons are Medicare enrollees, where applicable.

3. Pharmacy agrees that in no event, including, but not limited to, nonpayment by Medco Health, Medco Health's insolvency, or breach of Pharmacy's Agreement with Medco Health, shall Pharmacy, or its subcontractors, bill, charge, or collect a deposit from, seek compensation, remuneration, reimbursement or payment from, or have recourse against, Eligible Persons for Covered Services provided pursuant to Pharmacy's Agreement with Medco Health. This provision shall not prohibit the collection of coinsurance, co-payments, or deductibles or charges for non-Covered Services, where applicable. Pharmacy further agrees that this provision shall survive the termination of Pharmacy's Agreement with Medco Health regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the applicable Eligible Person(s).

4. For Covered Services to applicable Eligible Persons, Pharmacy must allow review by the utilization management and quality assurance committees/staff of the applicable Sponsor.

5. Pharmacy's payment rate for Covered Services provided to applicable Eligible Members is set forth in one of the schedules to Pharmacy's Agreement with Medco Health and/or communicated via the TelePAID® System to Pharmacy.

6. The Medicare-approved Drug Discount Card Program requires that the pharmacy:

   A. Make available to an enrollee the balance of traditional assistance at the point of sale;

   B. Provide negotiated pricing to enrollee;

   C. Provide the enrollee with the difference in price between the drug being purchased and the lowest-priced equivalent generic drug available at the pharmacy; and

   D. Apply the correct coinsurance account as indicated through the TelePAID® System.

1. Provider shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of HMO.
2. This Agreement shall not be terminated by Medco Health because Pharmacy expresses disagreement with HMO's decision to deny or limit benefits to an Eligible Person or because a Pharmacy discusses with a current, former, or prospective Eligible Person any aspect of such Person's medical condition, any proposed treatments or treatment alternatives, whether covered by the HMO or not, policy provisions of HMO, or Pharmacy's personal recommendations regarding selection of an HMO based on the Pharmacy's personal knowledge of the health needs of such Persons.
3. Pharmacy shall retain Eligible Person records for no less than 5 years after the last date of service.
4. In the event that this Agreement is terminated by Medco Health without cause and Medco Health has not provided 60 days' prior written notice to Eligible Persons of this termination, Pharmacy shall continue to provide Covered Services to Eligible Persons for 60 days after termination of this Agreement.

1. If requested to do so, Pharmacy shall continue to provide Covered Services to Eligible Persons with special circumstances following termination of this Agreement for any reason, other than quality of care or fraud, until the 90th day after the effective date of termination under the same guidelines and payment schedule as required by this Agreement. Special circumstances shall include when Eligible Persons have a disability, a congenital condition, or a life-threatening illness. This provision shall survive termination of this Agreement.

1. Pharmacy shall not differentiate nor discriminate in the treatment of Eligible Members as to the quality of services rendered on the basis of membership with Medco Health, source or amount of payment, race, sex, age, color, religion, national origin, handicap, or health status. The rights of Eligible Members shall be observed, protected, and promoted. Prescription services shall be rendered to Eligible Members in the same manner, in accordance with the same standard, and with the same time availability as offered to all other patients of Pharmacy.

2. Pharmacy agrees that in no event, including, but not limited to, nonpayment by Medco Health, Medco Health's insolvency, or breach of this Agreement, shall Pharmacy, or its subcontractors, bill, charge, or collect a deposit from, seek compensation, remuneration, reimbursement or payment from, or have recourse against, Eligible Member(s) for Covered Services, where applicable. Pharmacy further agrees that this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the applicable Eligible Member(s).

3. This Agreement, and all matters or disputes relating hereto, shall be governed by the laws of the State of Maryland without regard to choice of law provisions.

1. If requested to do so, Pharmacy shall continue to provide Covered Services to Eligible Persons with special circumstances following termination of this Agreement for any reason, other than quality of care or fraud, until alternate arrangements for such care can be made by Medco Health or Sponsor. This provision shall survive termination of this Agreement.
2. Neither party to this Agreement may terminate the Agreement without cause. Prior to termination of this Agreement by Medco Health for cause, Medco Health shall provide Pharmacy with written notice of the reason(s) for termination.
3. Medco Health and Sponsor shall not terminate this Agreement or withhold compensation due to Pharmacy for Covered Services solely because Pharmacy has in good faith communicated with or advocated on behalf of one or more of Pharmacy's prospective, current, or former patients regarding the provision, terms, or requirements of Sponsor's health benefit plans as they relate to the needs of such patients or regarding to the method by which Pharmacy is compensated for services provided under this Agreement. Nothing herein shall be construed to allow Pharmacy to disclose confidential specific compensation terms of this Agreement.
4. Pharmacy is not required to indemnify Medco Health or Sponsor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Medco Health or Sponsor based on Medco Health or Sponsor's management decisions, utilization review provisions or other policies, guidelines or actions.
5. This Agreement may not contain any incentive plan that includes a specific payment made to a Pharmacy as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

   a. Pharmacy shall not profit from provisions of covered services that are not medically necessary or medically appropriate.

   b. Medco Health or Sponsor shall not profit from denial or withholding of Covered Services that are medically necessary or medically appropriate.
6. Medco Health shall notify Pharmacy in writing of modifications in payments, modifications in Covered Services or modification in procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Pharmacy and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between Medco Health and Pharmacy.
7. Pharmacy shall not bill patients for nonpayment by Medco Health or Sponsor amounts owed under the contract due to insolvency. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.
8. Utilization review is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

1. **Reimbursement.** Pharmacy agrees to look solely to HMO for pharmacy services provided to HMO Eligible Persons except to the extent the collection of co-payment may be required.

2. **Utilization Management, Quality Improvement, and Other HMO or Medco Health Programs.** Pharmacy shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, member grievance, on-site review, or other similar programs that Medco Health or HMO may have in place.

