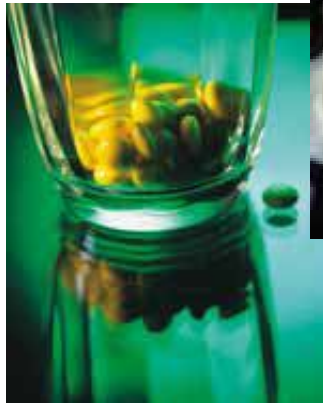




Pharmacy



Manual

Network

**Guidelines, Policies and Procedures
for
Express Scripts, Inc.
Network Pharmacies**

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Express Scripts' Vision

Express Scripts strives to be the industry leader through excellent and innovative pharmacy services. We provide the trusted, impartial and practical counsel that enables our Plan Sponsors to navigate the rapidly changing pharmaceutical landscape. We recognize the important role the retail pharmacy plays in serving our Sponsors' Members, and our goal is to support community pharmacists in providing this service.

Express Scripts is one of the largest pharmacy benefits management (PBM) companies in North America, independent of pharmaceutical manufacturer ownership. Headquartered in St. Louis, Missouri, we employ nearly 10,000 people and operate major satellite offices in seven states and Canada. Express Scripts serves more than 52 million members in thousands of Plan Sponsor groups, including managed-care organizations, insurance carriers, third-party administrators, employers, and union-sponsored benefit plans.

At Express Scripts, progressive healthcare management is relevant to everything we do, and we are committed to innovation and excellence. By leveraging our PBM expertise, we develop strategies for controlling total healthcare spending and improving health outcomes.

Express Scripts provides fully integrated PBM services, including network pharmacy claims processing, mail pharmacy services, benefit design consultation, drug utilization review, formulary management, disease management, and clinical and utilization management programs. Express Scripts also provides complementary services, including specialty pharmaceutical distribution services.

By negotiating discount rates with retail pharmacies, Express Scripts reduces unit costs for prescription drugs. In addition, we help our Sponsors manage costs when using our networks by offering programs that increase formulary compliance and generic utilization.

By using a managed-care focus, our businesses deliver cost-effective, quality programs. We combine proven fundamentals with advanced capabilities, resulting in value-added products and services for our Sponsors.

Providing Value to Our Customers

Above all, we value client relationships. Our dedicated, highly skilled account management organization uses innovative and technological strategies to provide superior customer service.

We also value our relationships with our retail pharmacies. Express Scripts promotes cost efficiency among retail pharmacies by administering a point-of-service claim system that avoids costly manual billing for more than 99% of prescriptions.

Section 1. Express Scripts Pharmacy Network Information

1.1 Support Phone Numbers and Hours

For all online inquiries including claims processing, eligibility, or online messaging, contact the **Pharmacy Help Desk**. The appropriate number is printed on the Member Identification Card:

Pharmacy Help Desk Numbers	
St. Louis, MO	800-235-4357
Tempe, AZ	800-763-5550
Bloomington, MN	800-824-0898
Farmington Hills, MI	800-824-0898
Albuquerque, NM	800-824-0898
Troy, NY	800-964-1888
St. Mary's, GA	800-795-7643

Pharmacy Help Desk hours: 24 hours a day/7 days a week

1.2 Pharmacy Provider Agreement Information

For Pharmacy Provider Agreement requests, contact the **Pharmacy Recruitment Department** at 800-824-0898 and follow attendant instructions.

Monday through Friday	8 a.m. to 5 p.m. Central Time
------------------------------	--------------------------------------

If a Pharmacy is covered under an existing corporate contract, a new Express Scripts Pharmacy Provider Agreement is not needed. However, Express Scripts must be notified each time a store is opened, closed, relocated, or acquired.

Participation in ESI Networks (i.e., standard, performance-based network, restricted network, Express Access) is voluntary. Participation in one network does not mandate participation in another unless agreed upon by the provider and Express Scripts.

1.3 Online Transmission Information

The following table contains basic information for the online adjudication of Express Scripts claims:

Standard Transmission Guidelines	
Standard Format:	NCPDP Version 5.1
Maximum prescriptions per transaction:	2 (4) prescriptions using NCPDP Version
For direct lease line information:	800-824-0898 and follow attendant instructions (Pharmacy Network Support)
Claim Submission and Reversals	⇒ 90 days claim submission (Sponsor exceptions may apply) ⇒ 120 days claim reversal (Sponsor exceptions may apply)

1.4 Pharmacy Additions/Deletions or Address Changes

Express Scripts must be notified in writing when a chain or independent retailer requests to add, change or delete a pharmacy under an existing contract. Only claims from contracted Pharmacies will be accepted. Please forward any new or changed addresses along with all closed Pharmacy notices to Express Scripts.

Please provide the following information for new stores or address changes:

- NCPDP#
- NPI National Provider Identifier (becomes effective May 15, 2007)
- Store Name
- Chain code (if applicable)
- Mailing address
- Physical address
- City
- State
- Zip Code
- Website address
- Phone #
- FAX #
- State License #
- Federal Tax ID
- Medicaid ID (if applicable)
- Medicare ID (if applicable)

Fax: 877-789-1867, Attn: Provider Relations, Contract Team

Mail:

**Express Scripts, Inc.
Attn: Provider Relations Contract Team STL10N
14000 Riverport Drive
Maryland Heights, MO 63043**

E-Mail: provrel@express-scripts.com

1.5 Member Eligibility Verification

Each Express Scripts Member should present an Identification Card when getting a prescription filled. Express Scripts Sponsors may choose an Express Scripts card, their own card with an Express Scripts logo, or their dual purpose medical/prescription card with or without an Express Scripts logo.

Sample Express Scripts Member ID Card

Express Scripts has chosen to adopt the NCPDP Standard Format for all cards. We also make it a priority to convey the importance of incorporating the NCPDP standard elements into the Sponsor-produced ID cards. Our purpose for this initiative is to make processing easy for pharmacists and to reduce errors due to insufficient information on the ID card.

Express Scripts logo: Required for pharmacist recognition.



Client logo: Required for pharmacist recognition.

Applicable member call center number and the pharmacist call center number will appear on the card.



Rx BIN #, Processor Control #, Rx Group #, Member ID, and person code (if necessary): Required information to process a claim.

1.5 Member Eligibility Verification (Continued)

Before dispensing a new or refill prescription, examine the ID card carefully to confirm whether the prescription to be filled is for the cardholder or an eligible dependent. Also confirm that Express Scripts is set up in your computer as the processor.

If a person claims to be an Express Scripts Member and does not have a card, submit the claim online. If you receive a “*Missing/Invalid Cardholder ID*” rejection code, verify eligibility by contacting the Pharmacy Help Desk.

If verification of eligibility cannot be confirmed, collect the total Usual and Customary Retail Price of the prescription dispensed and instruct the Member to contact his or her benefit Sponsor or Express Scripts Customer Service.

If the Member’s Prescription Drug Program coverage allows, the individual claiming eligibility without a card should send in the receipt and claim form for reimbursement to:

Express Scripts, Inc.
ATTN: Pharmacy Claims
P.O Box 66773
St. Louis, MO 63166-6773

If eligible, reimbursement will be forwarded directly to the Member. The amount reimbursed will depend on the Sponsor’s contractual agreement, less any Copay or deductible due under the applicable Prescription Drug Plan.

Express Scripts Standard Input Values

Data Element	Value	Codes	
Relationship Codes	Cardholder Spouse Child Other Dependent Unspecified	1 2 3 4 0	Eligibility Clarification Codes 0 = Not specified 1 = No Override 2 = Override 3 = Full Time Student 4 = Disabled Dependent 5 = Dependent Parent 6 = Significant Other
Sex	Male Female Unspecified	1 2 0	
Prescriber ID Format	DEA State License Number	2 Alpha followed by 7 Numeric Varies by State	
Person Codes	Member Code	00 to 99	

Section 2. Express Scripts Claims Adjudication Guidelines

2.1 General Claims Submission Policies

- All claims must be submitted online in current NCPDP HIPAA-approved format, including medications when the Pharmacy's Usual and Customary retail price is less than the Copay.
- All claims submitted must include the Pharmacy's Usual and Customary retail price, including all discounts on applicable date of fill.
- The Copay must be the amount charged to the Member and cannot be changed.
- All online messages for both rejected and paid claims transmitted from Express Scripts must be displayed for the dispensing pharmacist. This requirement includes Drug Utilization Review messaging.
- All claims must be transmitted to Express Scripts indicating the actual date of fill.
- The submitted NDC must be the actual NDC of the medication dispensed, including the package size.
- The fee charged for processing of Universal Claim Forms (UCFs), tape or batch claims is \$1.00 per prescription. If a Universal Claim Form is required by Express Scripts for a specific drug, the fee will be waived. All UCFs should be mailed to:

Express Scripts, Inc.
ATTN: Pharmacy Claims
P.O Box 66773
St. Louis, MO 63166-6773

2.2 Generic Substitution

Generic Drugs should be dispensed whenever possible and permitted by applicable law. Fill Prescriber Dispense As Written (DAW 1) prescriptions in accordance with applicable laws and regulations. The Copay may vary depending on the guidelines of the Member's specific plan. The total Copay to be collected will be calculated and displayed electronically in the Copay field during online claims transmission.

Express Scripts appreciates your assistance in helping contain medical costs by contacting the physician to see if a generic medication may be substituted. Express Scripts reviews all Generic Drugs which are "A" rated by the Food and Drug Administration (FDA) Orange Book (see page 7-1 for further details).

If a Member insists on receiving the Multi-Source Brand name drug when the prescription provides that generic substitution is permitted by the Prescriber, a DAW 2 Code must be transmitted. The online system will indicate the Copay to be collected. For certain plans, the Copay may include an amount equal to the difference between the contracted brand price and the contracted generic price plus the Copay. The contracted price could include AWP, submitted price, Maximum Allowable Cost (MAC), baseline, or the Pharmacy's Usual and Customary retail price.

2.3 Online Reimbursement Calculation

The Express Scripts online claims processing system audits every claim. You may be paid an amount other than what you submit as your ingredient cost, dispensing fee, or your Usual & Customary retail price. Express Scripts' reimbursement is based on the lower of:

- Average Wholesale Price (AWP) less the contracted discount baseline price (as calculated by First DataBank) less the contracted discount for the specific network;
- MAC or submitted cost plus the contracted dispensing fee for that network, or U&C, whichever is lowest.

Express Scripts will utilize First DataBank or other comparably reliable sources as determined by Express Scripts, and will update drug information on a daily basis. When applicable, taxes, surcharges and incentive fees are included in the reimbursement.

2.4 Deductibles/Benefit Maximums/Caps

Some Express Scripts Sponsors require a Member or family deductible or benefit limit to be calculated and tracked online. The deductibles or caps are reset at specific intervals. The online system will transmit the appropriate Copay based on the plan's benefit parameters. Should a Member have a question about his or her Copay, please instruct them to call the Customer Service number listed on their card.

2.5 Taxes, Surcharges and Fees

If permitted by the terms of Express Scripts contract with the Sponsor, Express Scripts will bill the Sponsor for any federal, state or local sales taxes payable with respect to any sales of a Covered Drug to a Member, and will remit to the Pharmacy any such taxes collected from Sponsors. Pharmacy shall remit, or cause the Pharmacy(ies) to remit, any such taxes to the appropriate taxing authority.

2.6 Prescriber Identification Numbers

Pharmacies are required to submit an appropriate Prescriber ID on all claims. The required identifier is the Prescriber's DEA number, unless the plan utilizes the Prescriber's state license number, or in the case of some managed care Sponsors a unique assigned Prescriber identifier. Failure to submit the complete and accurate required Prescriber identifier will result in a rejected claim.

2.7 Days Supply

The exact number of consecutive days supply must be submitted, with the calculation based on the metric quantity prescribed and the Prescriber's exact written directions. If the Prescriber does not provide exact directions, or writes "as directed" or "prn," the pharmacist must call the Prescriber or ask the Member for the directions, document such directions on the prescription, initial the same, and submit the exact days supply based on those directions and the quantity prescribed. Should the days supply submitted exceed the plan's limitation, you will receive a "*days limit = 'x'*" online message. In this case, based on the Prescriber's directions, reduce the quantity dispensed to the Member accordingly.

2.8 Quantity

The exact metric quantity of the drug prescribed must be submitted. The Pharmacy should not reduce the quantity unless required due to a "*quantity limit = 'x'*" online message. In this case, reduce the quantity accordingly.

2.9 Pre-Authorization

The online system will identify medications requiring pre-authorization for specific plans or Members. Pre-authorization may be required for specific drugs, excessive quantities, excessive days supply, or unusually high costs. The online message field displays appropriate information to remedy the situation or the plan pre-authorization phone number. You may also call the Express Scripts Pharmacy Help Desk number printed on the Member Identification Card for assistance.

2.10 Non-Standard National Drug Code (NDC) Numbers

The HIPAA standards expressly prohibit the use of all non-standard NDC codes. The company policy follows this standard, *i.e.* the adoption of National Drug Codes (NDCs) as the standard for reporting drugs and biologic agents. The list of NDCs provides prescription drug codes with a few over-the counter (OTC) drugs.

2.11 Claims Adjustments

Claims adjustments will automatically be credited to or debited from your remittance. When a complete claim reversal cannot be applied, a manual adjustment will be posted to your next remittance. If a claim reversal or manual adjustment cannot be applied, a manual invoice will be sent for unapplied adjustments outstanding for more than 90 days.

2.12 Compounds

There are two (2) ways in which a compound claim can be submitted through the National Council for Prescription Drug Programs (NCPDP) Version 5.1 format. They are as follows:

1. **Claim Segment**

The highest cost legend ingredient NDC is submitted in the Product/Service ID (407-D7) field. The pharmacy will enter a “2” in the Compound Code (406-D6) field referencing that the claim submitted for adjudication is a compounded prescription.

2. **Compound Segment**

The Compound Segment allows the availability to itemize ingredients used in the composition of a compound individually by line.

At this time, Express Scripts supports the first process as referenced above. Compounded prescriptions must be submitted electronically using the following guidelines:

- Each compound prescription must contain at least one Legend Drug ingredient (must be covered under Member’s benefit).
- The NDC number of the most expensive Legend Drug should be used.
- The total quantity of the compounded ingredients must be entered.
- The AWP of the combined compounded ingredients must be entered.
- The compound indicator of the Pharmacies’ online screen must reflect that the claim is a compound.
- Compounded prescriptions using a Legend Drug, where there is no approved FDA treatment, are not covered. (An example is Questran for diaper rash).
- Bioequivalent compounds of manufactured products will be reimbursed at no greater than the equivalent manufactured product cost.
- Compounded sustained release products are not covered.
- All compound medication ingredients must be approved for human use.

2.13 Online Coordination of Benefits

Express Scripts supports point-of-service Coordination of Benefits (COB) under the National Council for Prescription Drug Programs (NCPDP) version 5.1 COB segment. This enhancement allows pharmacy providers to submit COB claims through point-of-service processing.

Online COB submission does not impact or change Express Scripts existing manual process for COB submission by Members.

We offer non-duplication processing at the point of service, which means that Express Scripts will never pay more for a COB claim than the plan Sponsor would have paid as the primary payer. Initially, the system determines the Sponsor and Member responsibility for payment as though the Sponsor is the primary payer of the claim. That calculated amount is then reduced by the other payer amount, and the pharmacy is paid the resulting balance minus the member copay if applicable.

2.14 COB Secondary Messaging and Sponsor Coverage Codes

Pharmacies should rely on claims adjudication responses in the Additional Message Information (526-FQ) field for specifics needed to process COB claims. Examples include:

Reject Code	Additional Message Information Field
41	COB Not an Option Under Member's Benefit
	Process Claim as Primary
	This OCC Not Allowed for Use by Plan
H9	Copay Only Billing Not a Benefit Option

As previously referenced, online COB will be implemented on an individual basis for each Sponsor, rather than as a global process for all Sponsors. Sponsors select the Other Coverage Codes (OCC) they will allow to be submitted by the pharmacy that reflect their plans' parameters for coordination of benefits.

Express Scripts distributes monthly updates to pharmacies about Sponsors electing to participate in online COB, along with a list of the OCC they select.

2.15 Partial Fill Transactions

Partial Fill claims occur when a pharmacy attempts to fill a prescription and determines that there is not enough of the drug in stock to provide the entire prescribed quantity/days supply.

On April 1, 2003, Express Scripts began accepting Partial Fill transactions from pharmacies using NCPDP v5.1. The unique fields used in a Transaction Code B1, Billing, Partial Fill transaction are as follows:

Partial Fill Field Name	Field Description
Dispensing Status 343-HD	The code in this field indicates that the quantity dispensed is an initial partial fill “P” or the completion of a partial fill “C”.
Associated Prescription/Service Date 456-EP	Date of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
Associated Prescription Service/Reference Number 456-EN	The prescription or service reference number of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
Quantity Intended to be Dispensed 344-HF	The metric decimal quantity that would have been dispensed if adequate inventory were available. This field is used only in association with a “P” or “C” in the Dispensing Status field. NOTE: If populating this field, an assumption is made that the “Days Supply Intended to be Dispensed” is also sent.
Days Supply Intended to be Dispensed 345-HG	Days supply for the metric decimal quantity that would have been dispensed if adequate inventory was available. This field is used only in association with a “P” or “C” in the Dispensing Status field.

2.16 Partial Fill Transaction Edits

Express Scripts edits Partial Fill Transactions as follows:

1. The Intended field information is edited in order to notify the pharmacy when the intended days supply or quantity would cause the claim to reject if the claim had been submitted as a full claim.
2. The Actual Days Supply and Quantity will be edited according to the Member’s benefit.
3. The Completed Claim will be edited based on balancing exactly to the Intended Days Supply, Quantity, and NDC of the Partial Claim. If these fields do not balance or if the NDC does not match, the claim will reject.
4. The Completed Claim will be edited against the files that existed during the partial fill date of service (e.g. the Member was eligible during the partial fill date filled, the Member is still eligible). The exception would be if a Member is retro-termed, if the retro-term date encompasses the Partial Fill Claim date of service, the claim will reject.
5. The Partial and Completed Claim will be counted as **one** filled script.

6. The Refill Too Soon and Quantity Limit edits will apply to the Partial and Completed Claim since a full claim could be filled between these two transactions.
7. Ample supply editing will be based on the fill date of the Partial Claim.
8. A Completed Claim does not need to be submitted in order to fill a subsequent full claim.

2.17 Partial Fill Claims Pricing and Member Copay

1. The claim will be priced and a copay assigned based on the Intended Days Supply and Quantity.
2. The claim will be priced based on the final cost calculation of the Intended Quantity.
3. The Partial and Completed Claim will be prorated based on the Actual Days Supply and Quantity dispensed on each claim.
4. The Member will pay a pro-rated copay based on the actual quantity dispensed.
5. The pharmacy will receive a prorated dispensing fee based on the actual quantity dispensed for both the partial and completed claim. This was necessary in order to accurately balance the payable amount to the pharmacy and the Member copay between the two claims.

2.18 Repackaging

Express Scripts may not reimburse network pharmacies, or may reduce reimbursement for repackaged products submitted with a higher AWP than the original manufacturer's product.

2.19 Dispense As Written (DAW) Codes

The DAW/Product Selection Code indicates the reason a product was dispensed by the pharmacist. Reimbursement considerations depend on the parameters of the Prescription Drug Program when these DAW Codes are used. Express Scripts requires a DAW Code for each claim transmitted.

DAW Code	Description	Product Type	Copay Impact	Reimbursement Impact
0	No Product Selection Indicated This is the field default value appropriate for use when selection is not an issue.	Single Source	Brand	Brand
	Examples include prescriptions written for Single Source Brand products, Cross Licensed products, and prescriptions written using the generic name and the generic product is dispensed.	Cross Licensed Generic Multi-Source	Brand Generic	Brand Generic

2.19 Dispense as Written (DAW) Codes (Cont.)

DAW Code	Description	Product Type	Copay Impact	Reimbursement Impact
1	Substitution Not Allowed by Prescriber This code must be used when the Prescriber indicates, in a manner specified by applicable law, that the product is to be Dispensed As Written.	Multi-Source	Brand Copay or ancillary charge + Copay (determined by the Sponsor)	Brand (Generic if determined by the Sponsor)
2	Substitution Allowed - Patient Requested the Product Dispensed This code must be used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted for the Multi-Source Brand and the Member requests the brand name product.	Multi-Source	Brand Copay or ancillary charge + Copay (determined by the Sponsor)	Brand (Generic if determined by the Sponsor)
3	Substitution Allowed - Pharmacist Selected the Product Dispensed This code must be used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted and the pharmacist determines that the brand name 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.	Multi-Source	Generic	Generic
4	Substitution Allowed – Generic Drug Not In Stock This code must be used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted and the brand product is dispensed when a currently marketed generic is not stocked in the Pharmacy. This situation is the result of the buying habits of the pharmacist, not the unavailability of the generic product in the marketplace.	Multi-Source	Generic	Generic

2.19 Dispense as Written (DAW) Codes (Cont.)

DAW Code	Description	Product Type	Copay Impact	Reimbursement Impact
5	<p>Substitution Allowed – Brand Drug Dispensed as Generic This code must be used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.</p>	Multi-Source	Generic	Generic
6	<p>Override Not currently used by Express Scripts.</p>	N/A	N/A	N/A
7	<p>Substitution Not Allowed – Brand Drug Mandated by Law This code must be used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted, but applicable law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.</p>	Multi-Source	Brand	Brand
8	<p>Substitution Allowed – Generic Drug Not Available in the Marketplace This code is used when the Prescriber has indicated, in a manner specified by applicable law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable.</p>	Multi-Source	Evaluated by Express Scripts on a product by product basis.	Evaluated by Express Scripts on a product by product basis.
9	<p>Other Not currently used by Express Scripts.</p>	N/A	N/A	N/A

Section 3. Pharmacy Reimbursement

3.1 Pharmacy Reimbursement Schedule

The Pharmacy will receive reimbursement from Express Scripts for Pharmacy services provided as specified for a covered medication and/or reimbursable service as identified in the Pharmacy Provider Agreement, amendments, exhibits, or the Pharmacy Network Manual. The net reimbursement will be less the applicable Member copay and any deductibles.

Net reimbursements will be based on the claims submitted to Express Scripts following the procedures outlined in this manual. Remittances are paid on a twice monthly reimbursement cycle in a 30-day average time frame from Express Scripts' receipt of a reimbursable claim.

Workers' Compensation claims submitted for reimbursement may adjudicate under applicable State fee schedules. The Pharmacy Rates for Covered Medications shall be the lowest of the Pharmacy's Usual and Customary Retail Price, Pharmacy's submitted ingredient cost plus dispensing fee, the Member's Copayment, the applicable State fee schedule, or the rates set forth in such applicable Exhibits.

3.2 Disputed Claims

The participating Pharmacy is obligated to review remittance advices when received to verify their accuracy. **To dispute a claim payment or adjustment, the Pharmacy must notify Express Scripts in writing, within 30 days of Pharmacy's receipt of the remittance advice.** The pharmacy must list the details of the disputed claim payment or adjustment. Express Scripts is responsible for investigating any Pharmacy remittance advice dispute only if properly notified in the manner and time frame specified above.

3.3 Remittance Media

Express Scripts provides a detailed remittance advice with your pharmacy payment. Chain Pharmacies with more than 50 stores may request to receive remittance advice reports via magnetic tape, cartridge or FTP.

To change your remittance medium, simply contact Pharmacy Network Support at 877-776-8735 and follow the instructions.

If you receive your Pharmacy remittance via magnetic tape, please return the tape within 15 days of receipt. The Pharmacy will be billed \$25.00 for each non-returned tape.

Please return tapes to the appropriate address found on the label of the tape.

Express Scripts
Attention: Tape Library
14000 Riverport Drive
Maryland Heights, MO 63043

Express Scripts
Attention: Tape Library
1700 N. Desert Drive
Tempe, AZ 85281-1228

EDS
Attn: Tape Library
5400 Legacy Drive
Plano, TX 75024

3.4 Remittance Information Service Fees

Express Scripts will provide remittance information to Pharmacies for each reimbursement cycle. If the Pharmacy loses or requires an additional remittance report, Express Scripts will automatically deduct a fee from the Pharmacy's future remittance.

Remittance Information Service	Service Fee*
Magnetic Tape	\$100.00
Cartridge	\$100.00
Paper remittance over 20 pages	\$75.00
Paper remittance under 20 pages but more than 5 pages	\$15.00
Paper remittance under 5 pages	\$0.00
Check Trace/Stop Payment	\$25.00
Claim payment verification	\$1.00 per claim

* Fees are subject to change without notice.

If you receive an unreadable tape or cartridge, immediately call Pharmacy Network Support 877-776-8735. If Express Scripts is notified within 15 days of original mail date, Express Scripts will replace the electronic remittance advice at no additional cost.