3. **Member Protection Provision.** This provision supersedes and replaces all other payment provisions when a HMO is the payer, when required by a specific payer other than a HMO, or when required pursuant to applicable statutes and regulations:

   In no event, including but not limited to, nonpayment by payer, including HMO, for pharmacy services rendered to Eligible Persons by Pharmacy, insolvency of Medco Health or HMO, or breach by HMO or Medco Health of any term or condition of their agreements, shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Eligible Person or persons acting on behalf of the Eligible Person for pharmacy services eligible for reimbursement under the agreement; provided, however, that Pharmacy may collect from the Eligible Person, expenses or charges for services not covered under the Eligible Person's benefit contract. Pharmacy agrees not to maintain any action at law or in equity against an Eligible Person to collect sums that are owed to Pharmacy for pharmacy services, even in the event that the HMO or Medco Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this agreement.

   The provisions of this section shall (1) apply to all pharmacy services rendered while this agreement is in force; (2) with respect to pharmacy services rendered while this agreement is in force, survive the termination of this agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Eligible Persons; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Pharmacy and an Eligible Person or person acting on an Eligible Person's behalf, that requires the Eligible Person to pay for such pharmacy services.

4. **Laws, Regulations, and Licenses.** Pharmacy shall maintain all Federal, State, and local licenses, certifications, and permits, without material restriction, which are required to provide healthcare services according to the laws of the jurisdiction in which pharmacy services are provided, and shall comply with all applicable statutes and regulations. Pharmacy shall also require that all healthcare professionals employed by or under contract with Pharmacy to render pharmacy services to Eligible Persons, comply with this provision.

5. Government and Accrediting Agency Access to Records. Pharmacy agrees that the Federal, State, and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall to the extent permitted and/or required by law have immediate and complete access to, and Pharmacy shall release, all information and records or copies of such, within the possession of Pharmacy, Medco Health, or HMO, which are pertinent to Eligible Persons if such access is necessary to comply with accreditation standards, statutes or regulations applicable to HMO or Medco Health.

NEW YORK REQUIREMENTS

Medco Health New York Independent Practice Association, L.L.C., will perform all those services which are required under New York State Public Health Law and/or regulations to be performed by an independent practice association.

In addition, Pharmacy agrees that Covered Services provided to Eligible Persons who are members of a New York licensed health maintenance organization which has contracted with Medco Health to provide pharmacy services (each, an "HMO") shall be subject to the following terms and conditions only in respect to pharmacy services provided to Eligible Persons of such New York HMOs:

1. Pharmacy agrees that in no event, including, but not limited to, nonpayment by HMO, insolvency of HMO, or breach of this Agreement, shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an HMO Eligible Person or person (other than HMO) acting on the HMO Eligible Person's behalf, for services provided pursuant to this Agreement. This provision does not prohibit Pharmacy from collecting co-payments or coinsurance, as specifically provided in the certificate of coverage, or fees for non-Covered Drugs delivered on a fee-for-service basis to an HMO Eligible Person; provided, however, that Pharmacy informs the HMO Eligible Person in advance that such services are non-Covered Drugs and that the HMO Eligible Person, not HMO, shall be financially responsible to Pharmacy for payment of such services. Where pharmacy has not been given a list of non-Covered Drugs by HMO, and/or Pharmacy is uncertain as to whether a service is covered, Pharmacy shall contact Medco Health and obtain a coverage determination prior to advising an HMO Eligible Person as to coverage and liability for payment and prior to providing the service.

2. Pharmacy shall implement a quality and utilization management program, consistent with the HMO quality and utilization management policies and procedures, of which Pharmacy receives notice. Pharmacy shall furnish, to the extent permitted by law, such pertinent sections of records relating to services performed under this Agreement as may be required to implement the quality and utilization management program.

3. Upon termination of this Agreement, the rights of each party hereunder shall terminate provided that such termination shall not: (i) release Pharmacy of the professional obligation and duty to assigned HMO Eligible Persons to complete a course of treatment until satisfactory arrangements are made for care of HMO Eligible Persons either by selection of other Pharmacies by the HMO Eligible Person or assignment by HMO of other Participating Pharmacies acceptable to the HMO Eligible Persons; or (ii) release HMO from liability for monies owed to Pharmacy with respect to health care services provided to HMO Eligible Persons through the date of termination, or following termination for extended services.

4. Pharmacy agrees not to discriminate or differentiate in the treatment of patients on the basis of race, sex, age, religion, marital status, sexual orientation, color, national origin, place of residence, health status, source of payment for services, or membership in HMO. Pharmacy agrees not to deny patients access to care or treatment based on their source of payment or to provide or threaten to provide inferior care or to imply to patients that their care shall be inferior or of inferior quality due to source payment. Violation of this provision shall be grounds to terminate this Agreement immediately.

5. Pharmacy shall retain patient records of HMO Eligible Persons for no less than 6 years from the last date of service, or, in the case of minors, 6 years from the age of majority. Unless expressly prohibited by law regarding confidentiality or otherwise, Pharmacy agrees, upon prior notice and reasonable request, to make the patient records of all HMO Eligible Persons available to HMO and the New York State Department of Health or any other State or Federal regulatory agency having regulatory oversight over HMO. All patient records shall be treated confidentially and that no third parties other than HMO, the New York State Department of Health, or CMS may obtain such records without the written consent of the patient. Pharmacy further agrees, upon prior notice and reasonable request, to permit HMO and/or appropriate Federal, State, County, and City regulatory agencies to inspect and copy on-site, any financial, billing, encounter, utilization, and administrative information maintained by Pharmacy related to services provided to HMO Eligible Persons. Such access to, and copying of, patient records or any other information shall be permitted at no cost to the New York State Department of Health or CMS. This provision shall survive termination of this Agreement for any reason.