3.5 Express Scripts Sample Remittance Advice

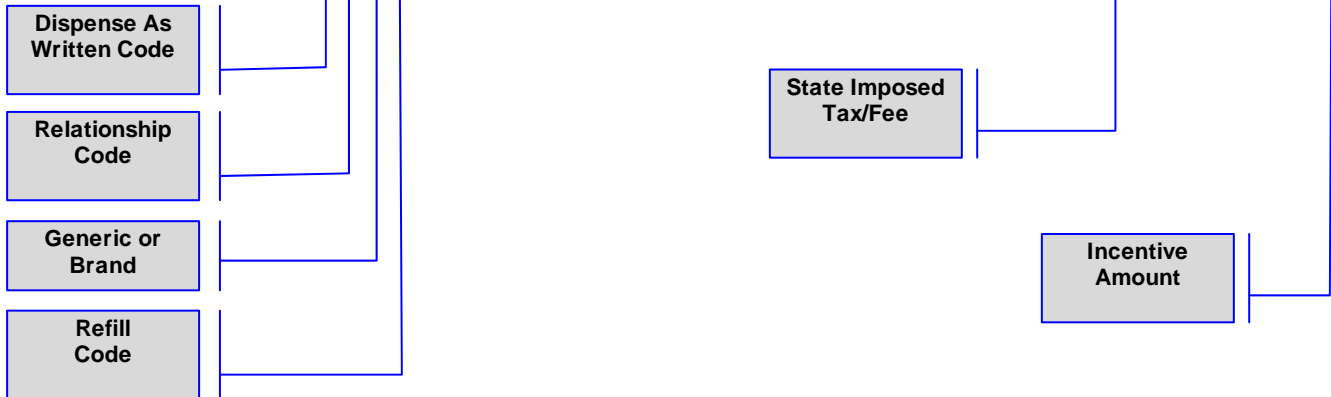
Pharmacy No: 2978039
SPECIALTY PHARMACY LLC

EXPRESS SCRIPTS REMITTANCE ADVICE

Page: 1
Release Date: 12/10/2002
Process Date: 12/10/2002

Rx Number	Date Filled	Reference Number	DAW/Rel/Gen/Ref	Drug Name	Drug Dose	Oth Payr Amount	U&C Amount	State Tax/Fee	Incent Amount	Trans Fee	Amount Paid
Rel Cde	Carrier Id	Subscriber/Member ID	NDC Number	Drug Qty	Days Supply	Ingrd Claim	Ingrd Paid	Disp Fee	Copay Amount	Amount Paid	
006001449	11/22/02	052745264	0/C/G/R	SULFAMETHOXAZOLE/TMP	800.000		19.00				
	DPS MAS	548881410-00		00677078405	12.000	028	10.24	2.81	2.00	4.81	.00
006001450	11/26/02	052153408	0/C/B/R	VALTrex 500MG CAPLET	500.000		146.00				
	DPS MAS	548881410-00		00173093303	30.000	030	120.90	103.97	2.00	20.00	85.97
006001451	11/22/02	001833115	0/C/B/R	ZITHROMAX 600MG TABL	600.000		166.00				
	DPS MAS	548881410-00		00069308030	8.000	028	140.61	120.92	2.00	20.00	102.92
006001452	11/22/02	001306115	0/C/B/R	VIAGRA 100MG TABLET	100.000		51.00				
	DPS MAS	548881410-00		00069422066	4.000	030	38.36	32.98	2.00	31.18	3.80
006001467	11/22/02	001530115	0/C/B/R	EMLA CREAM	2.500		70.00				
	DPS MAS	548881410-00		00186151601	30.000	030	53.19	45.74	2.00	20.00	27.74
TOTALS FOR PHARMACY 2978039 SPECIALTY PHARMACY LLC						.00	452.00	.00	.00		
							363.30		10.00	95.99	220.43

Formulary Incentive Rx Count:	0	Claims Submitted:	5	DAW0:	5	DAW5:	0	Brand/SS (B):	4
Formulary Incentive Paid:	\$0.00	Claims Rejected:	0	DAW1:	0	DAW6:	0	Brand/MS (M):	0
Missed Formulary Incentive Count:	0	Claim Reversals:	0	DAW2:	0	DAW7:	0	Generic (G):	1
Missed Formulary Incentive Fee:	\$0.00	Claims Paid:	5	DAW3:	0	DAW8:	0	Compound (C):	0
Usual and Customary Claim Count:	0			DAW4:	0	DAW9:	0		



3.6 Express Scripts Sample Remittance Advice (Worker's Compensation)

Pharmacy No: 999999 / A99999C
XYZ1 DRUG #9999

EXPRESS SCRIPTS REMITTANCE ADVICE

Page: 2
Release Date: 11/16/2003
Process Date: 10/29/2003

Rx Number	Date Filled	Reference Number	DAW/Rel/Gen/Ref/	Drug Name	Drug Dose	U&C Amount	State Tax/Fee	Incent Amount	Trans Fee	Amount Paid
0000011	09/15/03	999999999	0/C/B/M	MOBIC	7.5MG	22.00	.35			
	EC2 KEE	123456789-99		00597002901	30 30	17.50	17.50 C	.00	.00	17.85
0000012	09/15/03	999999999	0/C/G/M	AMITRIPTYLINE HCL	50MG	21.00	.36			
	EC2 KEE	123456789-99		00781148801	30 30	18.00	18.00	.00	.00	18.36
0000013	09/15/03	999999999	0/C/B/M	CELEXA	40MG	24.00	.43			
	EC2 KEE	123456789-99		00456404001	30 30	21.25	21.25 C	.00	.00	21.68
0000014	09/15/03	999999999	0/C/B/M	CELEBREX	200MG	23.00	.40			
	EC2 KEE	123456789-99		00025152531	30 30	19.75	19.75 C	.00	.00	20.15
TOTALS FOR PHARMACY 999999 XYZ1 DRUG #9999						90.00		.00		
							1.54			
						76.50		.00		
							76.50		.00	78.04

Formulary Incentive Rx Count:	0	Claims Submitted:	4	DAW0:	4	DAW5:	0	Brand/SS (B):	3	
Formulary Incentive Paid:	\$0.00	Claims Rejected:	0	DAW1:	0	DAW6:	0	Brand/MS (M):	0	
Missed Formulary Incentive Count:	0	Claim Reversals:	0	DAW2:	0	DAW7:	0	Generic (G):	1	
Missed Formulary Incentive Fee:	\$0.00	Claims Paid:	4	DAW3:	0	DAW8:	0	Compound (C):	0	
Usual and Customary Claim Count:	0			DAW4:	0	DAW9:	0			

Dispense As Written Code

Relationship Code

Generic or Brand

Refill Code

State Imposed Tax/Fee

"C" = Claim has been reduced to pharmacy's contracted reimbursement.

Incentive Amount

Section 4. Problem Solving

4.1 Express Scripts Web Site for Pharmacists

Log onto www.express-scripts.com to utilize a web-based tool that allows pharmacists to retrieve claims rejection information during the adjudication process. The pharmacy's NCPDP and federal tax identification numbers are both required to complete the online registration process. The website will display information the pharmacist needs to successfully resubmit a claim based on the type of rejection and by allowing retrieval of appropriate reference data from the adjudication system.

4.2 Most Common Reasons for Claims Rejections

The following table describes the top 10 reasons claims reject during the adjudication process:

Rejection Code	Rejection Message/Definition	Action
06	Missing/Invalid Group Number	Group has not been added, does not have coverage, or group has been terminated. Verify the information on the Member's card. If the information in your system matches the card, call the appropriate help desk number on the back of the Member's card for assistance.
07	Missing/Invalid Cardholder ID	Verify that you entered the correct ID for the Member. If the information in your system matches the card, verify that the processor control and group numbers are correctly entered.
09	Missing/Invalid Birth Date	Verify with the Member that the birth date entered is correct for the cardholder or the dependent for whom the prescription was written.
18	Quantity limit = X	Enter the metric quantity consistent with the dosing schedule and within the plan limitations. The plan quantity may be displayed in the online rejection message.
19	Days limit = X	Enter the number of days supply consistent with the dosing schedule and within the plan limitations. The plan days supply may be displayed in the online rejection message.
69	Filled After Coverage Terminated	Verify the Identification number information on the Member's most current Identification Card. If the information matches in your system, verify that the correct processor control and group numbers are entered.

4.2 Most Common Reasons for Claims Rejections *(Continued)*

Rejection Code	Rejection Message/Definition	Action
70	Drug Not Covered	Drug is not covered for the Member; an alternative may be displayed in the online message.
79	Refill Too Soon	Verify that the Member actually needs the prescription filled early, due to Prescriber increased dose, or verify original day supply entered incorrectly. For vacation supply, contact the appropriate help desk number on the back of the Member's card.
83	Claim Previously Processed	The claim was processed and paid on the same day at your Pharmacy or at another pharmacy. If you did not receive a paid message, try to reverse from your system and re-transmit.

4.3 Drug Utilization Review (DUR) Codes

The following table details Express Scripts' DUR codes:

Module	Purpose	Message Transmitted to Pharmacy	Example
<i>Drug Disease Inferred (DC)</i>	Provides an alert when the transmitted claim is contraindicated for a patient's disease state as inferred from previous medication use.	The message transmitted to the pharmacy indicates the contraindicated disease state for the medication.	Disease: Alzheimer's
<i>Drug Interactions (DD)</i>	Identifies the potential for an adverse reaction resulting from an interaction between the transmitted claim and an active medication in the patient's medication history.	Name from the interacting prescription in the patient history and if space available the transmitted drug.	Proton Pump Inhibitors/ Atazanavir
<i>Drug Protocol Management - High Dose (HD)</i>	Provides an alert message when the daily dose for the transmitted drug exceeds 200% of the First Data Bank (FDB) maximum adult daily dose.	Potential Overdose	Fluoxetine 20mg capsules have a four capsule maximum daily dose in FDB. Currently we alert at 8 capsules per day.
<i>Ingredient Duplication (ID)</i>	Provides a duplicate ingredient alert when the first 12 positions of the GPI-14 code are the same as a current active prescription and the current prescription is less than 75% complete and the second prescription is from a different pharmacy than the first prescription.	The message transmitted to the pharmacy indicates the active ingredient is the same.	Same ingredient as other active Rx
<i>Drug Protocol Management - Low Dose (LD)</i>	Provides an alert message when the drug is prescribed outside of minimum recommended daily doses for approval of indications applicable to adults between 18 and 65 years of age.	Potential Overdose	Glyburide doses below 2.5 mg per day

4.3 Drug Utilization Review (DUR) Codes *(Cont.)*

Module	Purpose	Message Transmitted to Pharmacy	Example
<i>Therapy Adherence (Underuse) (LR)</i>	Identifies when a patient is taking a medication less frequently than prescribed. Mainly acute medications are excluded from the precaution edit.	Potential Underutilization	
<i>Excessive Duration (Overuse) (MX)</i>	Identifies when a patient is taking a medication more frequently than prescribed. (Similar to sample supply edit for X-day grace period. Ample supply edit overrides.	Potential Overutilization	
<i>Drug-Age Management (PA)</i>	Provides age-dependent precautions for a drug. 780 months (patients older than 65 years is the parameter) Proved age-dependent precautions for a drug. Inclusive minimum and maximum ages are set in the system dependent on the drug.	Message transmitted to the pharmacy is specific to the drug conflict and drug.	Methocarbromal - Caution in renal impair. Fluoroquinolone-type antibiotics (0 and 216 months) - May cause permanent joint lesions.
<i>Drug Protocol Management – Pregnancy (PG)</i>	Provides information regarding drug use during pregnancy. Parameters are set for female patients inclusively between 15 and 45 years old.	The message transmitted to the pharmacy is specific to the drug conflict and drug. The message will reflect, “Precaution if Pregnant.”	Losartan (Cozaar) - Not recommended in 2nd and 3rd trimesters.
<i>Drug Protocol Management – Gender (SX)</i>	Provides gender-dependent precautions for a drug.	The message transmitted to the pharmacy is specific to the drug conflict and drug	Finasteride (Proscar) use in a female is contraindicated.
<i>Therapeutic Duplication (TD)</i>	Identifies when there is a therapeutic overlap of medications in a patient’s drug regimen.	Name from the previous conflicting prescription.	Two prescriptions for two different ACE Inhibitors.

DISCLAIMER

The information provided through the Express Scripts DUR module is intended to supplement the knowledge of the physicians, pharmacists, and other health care professionals regarding potential adverse therapeutic conditions. This information is advisory only and is not intended to replace sound clinical judgment in the delivery of health care services. Express Scripts disclaims all warranties, whether expressed or implied, including any warranty as to the quality, accuracy, or suitability of this information for any particular purpose.

Section 5. Formulary Programs and Policies

5.1 Overview of Formularies

Express Scripts manages numerous Formularies and Formulary programs. The Formulary programs fall under the Express Scripts Express Preference™ drug therapy management umbrella. These programs include:

- Closed Formularies – only selected products are covered.
- Partially closed Formularies – featuring unique pairings of Formulary and Non-Formulary products within certain therapeutic categories.
- Physician Formularies – the physician decides whether or not the Non-Formulary product can be dispensed under the plan.
- Voluntary Formularies – the physician and member decide whether the Non-Formulary product can be dispensed under the plan.

In addition, all Express Scripts Sponsors participate in an Approved Formulary, **which means the Pharmacy should not substitute** another product for those on the approved list unless medically necessary. Some Formularies and programs are Sponsor-specific; therefore the pharmacist must depend on the online messaging to identify Formulary and Non-Formulary products. However, generic substitution of A-B rated equivalents is always permitted and, with physician approval, therapeutic substitution of lower cost brand or generic drugs is encouraged.

Pharmacy agrees that for all Express Scripts Sponsors and their Members, Express Scripts manufacturer agreements, therapeutic programs and Formularies take precedence over any agreements or programs to which the Pharmacy or Provider is a party. Pharmacy also agrees not to implement any substitution programs for Members of Express Scripts Prescription Drug Programs that are inconsistent with such programs.

5.2 Formulary, Preferred and Approved Products

The terms “Formulary,” “Preferred,” or “Approved,” refer to Formulary products. The Express Scripts Pharmacy & Therapeutics (P&T) Committee and Express Scripts Sponsors have selected these products as Formulary products and, as such, prefer the prescribing or dispensing of these particular medications even though a number of other therapeutic equivalents are available. These products are not necessarily maintenance therapy drugs. The Formulary status is based on overall prescription utilization and cost-effectiveness. With rare exceptions (*e.g.*, plans not covering omeprazole since it has an OTC equivalent), generic drugs are always considered to be on formulary.