6. The parties agree to comply with all Federal and State law requirements applicable to the Medicare, commercial and Child Health Plus plans offered by HMO and agree to amend this Agreement to comply with applicable Medicare, Child Health Plus, and New York State Department of Health laws and regulation. Any material amendment to this Agreement with respect to services performed for New York HMO Eligible Persons is subject to the prior approval of the New York State Department of Health. The parties agree to terminate this Agreement with respect to New York HMOs at the direction of the Department effective upon 60 days' notice, subject to applicable law.

7. Nothing within Pharmacy's Agreement with Medco Health and IPA or this Manual, is intended to, or shall be deemed to, transfer liability for the Sponsor's or IPA's own acts or omissions, by indemnification or otherwise, to Pharmacy.

8. Notwithstanding any other provision of Pharmacy's Agreement with Medco Health and IPA or this Manual, Pharmacy, Medco Health, and IPA shall comply with the provisions of the Managed Care Reform Act of 1996 and all amendments thereto.

9. The Commissioner of the Department of Health of the State of New York is not bound by any arbitration carried out under the terms of this Manual. Arbitration shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

Pharmacy agrees that Covered Services provided to Eligible Persons who are members of a New Jersey licensed Health Maintenance Organization which has contracted with Medco Health to provide phamacy services (each, an "HMO") shall be subject to the following additional terms and conditions:

1. **No Penalty for Acting as Advocate.** Pharmacy may not be terminated as a Medco Health Participating Pharmacy or penalized solely because of its filing a complaint or appeal as permitted by applicable law or regulation, including as provided in N.J.A.C. 8:38-15.2.

2. **Co-payments/Coinsurance.** Pharmacy will bill and collect from Eligible Persons only co-payment/ coinsurance, and deductibles, if any, provided for under the applicable plan covering such Eligible Person(s) and set forth on the Eligible Person's Member ID card, communicated to Pharmacy via the TelePAID® System, or which Pharmacy is otherwise notified by Medco Health as being in effect. Nothing in the foregoing sentence will preclude Pharmacy from billing an Eligible Person for non-Covered Services. Except as provided for with respect to such co-payments/coinsurance and deductibles, or any fees for non-Covered Services, Pharmacy will not hold any Eligible Person financially responsible for Covered Services, whether or not Pharmacy believes that the compensation received from Medco Health is adequate. Pharmacy will accept payment from Medco Health as provided herein as payment in full by Medco Health and HMO for all Covered Services rendered to Eligible Persons pursuant to Pharmacy's Agreement with Medco Health. Pharmacy will not balance bill Eligible Persons. Pharmacy will not, and will cause any agents, trustees or assignees of Pharmacy not to, maintain any action at law or in equity against an Eligible Person to collect sums that are owed by Medco Health under the terms of Pharmacy's Agreement with Medco Health, even if Medco Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of Pharmacy's Agreement with Medco Health. This section will survive termination of Pharmacy's Agreement with Medco Health, regardless of the cause of termination. Pharmacy will bill to, and collect directly from, Eligible Persons all co-payments/coinsurance and deductible payments relating to Covered Services.

3. **Nondiscrimination.** Pharmacy shall not differentiate or discriminate in the treatment of Eligible Persons as to the quality of services rendered on the basis of membership with HMO. Prescription services shall be rendered to such Eligible Persons in the same manner, in accordance with the same standard, and with the availability as provided to all other patients of Pharmacy.

4. **Quality Assurance and Utilization Review Programs.** Pharmacy will be bound by and comply with the HMO Quality Assurance and Utilization Review Programs (the "Programs") as may be implemented and modified from time to time by HMO, upon written notice from Medco Health or HMO to Pharmacy. Pharmacy

will cooperate and participate with Medco Health and HMO in the operation of the Programs, including, without limitation, the development of any applicable treatment plans, credentialing, and external audits.

5. **Patient Records.** Pharmacy will maintain records for each Eligible Person as dictated by generally accepted pharmaceutical practice and as may be necessary to comply with applicable law. Pharmacy will maintain the confidentiality of such records as provided in Pharmacy's Agreement with Medco Health. Pharmacy will provide Medco Health and HMO or either of their respective designees reasonable access during regular business hours to such records, for the period required by applicable law and anytime thereafter that such access is required in connection with the provision of Covered Services to an Eligible Person. Each of Medco Health and HMO will have access at reasonable times upon demand to all books, records, and papers of Pharmacy relating to the Covered Services provided to Eligible Persons, to the cost thereof and to payments received by Pharmacy directly from Eligible Persons (or from others on their behalf). The obligations set forth in this paragraph shall survive the termination of Pharmacy's Agreement with Medco Health.

6. **No Obligation to Violate Rules.** Nothing in Pharmacy's Agreement with Medco Health (including these New Jersey HMO Requirements) shall be interpreted to impose obligations or responsibilities on Pharmacy to violate the statutes or rules governing licensure of Pharmacy.

7. **Privity of Contract.** Pharmacy acknowledges and agrees that HMO shall be deemed to have privity of contract with Pharmacy with respect to Pharmacy's Agreement with Medco Health, such that HMO shall have standing to enforce Pharmacy's Agreement with Medco Health in the absence of enforcement of such Agreement by Medco Health.

8. **General.** Any provision required to be in Pharmacy's Agreement with Medco Health by N.J.A.C. 8:38-15.2 or 15.3 will be binding upon Medco Health, HMO and Pharmacy whether or not specifically provided for herein.

9. **Termination Due Process.** If a Pharmacy's participation is terminated other than at the end of a term, Medco Health will give the Pharmacy 90 days' advance written notice. The Pharmacy may request a written statement of reasons for the termination. Medco Health will follow the procedures as required by law for conducting a hearing within 30 days of the Pharmacy's request. If the Pharmacy requests a hearing, the Pharmacy's participation will not be deemed an abrogation of his/her rights. Pharmacy is entitled to 90 days' notice and a hearing; however, if the Pharmacy's participation is terminated due to a determination that the Pharmacy has engaged in fraud, breached this agreement, or represents an imminent danger to a patient(s) or the public health, safety, and welfare, as determined by Medco Health, the Pharmacy will not be entitled to such a hearing.