The pharmacist should make his or her best effort to dispense the Formulary product, and except for generic substitution or for reasons of medical necessity, **should never switch a Member from the Preferred product to a Non-Preferred product when filling a prescription for any Express Scripts Member.** Since Preferred products may change from time to time, it is important to utilize the online messaging.

5.3 Additional Program Features

In cooperation with Sponsors and Prescribers, Express Scripts has implemented a Prescriber program for use by selected plans. This program is implemented when the dispensing pharmacist has not successfully converted a Non-Formulary prescription to a Formulary product. We have provided this procedure to assist the pharmacist in improving the Prescription Drug Program and reducing its cost.

We review the Member's medication profile and when we find a medication to be of a particular benefit, we consult with the Prescriber to determine if a change in medication is appropriate.

The Member and Pharmacy are notified via letter only when the physician has approved the change. In addition, should you transmit the Non-Formulary drug after the physician has authorized the Formulary product, you will receive the following online message: *"MD approved switch to- (name of Formulary drug)."* The physician will be prepared for your call. You will only need to confirm the number of authorized refills and the fact that the physician did authorize the Formulary product to replace the Non-Formulary product.

5.4 Closed Formularies

Closed Formularies cover only a select group of brand products as well as most generics. This type of Formulary is usually adopted by an HMO. Should you transmit a claim for a Non-Formulary drug, you will receive a *"(name of Formulary drug) is covered,"* or a *"drug not covered"* online rejection message, depending on whether or not a paired Formulary product is available. At this time you should contact the physician to change to a Formulary product. In the HMO environment, the physician is usually willing to change to a Formulary drug. **If the physician refuses to change the drug, the Member would have to pay full amount for the prescription.**

5.5 Select Preference Program

Partially closed Formularies utilize the pairing of Formulary and Non-Formulary products within certain therapeutic categories. Should you transmit the Non-Preferred product, you will receive an online rejection message stating: *"(name of Formulary drug) is covered."* At this time you should contact the physician to change to a Formulary

product. The physician will likely be willing to change to a Formulary drug. **If the physician refuses to change the drug, the Member would have to pay the full amount for the prescription.**

In some cases, the plan allows for the filling of the Non-Formulary product the first time the physician prescribes the drug for that Member. In this program, if you transmit a claim for a Non-Formulary drug, you will receive a paid claim message: “*Dsp (name of Formulary drug).*” At this time you should contact the physician to change to a Formulary product. Again, in a managed care environment, the physician is usually willing to change to a Formulary drug. The Member and physician will be informed that on subsequent fills only the Formulary product will be covered. The Non-Formulary product will be rejected on subsequent fills, and the Member will have to pay the full amount unless the physician authorizes you to change the prescription to the Formulary product.

5.6 Physician Preference

Should you transmit a Non-Formulary product, you will receive a paid claim message as follows: “*(Drug name) is non-formulary; use (name of Formulary alternative).*” At this time, you should contact the physician to change to a Formulary product.

If the physician refuses to change the drug, you can simply dispense the original claim and it will be covered for that fill for that Member. This program also has a physician education module. Should the physician subsequently allow the Formulary product, the Pharmacy and the Member will be notified so that arrangements can be made for the Formulary product.

Should you again transmit the Non-Formulary product after physician approval is obtained you will receive the online message: “*MD approved switch to (name of Formulary drug).*” The physician will be prepared for your call; therefore, you will only need to transcribe the new prescription and note the fact that the physician authorized the Formulary product to replace the Non-Formulary product.

5.7 Non-Formulary vs. Non-Benefit

Only drug exclusions are non-covered benefits. Non-Formulary drugs should always be handled as covered benefits, either through therapeutic interchange to Formulary drugs, or when allowed by resending the original claim via the online system.

5.8 Drug Choice Management Pharmacy Program

The “Preferred Product Program” is a formulary support mechanism designed to identify opportunities for cost savings associated with certain products in selected therapeutic classes.

The following list outlines the program:

1. A Member presents a prescription for a Non-Formulary product.
2. The prescription claim is transmitted to Express Scripts.
3. Express Scripts will return a message to you identifying the preferred drug product. At this point, the Pharmacy should attempt to contact the physician to obtain permission to change to this Formulary product. Should the physician not be available or refuse to switch to the Formulary product, the Pharmacy simply has to dispense the Non-Formulary product claim online to be reimbursed.
4. Express Scripts will attempt to contact the prescribing physician to request approval to change the prescription to the Formulary product for the next fill.
5. If the physician does not approve the change, no further action is taken and the Non-Formulary drug will continue to be covered for the Member.
6. If Express Scripts is unable to contact the physician and the Pharmacy refills the Non-Formulary product, Express Scripts will provide a message to the pharmacy indicating that the prescription is for a Non-Formulary product.
7. If the physician approves a change to the Formulary product, the approval is noted in the Member’s Express Scripts drug history file. Express Scripts will provide your phone or fax number to the doctor and the physician will then call you or fax you a new prescription for the Formulary drug. (We cannot guarantee that the physician will do this.)
8. Express Scripts will send a letter to the Member explaining that their physician has approved a change to the Formulary product. The Member will be told that a prescription for the new medication has been phoned or faxed to your Pharmacy and that they should contact you when they would like to have it dispensed.
9. The Member will then contact your Pharmacy to fill the new prescription for the Formulary drug when needed.
10. If the Member presents your Pharmacy with the Non-Formulary drug for a refill, the claim will be rejected. The online rejection message is: “*MD approved switch to (name of Formulary drug).*” Thus, you will be apprised of the name of the Formulary product and the fact that the physician has approved a change in advance. *Note: The Member should not take the Formulary and Non-Formulary products concurrently unless the Prescriber specifically instructs him/her to do so.*
11. If you cannot locate the new Formulary drug prescription, please call the physician for a new prescription. If the physician is not available, you should call the Express

Scripts Help Desk at **800-235-4357**. The Help Desk representative will authorize an interim supply of the Non-Formulary medication until the physician may be reached. The Member's copay will be waived for the interim supply.

As provided in the Pharmacy Provider Agreement, the pharmacist may not require the Member to pay more than the amount displayed in the Copay field.

5.9 Drug Choice Management Formulary Messages

Message Reason	Claim Status	Actual Message	What to Do
Non-Preferred Drug Dispensed	Rejected	<ul style="list-style-type: none"> MD approved switch to <u>(drug name)</u> 	Call MD for Preferred drug listed in the <u>(drug name)</u> portion of message. If MD unavailable or refuses to switch retransmit original Rx for Non-Preferred drug.
			Call MD for Preferred drug listed in the <u>(drug name)</u> portion of message for a lower copay or retransmit original Rx for Non-Preferred drug.
			MD pre-approved the Preferred drug listed in the <u>(drug name)</u> portion of the message. Confirm with MD.
			Call the MD only the Preferred drug listed in the <u>(drug name)</u> portion of the message is covered by the plan Sponsor.
Non-Preferred Drug Dispensed	Paid		On the next fill dispense the Preferred drug listed in the <u>(drug name)</u> portion of the message.
			On the next fill dispense the Preferred drug listed in the <u>(drug name)</u> portion of the message for a lower copay.
Preferred Drug Dispensed	Paid	<ul style="list-style-type: none"> Paid Claim – Preferred Drug dispensed Paid Claim - Formulary Drug dispensed 	No Action Required; Thanks for your support.

Section 6. Pharmacy Audits

6.1 Introduction

Express Scripts maintains an ongoing Pharmacy audit program as a service to our plan Sponsors as well as to assist network Pharmacies in complying with the terms of their Pharmacy Provider Agreement.

For up to five years from the date a prescription is dispensed to an Express Scripts covered Member (whether or not the Sponsor is still an Express Scripts Inc. Sponsor), the Pharmacy must permit Express Scripts or a third party authorized by Express Scripts to inspect, review, audit, and reproduce, during regular business hours and without charge, any business, financial, and prescription record maintained by the Pharmacy pertaining to Express Scripts Members or the Pharmacy Provider Agreement. In addition, the Pharmacy must cooperate and participate with Express Scripts in any and all quality assurance procedures, peer review, credentialing processes, audit systems, and any complaint resolution procedures established by Express Scripts.

6.2 Audit Triggers

The Express Scripts audit program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Generic, Multi-Source Brand, and Single Source Brand fill rates
- Generic substitution
- Dispense As Written (DAW) code usage
- Average claim amount
- Quantity dispensed versus days supply and FDA guidelines
- Quantity dispensed versus covered Member benefit plan limitations
- Usual and Customary retail prices
- Reversals
- Compounding
- Controlled Substance dispensing
- Formulary Compliance
- Prescriber Profiling

Other non-statistical audit triggers include, but are not limited to:

- Referral from plan Members
- Referral from plan Sponsors
- Random selection

6.3 Audit Programs

Express Scripts utilizes the following types of audit programs. This list is not intended to be all inclusive:

- **On-site Audits:** The Express Scripts auditor visits the Pharmacy to perform a comprehensive review of claims and quality assurance documentation, procedures, and credentialing.
- **Written Desk Audits:** Targeted documentation is requested from the Pharmacy and reviewed with in-house Pharmacy dispensing information.
- **Next Day Online Desk Audits:** Online claims from the previous day are automatically flagged utilizing predetermined criteria and subjected to audit procedures.
- **Physician Audits:** Targeted claims information submitted by the Pharmacy is comprehensively verified by the prescribing physician.
- **Member Audits:** Prescription receipt and specific claim information are substantiated through Member written verification.
- **Purchase Verification:** Quantities of medications submitted by pharmacies are verified from information provided by wholesalers.

On-site audits are normally scheduled with two weeks notice. However, under certain circumstances, less or no advance notice may be given.

NOTE: If any claim was paid based on incorrectly submitted data, Express Scripts will disallow reimbursement for that claim.

Express Scripts requires contracted pharmacies to comply with all provisions of the Provider Agreement and the Network Guidelines. Violations will be aggressively investigated and resolved by our Network Audit & Compliance Department. Pharmacies found to be in material violation of the Provider Agreement and the Network Guidelines will be subject to disciplinary actions as determined by the Pharmacy Disciplinary Action Committee (PDAC). Potential disciplinary actions include, but are not limited to, probation and assessment of fines and follow-up audit, suspension of status as an ESI Network Pharmacy, and termination of the Provider Agreement. To recoup the additional costs of investigating and enforcing the Provider Agreement, Express Scripts charges a Compliance Enforcement fee of \$50 per hour up to a maximum of \$1,500 to pharmacies whose actions cause such investigations.

6.4 Audit Guidelines

- **Quantities Dispensed:** Always submit the quantity prescribed, and submit the **exact** calculation of days supply per the Prescriber's dosing instructions. "As directed" or "PRN" Prescriber directions must be clarified with Prescriber or Member and an

accurate days supply submitted. Verifying pharmacist must document and initial the information on the prescription.

- **Dispense As Written Codes:** Submission of DAW 1 or 2 codes must be supported by hard copy prescription documentation on the original prescription, the telephone order, or prescription update, and is subject to local regulations. Express Scripts will disallow brand reimbursement for any claim submitted with missing or incorrect DAW Codes.
- **Formulary Compliance:** The pharmacist should make his or her best efforts to comply with Express Scripts Formularies, respond to messaging, and dispense the Express Scripts Formulary product. **Except for generic substitution or reasons of medical necessity, never switch from the Formulary product to the Non-Formulary product when filling a prescription for an Express Scripts Member.** Should a Formulary product be switched to a product other than a generic for any reason other than documented medical necessity, reimbursement for the Non-Formulary product may be disallowed.
- **Signature Logs:** All prescription claims paid by Express Scripts are subject to signature log verification. Claims not properly supported by documentation verifying receipt of the medication will be reversed on audit (see signature log below).
- **Compliance with Audit Procedures:** Failure to comply with any Express Scripts quality assurance or audit process will result in reversal of all applicable paid claims and may result in termination of the Pharmacy Provider Agreement. Express Scripts has the right to offset against any amounts owing to Provider any such amounts owing or potentially owed to Express Scripts for discrepant or unsubstantiated claims or other audit-related costs. The methods used to collect amounts due hereunder to Express Scripts as a result of audit discrepancies or unsubstantiated claims may include, but are not limited to, an offset against Provider's account payable. **Audit Response:** Pharmacies are given the opportunity to respond to audit findings within 30 days from receipt of the final audit report. At its sole discretion, Express Scripts may consider certain follow-up documentation. Findings regarding missing or incorrect Dispense As Written Codes, days supply or quantity, and Usual and Customary Retail Pricing are not subject to response.

6.5 Signature Log Requirements

Each Pharmacy must maintain a signature log for all claims in chronological order as prescriptions are received by the Member, including off-site delivery, with the following information:

Name of Patient	Fill Date	Rx Number	Member Identification Number	Third-party Program	Signature of Member (or Legal Representative)	Date Rx is picked up
John Doe	1/2/97	123456	123456789-00	Express Scripts	J. Doe	1/3/97

The signature log must be kept for five years from the date a prescription is dispensed.