10. Post Termination Continuation of Services. Pharmacy shall continue to provide Covered Services in accordance with the terms of this Agreement to Eligible Persons in special circumstances, whom are in the care of Pharmacy and for HMO is the insurer, on termination of this Agreement for up to 4 months or longer in accordance with Applicable Law or until alternate arrangements can be made by Medco Health or HMO. If this Agreement is terminated as a result of a determination that Pharmacy has engaged in fraud, breached this Agreement, or presented an imminent danger to the patient or the public health, safety, and welfare, as determined by Medco Health, the Pharmacy will not be permitted to continue to provide services after termination.

11. Prohibited Grounds for Termination. No Pharmacy shall be terminated or penalized solely for acting as an advocate for the Eligible Person in seeking appropriate medically necessary healthcare services. No Pharmacy may be penalized for discussing medically necessary or appropriate care with Eligible Persons.

12. Conformity of Law. Medco Health shall amend this Agreement to bring any provision which conflicts with Applicable Law into compliance with Applicable Law.

13. Appeals. To the extent that applicable law provides that a dispute between Pharmacy and Medco Health may be reviewed pursuant to applicable State or Federal external review proceedings, the dispute, if brought to such proceedings, shall be resolved pursuant to applicable law governing such proceedings.

14. Change to Agreement. Medco Health shall provide 30 days' notice to Pharmacy of material changes to this Manual.

15. Applicability to Other Members. The provisions of this Regulatory Appendix shall also apply to members insured through carriers' managed care plans as required by applicable New Jersey law and regulation.

16. Nonliability. Nothing in this Agreement will be construed to require Pharmacy to indemnify Medco Health and/or Sponsor for any tort liability resulting from acts or omissions of Medco Health and/or Sponsor.

1. If this Agreement terminates as a result of insolvency of a North Carolina licensed Health Maintenance Organization, Pharmacy shall continue to provide Covered Services to all Eligible Persons for the period for which premium has been paid.

2. This Agreement (including the Manual and any amendments hereto) constitutes the complete and sole contract between the parties and supersedes any and all prior or contemporaneous oral or written communications not expressly contained herein.

3. Pharmacy shall maintain licensure and credentials sufficient to meet Sponsors' credentialing requirements which have been adopted from Medco Health.

4. Pharmacy shall cooperate with Eligible Persons in member grievance procedures.

5. Pharmacy shall comply with Medco Health's sanctions program which has been approved and adopted by Sponsor.

6. Sponsor shall allow Pharmacy reasonable time to comply with any changes in benefit exclusions, administrative and Utilization Review requirements, credentialing and Quality Management programs, and provider sanctions policies.

7. Pharmacy shall be listed in provider directories produced by Medco Health for Sponsor or provider directories produced by applicable Sponsor and distributed to its Eligible Persons.

8. Pharmacy shall maintain records relating to the services provided by Pharmacy to Eligible Person in accordance with applicable laws, industry standards, and the standards set by Medco Health on behalf of the applicable Sponsor. Pharmacy shall provide copies of records relating to services provided by Pharmacy to Eligible Persons to the applicable Sponsor in accordance with all applicable confidentiality laws and regulations regarding such records and to the North Carolina Department of Insurance in conjunction with its regulation of Sponsor.

9. In the event of termination of this Agreement or insolvency of the Sponsor or Medco Health, Pharmacy agrees upon request to cooperate with the orderly transfer of administrative duties and Eligible Person's records.

10. Pharmacy understands and agrees that its obligation to comply with the Utilization Review programs, credentialing, Quality Management programs and provider sanctions programs of Medco Health and/or Sponsor shall not override the professional or ethical responsibility of Pharmacy not interfere with Pharmacy's ability to provide information or assistance to Eligible Persons.

11. In the event of termination of this Agreement or Medco Health's or Sponsor's insolvency, Pharmacy agrees to continue providing ongoing care until alternate arrangements for such care can be made by Medco Health or Sponsor. "Ongoing care" means the Pharmacy will dispense medications to Eligible Persons and charge the Eligible Persons the Pharmacy's Usual and Customary amount. The Eligible Person will submit claims to Medco Health or the Sponsor for reimbursement processing.

12. Participating Pharmacy shall not be obligated to pay interest to Medco Health for adjustments on overpayments made to Pharmacy and Medco Health shall not be obligated to pay interest to Participating Pharmacy for adjustments on underpayments made to Pharmacy.

13. Drug Utilization Review ("DUR") is performed by the pharmacist to determine a prescription's suitability with consideration to the health and drug history submitted by the patient, drug-to-drug interactions, drug contraindications, and appropriate standards of practice.

14. Inform the Eligible Person when a particular drug is not covered by the Plan Sponsor and that the Eligible Person would be responsible for payment of that drug.

The following provisions shall apply to the provision of Covered Services to Covered Persons who are enrolled in a Benefit Plan for Medicare+Choice ("M+C") beneficiaries and other applicable Medicare beneficiaries (hereinafter collectively referred to as "M+C Members").

1. **Government Right to Inspect.** Pharmacy shall give the U.S. Department of Health and Human Service (HHS) and U.S. General Accounting Office (GAO), and their authorized designees, the right to audit, evaluate, and inspect all books, contracts, medical records, patient care documentation, and other records of Pharmacy relating to Covered Services during the term of the Agreement and for a period of 6 years following termination or expiration of the Agreement for any reason, or until completion of an audit, whichever is later, unless such time frame is extended pursuant to 42 C.F.R. § 422.502 (e) (4) (such as in the event of fraud). This provision shall survive termination of the Agreement.

2. **Privacy and Confidentiality.** Pharmacy agrees to safeguard the privacy of any information that identifies a particular M+C Member in accordance with Federal and State laws and plan sponsor policy. Pharmacy shall maintain all M+C Members' records in an accurate and timely manner.

3. **Nondiscrimination Based on Health Status.** Pharmacy shall not deny, limit, or condition coverage or the furnishing of healthcare services or benefits to M+C Members based on health factors, such as medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

4. **Access to Benefits.** Pharmacy shall furnish Covered Services to M+C Members, consistent with requirements of the M+C Program, statutes, regulations, CMS pronouncements, and plan sponsor policies.

5. **Professionally Recognized Standards.** Pharmacy shall provide Covered Services to M+C Members in a manner consistent with professionally recognized standards of healthcare.

6. **Hold Harmless.**

   6.1 Pharmacy agrees to look solely to the plan sponsor or Medco Health, as applicable, for payment for services furnished to M+C Members unless explicitly notified by Medco Health for reason of coordination of benefits or subrogation. Pharmacy shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have claim or recourse against a M+C Member, or anyone acting on behalf of a M+C Member except a plan sponsor or Medco Health under any circumstance, unless explicitly approved for reason of coordination of benefits or subrogation. This provision shall not prohibit collection of

co-payments on the plan sponsor's behalf or Medco Health's behalf, made in accordance with the terms of the applicable Benefit Plan between the plan sponsor or Medco Health, and the M+C Member. In addition, Pharmacy agrees to seek no recourse for payment from any M+C Member for the reason of a plan sponsor's or Medco Health's insolvency. Pharmacy acknowledges that M+C Members are third-party beneficiaries to this clause. Pharmacy further agrees that this paragraph shall survive the termination (or expiration) of the Agreement, regardless of the cause of such termination, and that Pharmacy has not, and will not, enter into any agreement with a M+C Member or any other party contrary to this paragraph. This provision shall not prohibit collection of charges for services which are not Covered Services as defined in the relevant Benefit Plan provided that the M+C Member has been informed in advance of delivery of such services, that such services are not covered, and the M+C Member has agreed in writing, in a form substantially similar to the one attached hereto, to accept responsibility for payment for such services. Nor shall this provision prohibit payment for any Covered Services delivered after expiration of benefits under the relevant Benefit Plan. Pharmacy shall, upon the request of Medco Health, submit to Medco Health or the Payer, any M+C Member's written acknowledgement to accept responsibility for non-Covered Services provided by Pharmacy.

6.2 Any modifications, additions or deletions to the provisions of this section shall become effective on a date no earlier than 15 days after the Commissioner of Insurance of the relevant state has received written notice of such proposed change(s).

7. **Prompt Payment.** Medco Health agrees to use reasonable efforts to adjudicate clean claims submitted by Pharmacy within 60 days from the date Medco Health receives the claim, as long as the claims are for services (a) authorized by Medco Health; (b) provided to an eligible M+C Member; (c) billed according to arrangements set forth in the Agreement and Medco Health policy; and (d) that have no third-party involvement.

8. **Compliance with Medicare Requirements, Federal, and State Laws.** Pharmacy agrees to comply with all applicable Medicare laws, regulations and CMS instructions. Pharmacy further agrees to comply with all laws applicable to individuals and entities receiving Federal funds and all other applicable Federal and State laws, regulations, and governmental issuances, including but not limited to those governing participation in the M+C Program, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

9. **External Review.** Pharmacy agrees

to cooperate with all independent quality review and improvement organization activities required by CMS and or the plan sponsor pertaining to the provision of services for M+C Members.

10. **Medical Management Compliance.** Pharmacy agrees to comply with Medco Health's and the plan sponsor's medical policies, QA programs and medical management programs.

11. **Submission of Encounter Data.** Pharmacy agrees to submit to Medco Health or such other party designated by Medco Health in the form prescribed by Medco Health, all data required to be submitted in accordance with 42 C.F.R. 422.502(a)(8), 422.257 and 422.502(l)(3). Pharmacy certifies as to the completeness, truthfulness, and accuracy of such data that it shall submit.

12. **Influenza and Pneumococcal Vaccines.** Pharmacy acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to M+C Member cost sharing obligations.

13. **Termination Without Cause.** In the event that Pharmacy or Medco Health seeks to terminate the provision of Covered Services to M+C Members other than for cause, such party seeking to terminate shall provide the other party with at least 60 days' advance written notice.

14. **Exclusion of Certain Persons.** Pharmacy shall not employ or contract for the provisions of healthcare, utilization review, medical social work, or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Pharmacy hereby certifies that no such excluded person currently is employed by or under contract with Pharmacy relating to the furnishing of Covered Services to M+C Members.

15. **Compliance with Appeals Procedure Requirements.** Pharmacy shall cooperate and comply with all requirements of Medicare and the plan sponsor regarding the processing of M+C Member appeals, including the obligation to provide information (including medical record and other pertinent information) to the plan sponsor within the time frame reasonably requested for such purpose.

16. **Compliance with Policies, Procedures, and Manuals.** Pharmacy agrees to comply with all applicable plan sponsor policies, procedures, and manual provisions, which specifically include but are not limited to, where applicable, Payer's policies governing notice of noncoverage.

17. **Claims for Payment.** As required by 42 C.F.R. § 1001.952 (m)(l)(i), in the case of services furnished to M+C Members, Pharmacy shall not claim payment in any form from CMS or from any other agency of the United States or from any state for items and services furnished in accordance with the Agreement, except as may be approved by CMS or a State agency,

nor shall Pharmacy otherwise engage in any shifting of costs or seek increased payments from the M+C Program or any State healthcare program as a result of furnishing such services to M+C Members.