Section 7. HIPAA

(Heath Insurance Portability & Accountability Act)

7.1 Trading Partner Provisions

Express Scripts, Inc. or one or more of its subsidiaries (“ESI”) and [Pharmacy(ies)] are “trading partners” as that term is understood under the rules promulgated by the United States Department of Health and Human Services (“HHS”) regarding standard electronic transaction under 45 CFR Part 160 and 162 (“HIPAA Rules”), which require Pharmacy(ies) and ESI to enter into a “trading partner agreement” to comply with applicable sections of the HIPAA Rules prior to applicable Compliance Dates.

The following “trading partner” terms are incorporated into any and all Provider Agreements between ESI and a Pharmacy for purposes of compliance with the HIPAA standard transactions rules.

1. **“Compliance Date(s)”** shall mean the date established by HHS or the United States Congress for effective date of applicability and enforceability of the HIPAA Rules. The Compliance Date for the standard transactions currently is October 16, 2002, unless otherwise extended in accordance with law by virtue of a duly filed request for extension.
2. **Standard Transactions.** The HIPAA Rules provide for certain transaction standards for transfer of data between trading partners. Pharmacy shall submit to ESI, and ESI will be prepared to accept from Pharmacy(ies) the following:
 - The National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5 Release 1.
 - The ASC X12N 835 – Health Care Claim Payment/Advice Version 4010, May 2000, Washington Publishing Company, 00410X091.

The parties each hereby agree that it shall not change any definition, data condition or use of a data element or segment in a standard, add any data elements or segment to the maximum defined data set, use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the implementation specification, or change the meaning or intent of the implementation specification.

3. **Effective Date.** The above “trading partner” provisions shall commence as of the earliest applicable Compliance Date and shall be coterminous with the applicable Provider Agreement.

Section 8. Pharmacy Care Alliance Medicare Approved Prescription Drug Discount Card

8.1 Introduction

In 2003, the National Association of chain Drug Stores (NACDS) and Express Scripts, Inc. united under the Pharmacy Care Alliance umbrella to create the Pharmacy Care Alliance Prescription Drug Discount Card (the PCA Card). The goal of the PCA Card was (and is) to help Medicare beneficiaries get the most from the 2003 Medicare law authorizing prescription drug discounts to Medicare-eligible patients. However, the PCA card and all other Medicare Approved Discount Drug Card programs will be superseded by Medicare Part D beginning in 2006. (See Section 9 for details on Medicare Part D.)

Unlike many other Medicare discount cards, which focus on prescription medication primarily as a product, the PCA card demonstrates an appreciation for the valuable services pharmacists provide to ensure that patients receive optimal benefit from their medication therapy.

The PCA card is designed to provide Medicare-eligible beneficiaries with competitive discounts on medications while helping them maintain their relationships with the pharmacists they trust. The PCA card offers beneficiaries the ability to obtain a 90-day supply of medication at select local pharmacies.

Enrollment for the PCA Card began May 3, 2004 and the effective date was June 1, 2004.

8.2 PCA Program Features and Benefits

Following is information you should know about the PCA Drug Card program.

Features

- Two card choices:
 - **PCA Card #1**, which offers beneficiaries a \$30 enrollment fee with Rx discounts of 20 – 40%. This card targets beneficiaries who fill two or more prescriptions per month.
 - **PCA Card #2**, which offers a \$19 enrollment fee with discounts of 10-50%. Beneficiaries who select this card option will pay up to \$1 more per prescription than those who choose Card #1. (This card targets beneficiaries who fill fewer than two prescriptions per month.)
- Enrollment fees for Discount Card beneficiaries (those who do not qualify for the Medicare \$600 credit) are collected by the pharmacy with the first Rx they receive after their effective date. PCA will collect the enrollment fee from the pharmacy.

- The enrollment fee for \$600 Credit beneficiaries is billed to CMS.

- **Benefits**

The following table outlines the benefits of the PCA Medicare program.

Features	Benefits
<ul style="list-style-type: none"> • Pharmacy Centric Program 	Allows beneficiaries to continue their relationship with neighborhood pharmacists who can assist them in making sound clinical and cost-effective decisions.
<ul style="list-style-type: none"> • More than 43,000 network pharmacies 	Retail access for beneficiaries
<ul style="list-style-type: none"> • Retail pharmacies may dispense up to a 90-day supply 	Beneficiary choice of retail or mail pharmacy Beneficiary choice of 30, 60, or 90-day supply
<ul style="list-style-type: none"> • Multiple enrollment vehicles – phone, fax, mail, website, and in pharmacies 	Beneficiary convenience Multiple communication channels
<ul style="list-style-type: none"> • Enrollment fee is paid with first Rx 	Convenient, beneficiary-friendly enrollment process Beneficiaries do not have to pay out-of-pocket up-front
<ul style="list-style-type: none"> • PCA handles all operational services – enrollment processing, card production, call center 	One touch-point for beneficiaries
<ul style="list-style-type: none"> • Savings education programs • Total rebate amounts passed to beneficiaries at the point of sale • Competitive retail network rate 	Enables beneficiaries to stretch their pharmacy dollar

8.3 Enrollment Eligibility

Role of CMS

The role of the Centers for Medicare and Medicaid (CMS) is to determine the eligibility of a Medicare beneficiary for a **Medicare Approved Discount Card Program** and the **Additional Assistance Program in paying for their Prescription Drugs**.

All enrollment applications properly completed and with the signature of the applicant will be sent electronically (by fax for those requiring a signature) to CMS for determination of eligibility. CMS will process the application and inform the sponsor as of the enrollee's eligibility within 48 hours for a PCA Drug Card application and 72 hours for Additional Assistance applications.

Who is Eligible for Enrollment?

Beneficiaries are eligible to enroll in a Medicare Approved Discount Drug Card Program based on the following:

1. They are enrolled in Medicare Part A and/or Medicare Part B.
2. They are NOT currently receiving Medicaid outpatient prescription drug coverage at the time of enrollment.

3. There are no income qualifications. They enroll in only one Medicare Approved Discount Drug Card Program.
(They may enroll in a different Medicare Approved Discount card program during the renewal process November 15 –December 31.)
4. Under certain conditions members may enroll in a different Medicare Approved Discount Card Program other than during the renewal time frame.

Beneficiaries are eligible to enroll in a Medicare Approved Discount Drug Card AND Additional Assistance Program (\$600.00 credit) if they:

1. Are enrolled in Medicare Part A and/or Medicare Part B.
2. Are not enrolled in any other health insurance with prescription drug coverage except a Medicare + Choice plan or Medigap plan.
3. Do not have prescription drug coverage under a health plan or individual health insurance policy.
4. Do not have VA or DoD Prescription Drug Coverage.
5. Do not have coverage through FEHBP.
6. Have an annual income less than 135 % FPL*
 - a. Eligibility is self declared
 - b. CMS authorized to verify eligibility

100% of Federal Poverty Level 2005 Income Level Requirements		
One-Person Household	Two-Person Household	State(s)
\$ 9,570	\$12,380	Continental United States
\$11,010	\$14,760	Hawaii
\$11,950	\$16,030	Alaska

135% of Federal Poverty Level 2005 Income Level Requirements		
One-Person Household	Two-Person Household	State(s)
\$12,919	\$17,320	Continental United States
\$14,864	\$19,926	Hawaii
\$16,133	\$21,641	Alaska

Co-Insurance (Copay)

All Medicare beneficiaries with the \$600 Medicare credit will be charged co-insurance (copay) for prescription drugs at the pharmacy. The following table illustrates the amount of the copayment they will pay based on their income levels.

Co-Insurance (Copay) Breakdown		
One-Person Household	Two-Person Household	Amount of Copay
\$12,919 or less but more than \$9,570	\$17,320 or less, but more than \$12,919	10%
\$9,570 or less	\$12,919 or less	5%

These figures will be updated in February 2005. Medicare will pay the annual enrollment fee for beneficiaries who qualify for the \$600 Medicare credit.

Here is an example to illustrate how the copay works: A beneficiary with an income of \$11,600 wants to purchase a discounted drug for \$100 with his Medicare approved drug discount card and his \$600 credit. The normal price for the drug is \$120, but the discounted price is \$100. He presents his *Discount Card*, pays \$10 (10% copay) and \$90 is subtracted from his \$600 credit. He has \$510 credit remaining.

Role of Pharmacy

The role of the pharmacy is to answer questions that Medicare beneficiaries may ask about the Interim Medicare Discount Card Program. To help you in this effort, Section 8 of the Pharmacy Care Alliance (PCA) Medicare-Approved Discount Card Reference Manual (available on the “For Pharmacists” Portal of the ESI website www.express-scripts.com) contains Medicare Approved sample scripts addressing potential questions that may be asked by Medicare beneficiaries and other likely Q & As.

8.4 Enrollment Forms

Enrollment forms are designed primarily by CMS with little variation allowed. There are two separate enrollment forms for the two different enrollment types established by Medicare. Medicare beneficiaries may be eligible to enroll in either the **Medicare Approved Discount Card program** or the **Additional Assistance program** which provides a \$ 600.00 credit to help beneficiaries pay for their prescriptions. CMS will allow members to enroll through December 31, 2005.

To determine eligibility for the \$600.00 Medicare credit, Medicare verifies the beneficiary’s income and, if married, the couple’s combined income. Income must be less than 135% of the Federal Poverty Level (FPL). The actual dollar limits for 2004 are the same in all states except Alaska and Hawaii. The differences are displayed on the enrollment form.

In reviewing enrollment forms, Medicare beneficiaries may find the question about their current participation in the Medicaid program confusing. They may need clarification on

the Enrollment Form under Step One to answer the second statement, “I DO NOT have outpatient prescription drug benefits under my State Medicaid Program.”

Check “Yes” if a beneficiary DOES NOT have outpatient prescription drug benefits under a State Medicaid Program.

Check “No” if a beneficiary DOES have outpatient prescription drug benefits under a State Medicaid Program.

(Copies of the enrollment forms are included in the PCA Medicare-Approved Discount Card Reference Manual, available on the Pharmacy portal of the ESI website www.express-scripts.com.)

8.5 Enrollment Options

There are a number of ways a Medicare beneficiary may enroll in the PCA Card or the PCA Card program with a \$600.00 Medicare credit.

Beneficiaries may:

1. Mail completed enrollment forms to Pharmacy Care Alliance, P.O. Box 22079, Rochester, NY 14692-9988.
2. Call **1.800.PCA.7015 (1.800.722.7015)** to enroll in the PCA Card program by phone. The Medicare Additional Assistance (\$600.00 credit) enrollment process, however, cannot be done over the telephone. An original Medicare beneficiary signature is required by Medicare for enrollment in this program.
3. Log on to www.PCAcard.com and follow the simple prompts for enrolling online. Again, the Medicare \$600 credit enrollment form may be completed online but must be printed out and mailed because it requires a signature.
4. Obtain an enrollment application and fax the completed form to **1.866.745.8595**.
5. Call **1.800.PCA.7015 (1.800.722.7015)** to request a pre-enrollment packet containing all the necessary information about the program, along with an enrollment application form that can be completed and mailed to Pharmacy Care Alliance. Beneficiaries may also choose to fax back the application to the above fax number.
6. Stop at their local participating network pharmacy for information, complete an application and give it to the pharmacy staff for processing.

8.6 Enrollment Fees

CMS allows for an enrollment fee of up to \$30.00 for the Medicare Approved Discount Card programs. The PCA Card program allows for either a \$30.00 or \$19.00 enrollment fee option.

- PCA Card #1 includes a \$30.00 enrollment fee and offers discounts for beneficiaries of 10-50%. This program targets beneficiaries who fill two or more scripts per month.
- PCA Card # 2 includes a \$19.00 enrollment fee and offers discounts of 10 – 50 %. Beneficiaries will pay up to \$1.00 more per prescription than PCA card #1. This program targets beneficiaries who fill fewer than two scripts per month.

The enrollment fee is included in the patient copay and adjudicated with the first prescription the beneficiary receives after their effective date. PCA will collect the enrollment fee from the pharmacy. For beneficiaries with a Medicare \$ 600.00 credit, the enrollment fee is billed to CMS.

Enrollment fees are **not** collected at the time of enrollment.

8.7 Enrollment Process

When PCA receives an enrollment application, it is submitted to CMS in 48 to 72 hours of receipt by PCA.

PCA Rejects

If PCA rejects an enrollment application during pre-screening, three (3) attempts are made to reach the beneficiary by phone.

The Medicare-approved script if the beneficiary is NOT available is as follows:

- “My name is <NAME> with the Pharmacy Care Alliance Medicare Approved Drug Discount Card. We recently received your enrollment form, but we were unable to process it.
- Please call us at your earliest convenience at **800.PCA.7015** – that’s **800.722.7015**; TTY users should call 1.866.735.8556. We’re open 24 hours a day, 7 days a week, and we’d like to make sure your enrollment form is processed quickly. That number again is **800.PCA.7015**; or TTY users can call 1.866.735.8556. Thank you.

If the beneficiary does not return our call, a letter is sent letting them know that their enrollment application can not be processed. This letter also requests they please contact PCA so their enrollment eligibility application is not further delayed.

Denial Letter

If an enrollment application is rejected by CMS, PCA mails a denial letter to the beneficiary notifying them of the CMS denial. The denial letter is mailed within five days and provides the beneficiary with information on how to request “reconsideration” of their enrollment application. If the beneficiary believes they are eligible they should follow the reconsideration process outlined in the letter from PCA. At this point the beneficiary will work directly with CMS.