18. **Y2K Compliance.** Pharmacy agrees that all necessary actions and system changes to internal mission-critical systems have been made and tested so that Pharmacy is Year 2000 compliant. Year 2000 compliant means that the information technology of Pharmacy must accurately process date and time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the 19th, 20th, and 21st centuries, the years 1999 and 2000, and leap year calculations. Further, Year 2000 compliant information technology, when used in combination with other information technology, must accurately process date and time data if the other information technology property exchanges date and time data with it. Mission-critical systems are defined as those systems and interfaces which materially affect the accurate and timely performance of the functions performed by Pharmacy under the Agreement.

19. **Healthcare Integrity and Protection Data.** Pharmacy shall submit a report in writing to Medco Health within 30 calendar days of Pharmacy's knowledge of any and all civil judgments and other adjudicated actions or decisions against the Pharmacy related to the delivery of any healthcare item or service (regardless of whether the civil judgment or other adjudicated action or decision is the subject of a pending appeal).

20. **Conflicts.** In the event of any inconsistencies between this Amendment and any provision of the Payer Agreement with respect to M+C Members, the provisions of this Amendment shall govern.

1. **Member Grievances and Complaints.** Pharmacy shall immediately refer any Member grievances or complaints of which it becomes aware to Sponsor. Pharmacy shall cooperate with and participate in Sponsor's Member Grievance Procedures and Complaint Procedures as directed by Sponsor, and shall abide by the decisions of Sponsor's Grievance Committee and Complaint Committee. Pharmacy shall comply with Medicare grievance and appeals procedures for Medicare Members as set forth in Sponsor's Provider Manual and as required by CMS.

2. **Insurance.** Pharmacy shall secure and maintain a policy of general liability with minimum coverage limits of $1 million per occurrence/$3 million aggregate. Pharmacy shall provide Certificates of Insurance evidencing Pharmacy's insurance coverage to Medco Health upon request.

3. **Member Hold Harmless.**

   3.1. Pharmacy agrees that in no event, including but not limited to, nonpayment by Medco Health or Sponsor, the insolvency of Sponsor or Medco Health, or breach of this Agreement shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members, the Commonwealth of Pennsylvania or persons other than Sponsor or Medco Health for services provided under the Pharmacy Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Sponsor's behalf made in accordance with the terms of an enrollment agreement between Sponsor and Members. (Medicaid Members are not liable for any supplemental charges or copayments.)

   3.2. Pharmacy further agrees that (a) this hold harmless provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Sponsor's Members, and (b) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Pharmacy and a Member or persons acting on their behalf.

   3.3. No modification, addition, or deletion to the provisions of this section shall be given effect unless it has first been approved by the Pennsylvania Departments of Health and Public Welfare.

4. Quality Management. Pharmacy agrees to cooperate with and abide by Sponsor's Quality Management Program, which includes Sponsor's quality assurance and utilization review policies and procedures. All such programs and policies referred to in this section, or any other section of this Addendum, are limited to those required by the Commonwealth of Pennsylvania and/or those requiring approval by the Commonwealth.

5. No Termination for Member Advocacy or Filing Grievance on Member's Behalf. Neither Medco Health nor Sponsor may sanction, terminate or fail to renew the agreement with Pharmacy solely because

5.1 Pharmacy advocated for medically necessary and appropriate health care services on behalf of a Member as determined by reputable providers practicing within the legal standard of care;

5.2. Pharmacy filed a Grievance on behalf of and with the written consent of a Member, or helped a Member to file a grievance;

5.3. Pharmacy protested a Sponsor or Sponsor decision, policy or practice Pharmacy believed interfered with its ability to provide medically necessary and appropriate health care; or

5.4. Pharmacy took another action specifically permitted under 40 P.S. §§ 991.2113, 991.2121, and 99.2171.

6. Federal and State Funds. Pharmacy acknowledges that payments to it with respect to Members who are eligible for Medical Assistance are derived from federal and state funds and that Pharmacy may be held civilly and/or criminally liable to both Sponsor and the Pennsylvania Department of Public Welfare in the event of false claims, non-performance, misrepresentation, fraud, or abuse for services provided to Medical Assistance recipients (including Sponsor's Members who are Medical Assistance recipients).

7. No Interference with Professional Judgment.

7.1. Neither Sponsor nor Medco Health shall prohibit or restrict Pharmacy from, nor penalize Pharmacy for, discussing:

a. Medically Necessary and appropriate care with or on behalf of a Member, government health care officials, or the Pennsylvania Department of Public Welfare, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations or tests;

b. The process Sponsor or Medco Health use or propose to use to deny payment for a health care service; or

c. The decision of any managed care plan to deny payment for a health care service.

continued

7.2. This Agreement may not be terminated because Pharmacy: (i) advocates for medically necessary and appropriate health care as determined by reputable providers practicing within the legal standard of care; (ii) files a grievance on behalf of a Member pursuant to the procedures set forth in the Insurance Pharmacy Law of 1921, as amended by Article XXI of Act 68 of 1998 (P.L. 464, No. 68) and its applicable regulations, 28 PA. Code Chapter 9; (iii) protests a decision, policy, or practice that Pharmacy reasonably believes interferes with Pharmacy's ability to provide medically necessary and appropriate health care; or (iv) objects to the provision of or refuses to provide or refer a health care service on moral or religious grounds, provided that Pharmacy makes adequate information available to Members and prospective Members.

7.3. Pharmacy is specifically permitted to have such discussions on behalf of the Member with the Department of Public Welfare and other health care officials, provided that the Member consents to such discussions.

8. Records.

8.1. Pharmacy shall maintain records of the claims information for seven (7) years after the dispensing date or until all then pending audits or inspection activities as described in this section are completed. Such records shall be in a format and media deemed appropriate by Medco Health and approved by Sponsor. Each party may audit, review and duplicate such records, and any other records the parties have regarding the claims information made in connection with this Agreement ("Records") by providing reasonable prior written notice to the party holding the applicable Records. Such review and duplication shall occur during regular business hours at the place of business of the holder of the Records, and shall be subject to all applicable Laws regarding the confidentiality of such Records. The party requesting duplication of Records shall pay the party holding such Records its reasonable duplicating costs.