Reconsideration

Reconsiderations must be filed within 60 days from the date of notice of a negative eligibility determination (denial letter), unless the beneficiary can demonstrate good cause for why the 60-day time frame should be extended. The request must be sent to the Medicare Drug Card Reconsideration Contractor by one of the following methods:

1. **TELEPHONE:** Call the Medicare Drug Card Reconsideration Contractor at 800.567.0757. The beneficiary should have the denial letter with them when they call.
2. **MAIL:** A copy of the denial letter and request should be mailed to:
Medicare Drug Card Reconsideration Contractor
BOWLING GREEN STATION
PO BOX 5042
NEW YORK, NY 10274-5042
3. **FAX:** A copy of the denial letter and request may be faxed to the Medicare Drug Card Reconsideration Contractor at 1.917.228.8600.
4. Beneficiaries should keep a copy of the denial letter and request for their records.

Medicare Approval

Final eligibility determination is made by CMS.

- Notification will be made back to the sponsor within 48 to 72 hours of receipt of application.
- If eligible, ID card & member manual is mailed to enrollee within 5 days of receipt of eligibility.

Help Desk Number for PCA Medicare Calls

ESI has made a special toll-free number available for your Medicare-related questions. If you need assistance regarding a PCA Medicare claim, please call the **PCA Help Desk at 866.533.8515**. You will reach a PCA Medicare trained agent who will be happy to assist you.

Please **DO NOT** contact your existing Express Scripts Help Desk number for PCA Medicare-related questions, as these agents are not equipped to handle Medicare-related calls. Should you dial your regular Express Scripts Help Desk number in error, please select the new IVR option for Medicare claims so that your call can be re-directed to the agents who can best serve your needs.

Medicare Determines Eligibility

Final eligibility determination is made by CMS.

- Notification will be made back to the sponsor within 48 to 72 hours of receipt of application.
- If eligible, ID card & beneficiary manual is mailed to enrollee within 5 days of receipt of eligibility.

If an enrollment application is rejected by CMS, PCA mails a denial letter to the beneficiary notifying them of the CMS denial. The denial letter is mailed within five days of PCA's receipt of rejection, and provides the beneficiary with information on how to request "reconsideration" of their enrollment application. If the beneficiary believes they are eligible they should follow the reconsideration process outlined in the letter from PCA. At this point the beneficiary will work directly with CMS.

8.8 Grievance Process

What is a Grievance?

A **Grievance** is an escalated complaint from a beneficiary about a **specific event** relating to the Medicare Discount Card that has occurred within the last 60 days.

What is the difference between a Complaint and a Grievance?

A Complaint is a beneficiary expressing general dissatisfaction. HOWEVER, a **Grievance** is considered an escalated complaint about a **specific event** relating to the **Medicare Discount Card** that has occurred **within the last 60 days**.

Below are some examples of the difference between a Complaint and a Grievance:

Complaint:	Grievance:
Beneficiary is dissatisfied with the discount that he receives on medications when using his Medicare Discount Card	Beneficiary is dissatisfied with the discount that he received for his recent Zocor prescription under his Medicare discount Card
Beneficiary feels that agents are not friendly when he calls with questions about his Medicare Discount Card coverage.	Beneficiary felt that the agent to whom he spoke earlier today about his Medicare Discount Card coverage was not friendly

A grievance may also include a dispute concerning our failure to offer discounts on particular covered discount card drugs, ensuring pharmacies charge a certain price for covered discount drugs, applying the \$600 Medicare credit to an enrollee under the program, or correctly calculating the coinsurance amount for a covered discount card drug obtained by an enrollee who qualifies for Additional Assistance.

If the card enrollee has an issue that is encompassed in the above mentioned criteria and is still not satisfied, ask if the enrollee would like to file a grievance.

If the enrollee wants to file a grievance, make sure it meets the following criteria:

- Event causing dissatisfaction must have occurred within the past 60 calendar days
- Event must be related to PCA Drug Discount Card and not other health insurance, non-Express Scripts co-marketed discount cards, etc.

Please note: If the card enrollee demands information on how to file a grievance, the information must be provided.

Instruct the enrollee about the following method options:

- A grievance can be placed by phone at 866-533-8512, Monday-Friday 8am-5pm central standard time.
- A grievance can be placed in writing at the following address:
Director of Grievances
Pharmacy Care Alliance
PO Box 66517
Saint Louis, MO 63166-6517

The enrollee should include their name, ID number, date of birth, address, contact phone number, and as much information as possible concerning the event that caused the dissatisfaction.

8.9 Prescription Processing

ESI prescription processing steps will be as follows: BIN #003858, PCN A4, RxGroup PC5A. Claims must be submitted in NCPDP v5.1 format.

Processing Steps

Step 1	Enter RxBIN: 003858
Step 2	Enter RxPCN: A4
Step 3	Enter RxGrp: PC5A
Step 4	Enter Cardholder ID
Step 5	Enter Date of Birth



CMS Requirements

a. Generic Cost Savings

When a generic drug is available, the pharmacist is required to provide beneficiaries with the price savings.

The generic savings delta to be provided to the pharmacy when a brand drug is dispensed will appear in the Additional Message Information field (526-FQ).
 “CMS estimated brand/generic difference: XXX.XX.”

b. Medicare \$600 Credit Balance Available to Patient

The \$600 Medicare balance must be communicated to beneficiaries receiving Additional Assistance with the adjudication of each prescription.

Express Scripts will provide this balance to the pharmacy in the Remaining Benefit Amount field (514-FE).

Collection of Enrollment Fee

Enrollment Fee (for beneficiaries enrolled in the PCA Drug Card): Member will be charged an enrollment fee on the first eligible prescription. The enrollment fee will be added to the member copay.

The enrollment fee will be deducted from the pharmacy total payable amount and indicated as a negative balance in the Total Amount Paid field (509-F9). The Additional Message field (526-FQ) will state: \$XX enrollment fee applied to member copay.

8.10 Drug Coverage

Based on CMS requirements, covered Items are **all Legend Products** except the following:

- Cosmetic or Dermatology Agents
- Weight Management Products
- Vitamins, except prenatal and fluoride

- Barbiturates
- Benzodiazepines
- Medicare Part B Products*
- Durable Medical Equipment
- Agents for the symptomatic relief of Cough and Cold
- Contraceptives, except oral contraceptives
- Fertility Agents and Yohimbine
- Compounded Prescriptions
- Homeopathic Agents
- OTC Products, except diabetic supplies (syringes, needles, devices, pump supplies, swabs and gauze)

* Medicare Part B drugs that are denied by the discount card can be overridden to pay if the member does not have Medicare Part B coverage or if Medicare Part B denied the claim with an override of 444.

(The above list may be subject to change per CMS. Check website www.cms.hhs.gov/)

8.11 Reversal of First Rx w/Enrollment Fee

If a claim is reversed that originally included the beneficiary's enrollment fee, the enrollment fee will be reversed as well. That is, when the claim is reversed, Express Scripts will reset the member's eligibility file to indicate that the member still owes the enrollment fee and it will be collected on the next adjudicated claim.

8.12 Days Supply Limitation

The plan allows up to a 90-day supply at retail or mail.

8.13 Refill Too Soon/Vacation Supply

A Refill Too Soon edit will cause claims to reject if 25% or more of the days supply is remaining. Call the Help Desk at 1.866.533.8515 for emergency/vacation supply requests.

8.14 Sample Claims

Claim Paid at Pharmacy Contracted Rate w/\$30.00 Enrollment Fee

– Billed Transaction

Field #	Field Name	Dollar Amt
409-D9	Ingredient Cost Submitted	15.00
412-DC	Dispensing Fee Submitted	2.00
426-DQ	Usual & Customary	25.00
430-DU	Gross Amount Due	N/A
423-DN	Basis of Cost Determination	N/A

⇒ Express Scripts will not edit or review the Gross Amount Due or Basis of Cost Determination fields. The pharmacy may enter a value in those fields, however, ESI will not edit the values

– Response Transaction

Total Amount Paid Includes \$1.00 Withhold, \$30 Enrollment Fee Reduction, & \$4.00 Rebate

Field #	Field Name	Dollar Amt
505-F5	Patient Pay Amount	44.00
506-F6	Ingredient Cost Paid	15.00
507-F7	Dispensing Fee Paid	2.00
509-F9	Total Amount Paid	-27.00
522-FM	Basis of Reimbursement Determination	8

⇒ The Patient Pay Amount includes: The \$17.00 cost of the drug + \$1.00 withhold + \$30.00 enrollment fee (\$48.00) minus the \$4.00 rebate = \$44.00

⇒ The Total Amount Paid includes: Subtract from the payment to the pharmacy the \$30.00 enrollment fee + \$1.00 withhold (-\$31.00) and add the \$4.00 rebate = -\$27.00

Claim Paid at Pharmacy Submitted U&C

– Billed Transaction

Field #	Field Name	Dollar Amt
409-D9	Ingredient Cost Submitted	15.00
412-DC	Dispensing Fee Submitted	2.00
426-DQ	Usual & Customary	12.00
430-DU	Gross Amount Due	N/A
423-DN	Basis of Cost Determination	N/A

– Response Transaction

Ingredient Cost Paid Indicates \$1.00 U&C Reduction

Total amount Paid Includes \$4.00 Rebate

Field #	Field Name	Dollar Amt
505-F5	Patient Pay Amount	7.00
506-F6	Ingredient Cost Paid	11.00
507-F7	Dispensing Fee Paid	0.00
509-F9	Total Amount Paid	4.00
522-FM	Basis of Reimbursement Determination	4

- ⇒ The Ingredient Cost Paid will be the U&C cost, therefore, the U&C is reduced by \$1.00. U&C \$12.00 minus \$1.00 = \$11.00
- ⇒ The Patient Pay Amount includes: The \$11.00 cost of the drug minus the \$4.00 rebate = \$7.00
- ⇒ The Total Amount Paid includes: The \$4.00 rebate

Claim Paid at Pharmacy Contracted Rate w/\$30.00 Enrollment Fee & 5% Member Copay

– Billed Transaction

Field #	Field Name	Dollar Amt
409-D9	Ingredient Cost Submitted	18
412-DC	Dispensing Fee Submitted	2.00
426-DQ	Usual & Customary	25.00
430-DU	Gross Amount Due	N/A
423-DN	Basis of Cost Determination	N/A

– Response Transaction

Total Amount Paid Includes \$1.00 Withhold & \$4.00 Rebate

Field #	Field Name	Dollar Amt
505-F5	Patient Pay Amount	.85
506-F6	Ingredient Cost Paid	18.00
507-F7	Dispensing Fee Paid	2.00
509-F9	Total Amount Paid	19.15
522-FM	Basis of Reimbursement Determination	8
514-FE	Remaining Benefit Amount	583.85

- ⇒ Patient Pay Amount includes:
 - 5% copay = \$20 ingredient cost - \$4.00 rebate (\$16.00) + \$1.00 withhold (\$17.00) X 5% = .85 cents
 - Amount applied to TA balance = \$16.15

- ⇒ Remaining Benefit Amount = \$600.00 TA - \$16.15 = **\$583.85**
- ⇒ Total Amount Paid includes: \$20.00 cost of the drug due the pharmacy -
.85 Patient Pay Amount = \$19.15

Additional sample claims are included in the PCA Medicare Approved Discount Card Reference Manual available on the Pharmacy Portal at www.express-scripts.com

8.15 Payment and Remittance

Pharmacy Reimbursement Schedule

- PCA claims appear on regular consolidated ESI remittances.
- Carrier ID is DPS PC5.
- Enrollment fee will be deducted at a claim level and represented as a negative amount in the Amount Paid field.
- Withhold amount will be deducted at a claim level and represented as a net negative amount against the POS rebate payment to the pharmacy.
- Pharmacy is always paid its contractual rate.

Remittance Advice (PCA Drug Card Program)

Medicare Beneficiary Enrollment Fee - The enrollment fee will reduce the pharmacy payment at the pharmacy claim/level. The Additional Message Information field 526 FQ will indicate the beneficiary's enrollment fee as either \$19.00 or \$30.00. (A sample of the Remittance Advice for the PCA Medicare Approved Drug Discount Card Program is included in the reference manual.)

8.16 Web Services

The Pharmacy Care Alliance Medicare Approved Drug Discount Card offers an informational, consumer-friendly website (**PCAcard.com**). Visitors to the website may:

- Learn about the PCA Medicare Approved Drug Discount Card
- Submit or print an enrollment application form
- Print copies of the pre-enrollment kit or Member Handbook
- Check the status of a previously submitted enrollment form
- Get drug prices
- Locate a neighborhood network pharmacy
- Find general information about mail service
- Find contact information

Copies of sample website screens that beneficiaries will find on the PCA website, along with additional information, can be found in the PCA Reference Manual on the Pharmacy Portal of the Express Scripts website.

Section 9. Medicare Part D Prescription Drug Program

9.1 Introduction

Prior to the implementation of the Medicare Modernization Act, Medicare was identified as:

- Part A:
 - Covers inpatient care (e.g. hospital, skilled nursing facility care, home health care, hospice).
- Part B:
 - Covers outpatient care (e.g. Medical visits, DME, a few prescription drugs)
- Part C:
 - Managed care (enacted as Medicare + Choice in 1997, now called Medicare Advantage)

For the first time, a portion of the Medicare administration has been completely delegated to the private sector.