8.2. Pharmacy shall adhere to the applicable requirements of 42 CFR Subsection 434.6, including but not limited to those regarding maintaining an appropriate record system for services provided hereunder and safeguarding information concerning Covered Members in accordance with applicable federal statutes and regulations governing Medical Assistance programs.

8.3. The Pennsylvania Departments of Health, Insurance and Public Welfare, and any external quality review organization approved by the Departments of Health or Public Welfare shall be provided access to records of Pharmacy for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Pennsylvania laws and the Department of Public Welfare's contract with Sponsor. The records shall only be accessible to Departmental employees or agents with direct responsibilities for the enumerated activities.

continued

9. **Inspection.** The Pennsylvania Departments of Health, Insurance, and Public Welfare, and the United States Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness and timeliness of service performed hereunder.

10. **Program Integrity; Fraud and Abuse.** Pharmacy shall comply with all policies and procedures as developed and amended from time to time for the detection and prevention of fraud and abuse committed by providers, employees, or Members, and to ensure program integrity in the Pennsylvania Medical Assistance program. Such compliance may include, but not be limited to, the submission of statistical and narrative reports regarding fraud and abuse detection activities, referral or information of suspected or confirmed fraud or abuse to Sponsor, and Sponsor shall immediately notify the Pennsylvania Departments of Health and Public Welfare, as appropriate, regarding such suspected or confirmed fraud or abuse. Medco Health shall immediately terminate any Pharmacy precluded from participation in Medicaid, as it concerns such Pharmacy's participation in a Sponsor Medicaid Program, and shall make no payments to such Pharmacy after the effective preclusion date.

11. **Hold Harmless for Health Plan/Provider Dispute.** In the event that any dispute arises between Pharmacy and Medco Health, Pharmacy and Medco Health hereby agree to indemnify and hold harmless the Pennsylvania Department of Public Welfare and Members from any legal or financial liability arising out of or in connection with any such dispute.

12. **Non-Discrimination.** Pharmacy shall not discriminate in the hiring of its employees on the basis of sex, marital status, age, disability, race, color, religion, or any other basis prohibited by law. Furthermore, Pharmacy shall not discriminate or differentiate in the provision of services hereunder on the basis of sex, marital status, age, disability, race, color, religion, sexual orientation, health status, the fact that a Member is a Medicaid or Medicare beneficiary, or any other basis prohibited by law.

13. **ADA Compliance.** Pursuant to federal regulation promulgated under the authority of the Americans with Disabilities Act, as amended, Pharmacy understands and agrees that no individual with a disability shall, on the basis of the disability, be excluded from participation in this Agreement or from activities provided for under this Agreement.

14. **Commonwealth Hold Harmless.** Pharmacy agrees to hold harmless the Commonwealth of Pennsylvania, all Commonwealth officers and employees, and all Members in the event of nonpayment by Sponsor to Medco Health or Medco Health to Pharmacy. Pharmacy shall further indemnify and hold harmless the Commonwealth and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers, or employees, through the intentional conduct or negligent acts or omissions of Pharmacy, its agents, officers, or employees in connection with Pharmacy's performance of services hereunder.

15. Record Retention. Pharmacy shall retain the source records for its data reports for a minimum of seven (7) years and shall develop and maintain written policies and procedures for the storing of these records.

16. Definitions. In providing services under the Agreement, the following terms shall have the meanings set forth below.

16.1. "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

16.2. "Medically Necessary" shall have the meaning set forth in Health Plans' contract with the Pennsylvania Department of Public Welfare, namely: A service or benefit is "medically necessary" if it is compensable under the Pennsylvania Medical Assistance Program and if it meets any one of the following standards: (a) the service or benefit shall, or is reasonably expected to, prevent the onset of an illness, condition or disability; (b) the service or benefit shall, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability; or (c) the service or benefit shall assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age. The determination as to whether a service or benefit is medically necessary shall be based on the determination of a qualified and trained medical professional that takes into account information provided by the Member, the Member's family, and other medical professionals.

17. Submission of Encounter Data. Pharmacy shall submit claims electronically at the point of service.

18. **Continuation of Services.** Pharmacy agrees in the event of Medco Health's or Sponsor's insolvency or other cessation of operations, Pharmacy shall continue to provide benefits to Members through the period for which the premium has been paid.

19. **Notice of Change in Circumstances.** Pharmacy shall notify Medco Health immediately of any change in circumstances which would adversely affect Pharmacy's ability to render services under this Agreement, including, but not limited, to: (i) suspension or loss of license, certification, or accreditation; (ii) the imposition of sanctions under a federal or state health care program; (iii) the indictment, arrest, or conviction of a felony or any criminal charge of Pharmacy; (iv) the loss or reduction of liability coverage or professional malpractice coverage; (v) the filing of a malpractice or other negligence based claim by a Member against Pharmacy; or (viii) Pharmacy becoming insolvent or voluntarily or involuntarily filing for bankruptcy, the assignment for the benefit of creditors, the appointment of a receiver, or similar relief.

20. **Severability.** If any provision in the Agreement is deemed to be illegal or unenforceable, or any court of competent jurisdiction restricts or limits the applicability of any provision in the Agreement, the Agreement shall be interpreted as if the provision in question has been stricken or so restricted or limited, but shall not affect the other provisions of the Agreement.

21. **Fee-For-Service Window.** Medco Health and Pharmacy agree that Pharmacy shall provide services to a Plan Member enrolled in the Medical Assistance program during the period that the Member is covered under the Medicaid fee-for-service program prior to the effective date of his or her enrollment in the Sponsor's managed care program.