Title 1 of the Medicare Prescription Drug Improvement, and Modernization Act of 2003, which was signed into law on December 8, 2003, created a new Medicare Drug Benefit – Part D. The law established an Outpatient Prescription Drug Benefit for Seniors and Qualified Disabled Persons.

- Part D:
 - New with Medicare Modernization Act (MMA) Prescription Benefit Plan
 - New voluntary prescription drug benefit

9.2 Eligibility and Enrollment

Beneficiaries are eligible to enroll in Medicare Part D if:

- They have Medicare Part A and/or Part B, are age 65 or disabled, and/or have End-Stage Renal Disease.

Enrollment in Part D:

- Is voluntary; Medicare beneficiaries are not required to participate.
- Initial enrollment occurs from November 15, 2005 through May 15, 2006. Beneficiaries will not be enrolled automatically; they must decide to sign up for a drug plan.
- Following the initial enrollment period, open enrollment will be offered each year from November 15 through December 31.
- Will be ongoing for a seven-month time frame:
 - Beginning 3 months before the beneficiary turns 65

- Includes month in which the beneficiary turns 65.
- Continues for 3 months after the beneficiary turns 65.

Enrollment of Special Groups

- Auto-enrollment of Dual Eligibles (Medicaid and Medicare) began in October 2005.
- Supplemental Security Income (SSI) beneficiaries receiving SSI assistance will be auto-enrolled if they don't choose a Medicare Part D Plan by May 15, 2006.
- Dual-eligible and limited income beneficiaries may switch from their Medicare Part D plans to another plan before January 1, 2006 and every 30 days thereafter.
- Beneficiaries may switch from their auto-assigned plans before January 1, 2006 and every 30 days thereafter.
- Limited Income Beneficiaries: There is a two-step enrollment process for limited income subsidy program beneficiaries that began in July 2005 by Medicare.
- Medicaid coverage will be terminated December 31, 2005 for Medicare Part D covered products. Beneficiaries may verify coverage at <http://www.medicare.gov/medicarerereform/drugbenefit.asp>

Exceptions to Enrollment Outside the Annual Nov.15 – Dec. 31 Enrollment Period

- Permanent move out of plan service area
- Individual entering, residing, or leaving a long term care (LTC) facility
- Involuntary loss, reduction, or non notification of creditable coverage

9.3 Medicare Part D Drug Plans

Part D Plans include:

- Prescription Drug Plans (PDPs): Private stand alone plans that offer drug only coverage.
- Medicare Advantage Plans (MA-PDs): Plans that offer both prescription drug and health coverage. (e.g. HMOs PPOs)

CMS provides Medicare-eligible beneficiaries with information about plans in their area as well as nationally to help them determine which plan will best meet their needs. This information can be found on the medicare.gov website (see illustration below).

The Medicare Prescription Drug Plan Finder:

- Helps Medicare beneficiaries with plan selection go to www.medicare.gov
- This web tool will offer individualized reports based on drugs.
- Gives monthly and annual cost estimates based on drugs and plan selected.
- Drugs that have a prior authorization or are part of step therapy should be flagged.



9.4 Non-Medicare Part D Coverage

Creditable Coverage

A creditable plan is a qualified prescription drug plan offering what is called “creditable coverage” (*i.e.*, coverage must be as good as the standard CMS plan).

- CMS requires all creditable coverage plans to notify beneficiary by November 15th each year to confirm the plan is creditable. Beneficiary ***must keep*** copy of letter
- There is no penalty if beneficiary moves from a “creditable coverage” to Medicare Part D plan as long as it is done within 63 days from term of creditable coverage plan, and beneficiary is able to provide a copy of current letter of “creditable coverage” from plan

Wrap Plans

Medicare refers to “secondary payers” as “WRAP” plans. For a variety of reasons, health plans or employers may wish to supplement Medicare Part D drug coverage and fill in some of the “gaps,” such as coverage and/or copay. This benefit could be provided by employers or unions, similar to how these plans work today.

Creditable Coverage plans and Wrap plans are not Medicare Part D plans.

9.5 Covered & Non-Covered Drugs

Medicare Part D requires that at least two products in each therapeutic classification, plus all or nearly all products in the following six (6) drug classes be included in Part D plan formularies:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Anticancer
- Immunosuppressants
- HIV/AIDS

Formularies may include Quantity Level Limits (QLL), Step Therapy and Prior Authorization. Processing of these claims through ESI is business as usual.

Medicare Part D Non-Covered Drugs

- Agents when used for anorexia, weight loss, or weight gain
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride
- Non-Prescription Drugs (OTCs)
- Barbiturates
- Benzodiazepines
- Any drug for which payment would be available under Medicare part A or part B for that individual

9.6 Using Out-of-Network Pharmacies

The Medicare Modernization Act (MMA) policies require that Medicare Part D plans allow beneficiaries to obtain prescriptions at non-network pharmacies. ESI recommends that plan sponsors restrict and/or penalize out-of-network use.

9.7 Transition Period

The Medicare Part D program allows beneficiaries a brief transition period during which they may continue to receive drugs they may currently be taking that are not included on their new Medicare Part D plan formulary.

Retail

Beneficiaries will be able to receive a temporary one-month fill of non-formulary medication at retail if the medication is a chronic medication (as determined by First DataBank) and is a Part D eligible medication being filled within the first 90 days of the beneficiary's enrollment in a plan.

- ESI's system edits will handle the first fill of a non-formulary medication, but will return a reject code after the initial fill or after the allotted time expires. A Prior Authorization (PA) will be required after the initial fill if the plan allows.
- ESI will follow up with a member letter explaining that this is a temporary fill and requesting that the member have their physician call in either for an exception request or to change the member's prescription to a formulary agent.

Long Term Care (LTC)

LTC beneficiaries will be able to receive three 34 days supply (**total of 102 days supply**) of non-formulary medication if it is a chronic medication (as determined by First DataBank) and is a Medicare Part D eligible medication that is being filled within the first 90 days of enrollment in a plan.

Emergency Fill for LTC

If a beneficiary resides in an LTC facility and the pharmacy needs to dispense the medication in order to meet their LTC conditions of participation, ESI will authorize a seven (7)-day emergency supply until information can be gathered for an exception request.

9.8 Medicare Part B vs. Part D Drug Coverage

Drugs that are eligible to pay under Part B are not eligible for payment under Part D:

- The list of products eligible for payment under Part B is not based solely on the drug but is also based on the indication of the drug in certain situations.
- Because of this, ESI must include drugs on the formulary that will only pay under the Part D benefit in certain circumstances.
- To ensure that claims are allowed to process only under the correct situations, we will place a PA on these drugs. Methotrexate is an example of such a drug. The criteria will ask if it is used for arthritis or chemotherapy.
 - If used for arthritis it will be allowed to process through the Part D benefit.
 - If used for chemotherapy, the claim will be rejected and not allowed to process.

9.9 Prescription Processing

Medicare claims must be adjudicated one claim/transaction using NCPDP v5.1 for primary coverage. Other payer coverage claims for Medicare beneficiaries should also be submitted one claim per transaction.

The pharmacy will determine if a claim is covered under Workers Comp or Auto insurance when identified as primary coverage, to which Medicare is always secondary.

Addition of Patient Location Field

A Patient Location field has been added to the Patient Segment in NCPDP v5.1 for Medicare claims. For Medicare beneficiaries residing in LTC facilities, pharmacies should enter a value of three (**3**) in the Patient Location field. For Medicare beneficiaries residing in Assisted Living facilities, enter a value of five (**5**) in the Patient Location field.

When retail pharmacies fill for non-LTC patients, they must enter zero (0) in the patient Location Field, or the claim will reject with a Reject Code 12 M/I Patient Location.

The table below shows how this field appears on ESI's Medicare Part D Payer Sheet.

Addition of Patient Location Field

Patient Segment			
Field #	NCPDP Field Name	Value	Field Status
111-AM	Segment Identification	Ø1=Patient	M
3Ø4-C4	Date of Birth		R
3Ø5-C5	Patient Gender Code	1=Male 2=Female	R
31Ø-CA	Patient First Name		R
311-CB	Patient Last Name		R
322-CM	Patient Street Address	Plan Specific Requirement	R
323-CN	Patient City	Plan Specific Requirement	R
324-CO	Patient State or Province	Plan Specific Requirement	R
325-CP	Patient Zip/Postal Code	Plan Specific Requirement	R
3Ø7-C7	Patient Location	Ø=Not specified 1=Home 2=Inter-Care 3=Nursing Home 4=Long Term/Extended Care 5=Rest Home 6=Boarding Home 7=Skilled Care Facility 8=Sub-Acute Care Facility 9=Acute Care Facility 1Ø=Outpatient 11=Hospice	R The appropriate highlighted Value must be entered in Patient Location Field when processing LTC beneficiary claims.

Generic Savings Message

As part of the Medicare Part D Drug Program, the primary program messaging design will reference field **526-FQ** with the generic savings delta to the pharmacy when a brand drug is dispensed. The field (526-FQ) will note: "CMS estimated brand/generic difference: XXX.XX."

Partial Fill Prescriptions

ESI does not support "partial fills" for Medicare beneficiaries who also have "other coverage" indicated. If the beneficiary has other (secondary) coverage, a partial fill claim will reject with the Reject code RK: "Partial Fill Transaction Not Supported."

Other Beneficiary Coverage

The Centers for Medicare/Medicaid Services (CMS) requires the PDP or MA-PD to provide to the pharmacy with “other payer coverage” (supplemental-secondary/tertiary) for the Medicare beneficiary when responding to the initial primary Medicare claim submission. The paid claim will provide other payer eligibility to enable the pharmacy to bill the secondary payer. This information is displayed in the two message fields:

- 504-F4
- 526-FQ

Standardized Messaging

Messaging should be returned in field 504-F4 (Message Field) BEFORE any regular claims processing messages (*e.g.* notes on MAC reimbursement, formulary issues, etc.) on a PAID response.

A reject code of 41 “submit bill to other processor or Primary payer” conveys that the plan is not the primary payer. On a rejected response, processor messages would come first.

Field 504-F4 is a 200-byte field. If additional space is needed, the Additional Message field (526-FQ) is available.

Additional Insurance

ADD-INS: 1;BIN;123456;PCN:1234567890;GRP:123456789012345;
ID:12345678901234567890;PC:001;PH:8001234567;&

Unique BIN/PCN Number

The ESI BIN number is 003858 (see next page for payer sheet). To assist pharmacies in the identification of a Medicare “other coverage” billing (secondary or tertiary), a unique PCN number has been established by payers. When ESI is a secondary payer for a Medicare beneficiary, the unique PCN value will be “SC.” The unique PCN value will appear on the beneficiary’s ID card for those Plan Sponsors whose prescription benefit is administered by ESI.

As previously noted, Medicare Part D claims must be adjudicated one claim per transaction and in the proper coverage order (e.g. Primary, Secondary, Tertiary).

Reversal of Primary Medicare Part D Claims

The reversal of primary claims requires reversal of any Secondary/Tertiary claims billed. Likewise, the resubmission of a primary claim requires resubmission of Secondary/Tertiary claims.

Reversal of Primary Manual Medicare Part D Claims

The procedure outlined above also applies to manual claim reversals. If the pharmacy cannot reverse a claim and requests that ESI reverse it, the pharmacy must also make the same request to other payers in order to ensure accurate True Out-of-Pocket (TrOOP) reporting.

If the ESI Audit Team reverses a claim, then Audit will contact the other payers.


CMS Reporting Requirements

Medicare requires that plans provide CMS with monthly records of all claims submitted. This includes reporting on all rejected/denied claims. Therefore, any inquiries from CMS may require ESI to contact the pharmacy in order to be able to provide a response.

9.10 Medicare Part D Beneficiary ID Card

Medicare recognizes the NCPCP *Health Care Identification Card Implementation Guide* as the standard for the Medicare ID card with some additions.

The Medicare ID card requires the official Medicare mark in a certain place and a 9-character alpha-numeric plan ID number issued by CMS.

Part D Plan Sponsor Name/Logo		sponsor logo place- holder
RxBin	999999	
RxPCN	ABC1234567	 CMS - S5555 XXXX
RxGrp	ABC123456789	
Issuer	(80840)	
ID	12345678901	
Name	JOHN Q PUBLIC	

If a beneficiary presents a plan card without the Medicare mark, the claim should not be processed under Medicare, but under the plan information displayed on the ID card.

9.11 Grievances

A **Grievance** is an escalated complaint from a beneficiary about a specific issue not related to initial drug coverage or copay determination, but rather for example, if a prescription is not filled in a timely manner.

Beneficiary grievances regarding Medicare Part D will be handled by Express Scripts in accordance with CMS guidelines.

The ESI Corporate Quality Medicare Grievance Team is available to receive grievances, Monday – Friday, from 8:00 a.m. to 5:00 p.m., CST. During non-business hours, beneficiaries may leave a message and their calls will be returned on the next business day.

Grievances from beneficiaries will be received by the ESI Corporate Quality Medicare Grievance Team either by mail, phone, or fax.