22. **Confidentiality of and Access to Records.** Pharmacy agrees to maintain Sponsor's Members' records confidential in accordance with 40 P.S. 991.2131 and to comply with all federal and state laws and regulations regarding the confidentiality of patient records. The Pennsylvania Departments of Health, Insurance and when necessary, Department of Public Welfare, shall have access to records for purposes of quality assurance, investigation of complaints and grievances, enforcement or other compliance activities under the 40 P.S. 991.2101 through 991.2193, as amended, 28 PA. Code Chapter 9 and all other laws of the Commonwealth of Pennsylvania. Such records shall be accessible only to those Pennsylvania Department of Health employees or agents with direct responsibility for the activities mentioned in the previous sentence.

23. **Adherence to Laws.** Pharmacy agrees to adhere to all state and federal laws and regulations to which it is subject.

24. Timely Processing of Claims. If Medco Health fails to pay a clean claim within forty five (45) days of receipt of the claim, interest at the rate of ten percent (10%) per annum shall be added to the amount owed to Pharmacy. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. Medco Health shall not be required to pay interest calculated to be less than two dollars ($2).

25. Policies and Procedures. Pharmacy agrees to comply with any changes, including but not limited to amendments, repeals, and additions, to the Sponsor Provider Manual. Such changes shall be binding upon Provider thirty (30) days after Provider's receipt of written notice thereof, unless circumstances require an earlier effective date. If any applicable laws or regulations are enacted, amended, promulgated, repealed, or revised, whether or not retroactively, which affect any of the rights, duties, or obligations of the parties under the Agreement, including, without limitation, those concerning the eligibility of Members and the provision of Covered Prescription Drug Services, the Agreement shall be deemed amended effective as of the date such laws or regulations become or became effective.

PENNSYLVANIA IDS REQUIREMENTS

In compliance with the requirements applicable to "Integrated Delivery Systems" ("IDS"), set forth in 28 PA. Code § 9.724 (Plan-IDS Contracts) and 9.725 (IDS-Provider Contracts):

1. Pharmacy acknowledges and agrees that nothing contained in this Agreement limits:

   1.1. The authority of Sponsor to ensure Pharmacy's participation in and compliance with Sponsor's quality assurance, utilization management, Member complaint and grievance systems and procedures or limits.

   1.2. The authority of the Pennsylvania Department of Health or the Pennsylvania Department of Public Welfare to monitor the effectiveness of Sponsor's system and procedures or the extent to which Sponsor adequately monitors any function delegated to Medco Health, or to require Sponsor to take prompt corrective action regarding quality of care or Member grievances and complaints.

   1.3. Sponsor's authority to sanction or terminate Pharmacy, in the event that Pharmacy is found to be providing inadequate or poor quality care or failing to comply with plan systems, standards or procedures as agreed to by Medco Health.

2. Pharmacy acknowledges and agrees further that:

2.1. Any delegation by Sponsor to Medco Health for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to Sponsor's oversight and monitoring of Medco Health's performance. Pharmacy must meet the minimum credentialing standards established by Sponsor and approved by the Commonwealth of Pennsylvania. Sponsor retains the authority to accept, reject or terminate Pharmacy.

2.2. Sponsor, upon failure of Medco Health to properly implement and administer the systems, or to take prompt corrective action after identifying quality, Member satisfaction or other problems, may terminate its contract with Medco Health, and that as a result of the termination, Pharmacy's participation in Sponsor's network may also be terminated.

2.3. Data Reporting Requirements: Pharmacy agrees that it shall report data as required by the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare. Medco Health agrees that it shall notify Pharmacy of data reporting requirements.

1. Termination of this Agreement, except for reason of competence or professional behavior, shall not release Medco Health from the obligation to reimburse Pharmacy for services provided in special circumstances post-termination to Eligible Persons at less than the agreed-upon rate. This obligation shall not extend beyond the 90th day after the effective date of the termination.

2. Medco Health shall provide written notification of termination of this Agreement to Pharmacy at least 90 days prior to the effective date of termination, except if termination is related to (i) imminent harm to Eligible Person's health; (ii) action against Pharmacy's license to practice or loss of insurance or reduction in insurance by Pharmacy; or (iii) fraud, in which case Pharmacy's termination by Medco Health may be immediate.

3. Prior to termination of this Agreement, Medco Health will give Pharmacy a written explanation of the reason(s) for termination and Pharmacy may request and receive a review of the proposed termination by an advisory review panel. Such review shall not be provided in cases where termination is related to the provisions set forth in Section 2 above.

4. In the event of termination of this Agreement, Medco Health shall provide reasonable advance notice of the impending termination of Pharmacy to Eligible Persons receiving Covered Services at Pharmacy except in cases where termination is immediate and notice by Medco Health to such Eligible Persons shall be immediate.

5. Pharmacy shall post a notice to Eligible Persons on the process for resolving complaints with Medco Health or the Sponsor. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints.

6. Nothing in this Agreement will be construed to require Pharmacy to indemnify Medco Health and/or Sponsor for any tort liability resulting from acts or omissions of Medco Health and/or Sponsor.

1. Pharmacy shall provide 60 days' advance notice to Medco Health of termination of this Agreement.

2. In the event of insolvency of Sponsor, Pharmacy shall continue to provide Covered Services to Eligible Persons for the duration of the period for which premium payment has been made.

3. Claims adjudicated by Medco Health shall not be retroactively denied unless Medco Health has provided 30 days' notice to Pharmacy the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because Pharmacy was already paid for such services rendered or the services were not rendered by Pharmacy, or (iii) the claim was not submitted in accordance with the lesser of 12 months or the time frames set forth herein.

4. No amendment to this Agreement shall be effective unless Pharmacy has failed to notify Medco Health within 15 business days of receipt of the amendment of Pharmacy's intent to terminate this Agreement.

5. Medco Health shall not terminate this Agreement nor otherwise penalize Pharmacy solely because of Pharmacy's invoking of Pharmacy's right under this Agreement or applicable law or regulation.