1. **MAIL:** Grievances may be mailed to the following address:
Express Scripts
Attention, Director of Grievances
P.O. Box 66517
St. Louis, MO 63166-6517
2. **TELEPHONE:** Grievances may be phoned Monday – Friday, 8:00 a.m. until 5:00 p.m. CST by dialing 866.533.8512. (TTY number is 866.735.8556.)
3. **FAX:** Grievances may be faxed to 800.305.1686.

Beneficiaries will be notified of the grievance ruling within 30 days of the date the grievance was received by Express Scripts.

- All notification of grievance rulings submitted in writing will be provided in writing to the beneficiary.
- All notification of grievance rulings submitted orally will be provided in writing to the beneficiary, unless the beneficiary requests the ruling decision orally.
- All grievances related to quality of care will be provided in writing to the beneficiary.

If the grievance is determined to be invalid, the Grievance Facilitator will communicate to the beneficiary their ineligibility to file a grievance and direct them to 1-800-MEDICARE should they have further questions about Medicare policy. If the grievance is determined to be an appeal or duplicate, the Grievance Facilitator will communicate to the beneficiary the proper Medicare procedure and direct them to 1-800-MEDICARE should they have further questions about Medicare policy.

9.12 Beneficiary Rights

CMS-10147 *Medicare Prescription Drug Coverage and Your Rights* (Approved OMB#)

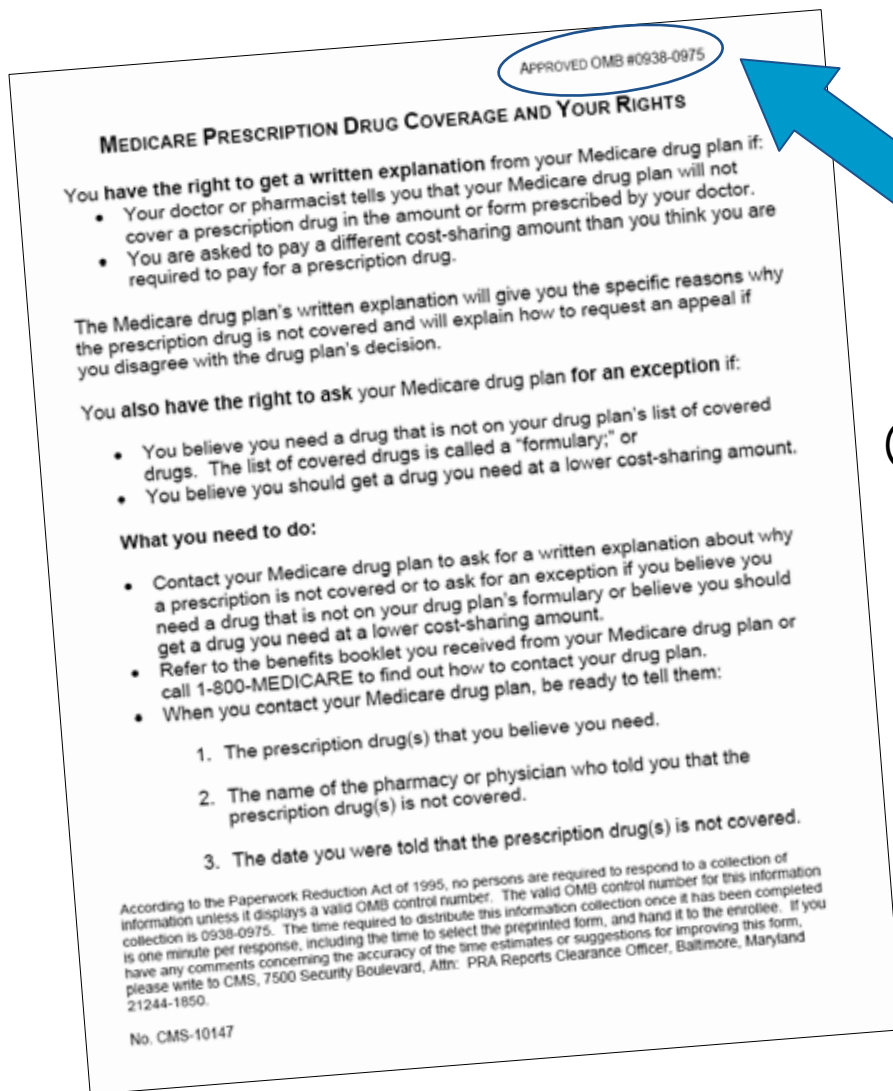
Medicare Part D plans must provide their network pharmacies with CMS-10147 *Medicare Prescription Drug Coverage and Your Rights* for use in instructing enrollees to contact their Part D plan (Medicare drug plan) to obtain a coverage determination or ask for a formulary or tier exception if the enrollee disagrees with the information provided by the pharmacist.

These may include situations in which a doctor or pharmacist tells the beneficiary their plan will not cover a specific drug or in the amount or form prescribed, or if a beneficiary is asked to pay a cost-sharing amount different from what they think they are required to pay.

CMS-10147 may be distributed to enrollees or conspicuously posted at the pharmacy. Posted notices must be at least as large as the individual notices distributed to enrollees, but larger dimensions and font sizes are permissible. This notice fulfills the requirements at 42 CFR §423.562(a)(3).

Medicare Prescription Drug Coverage and Your Rights is a standard notice. Part D plans may not deviate from the content. Please note that the OMB control number must be displayed in the upper right corner of the notice. (*See illustration below.*)

CMS 10147 – *Medicare Prescription Drug Coverage and Your Rights*



Approved
OMB #
(OMB control
number)

Beneficiaries have the right to a written explanation from their Medicare drug plan if:

- Their doctor or pharmacist tells them the plan will not cover a prescription drug in the amount or form prescribed.
- They are asked to pay a different cost-sharing amount than they think they are required to pay for a prescription drug.

Beneficiaries have the right to ask their Medicare drug plan for an exception if:

- They believe they need a drug not included on their drug plan's list of covered drugs (formulary); or
- They believe they should get the drug they need at a lower cost-sharing amount.

What Beneficiaries Need to Do:

- Contact their Medicare drug plan to request a written explanation of why a prescription is not covered, or to ask for an exception if they believe they need a drug not covered on their plan's formulary, or if they believe they should pay a lower cost-sharing amount.
- Refer to their Medicare drug plan benefits booklet or call **1-800-MEDICARE (800-633-4227)** for plan contact information.
- When contacting their Medicare drug plan, beneficiaries will need to provide the following:
 - Prescription drug name(s)
 - Name of physician or pharmacy who told them the drug is not covered
 - Date they were told their prescription is not covered

Notice of Denial of Prescription Drug Coverage – CMS-10146

Part D plans must complete and issue a CMS-10146 *Notice of Denial of Prescription Drug Coverage* whenever they deny a Part D plan enrollee's request for prescription drugs.

- Part D plans may not deviate from the content of this standard CMS form. The OMB number must be displayed in the upper right hand corner. (*See illustration next page.*)
- Information entered on this form must include the date, enrollee's full name and address, drug plan member ID number, the name(s) of the drugs for which coverage was denied, and the reason for the denial. The reason should include a description of any applicable Medicare coverage rule or Part D plan policy.
- CMS-10146 provides instructions for an enrollee to appeal the denial. The plan must add phone and fax numbers, TTY numbers, and address(es). The second page describes the enrollee's appeal rights.

CMS-10146 Notice of Denial of Prescription Drug Coverage

Approved OMB #0938-0975

[LOGO]

Notice of Denial of Medicare Prescription Drug Coverage

Date: _____

Enrollee's name: _____ Member ID number: _____

We have denied coverage of the following prescription drug(s) that you or your physician requested: _____

We denied this request because: _____

What if I Don't Agree With This Decision?

You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for an exception if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost-sharing amount. You can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. Your physician must provide a statement to support your exception request.

Who May Request an Appeal?

You or someone you name to act for you (your appointed representative) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State law to act for you.

You can call us at: () to learn how to name your appointed representative. If you have a hearing or speech impairment, please call us at TTY: ()

Form No. CMS-10146

Approved OMB #

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS
For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- If the doctor who prescribed the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, we will automatically expedite your appeal.
- If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days) - You can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

How Do I Request an Appeal?

For an Expedited Appeal: You or your appointed representative should contact us by telephone or fax at the numbers below.
Phone: () _____
Fax: () _____

For a Standard Appeal: You or your appointed representative should mail or deliver your written appeal request to the address(es) below.

What Happens Next? If you appeal, we will review your case and give you a decision. If you are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information: If you need information or help, call us at:
Toll Free: _____
TTY: _____

Other Resources To Help You:
Medicare Rights Center
Toll Free: 1-888-HMO-9050
TTY: _____

Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

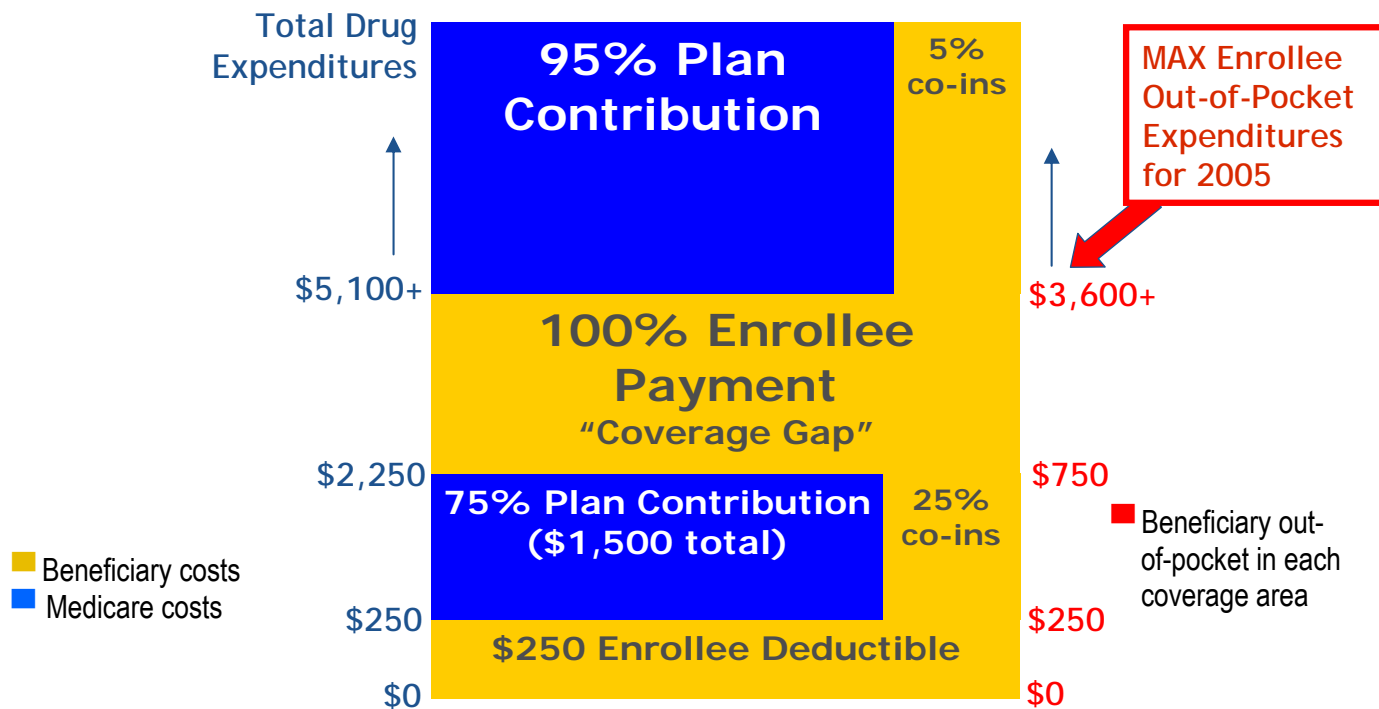
What Do I Include with My Appeal Request?
You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

CMS-10146 describes two kinds of appeals:

- Expedited (72 hours) – Enrollees may request this appeal if they or their doctor believe their health could be seriously harmed by waiting up to 7 days for a decision. If the enrollee’s request to expedite is granted, the plan must give them a decision within 72 hours after receipt of the appeal.
- Standard Appeal (7 days) – Drug plan must give the enrollee a decision no later than 7 days after receipt of the appeal.
- Enrollees must provide their name, address, member ID number, reason for the appeal, and any evidence they may wish to attach.
- If the plan still denies the enrollee’s request following an appeal, the enrollee may request an independent review of their case.

9.13 True Out-of-Pocket (TrOOP) & TrOOP Facilitator

TrOOP refers to the true out-of-pocket expenditures that identify when a beneficiary is eligible for coverage under the catastrophic limit of \$3,600 for 2006 as defined by CMS. (See illustration below.)



Incurred costs allowed for meeting the catastrophic limit have been defined as costs that are paid:

- By an individual or another person, such as a family member, on behalf of the individual.
- On behalf of a low income subsidy person.
- Under a state pharmaceutical assistance program (SPAP).

TrOOP and TrOOP Facilitator

CMS identifies the True Out of Pocket expenses paid by the beneficiary as TrOOP. The ability of Medicare to track TrOOP is extremely important as it is the "trigger" that determines when the catastrophic coverage benefit will kick in for the beneficiary.

- Incurred costs allowed for meeting the catastrophic limit have been defined as costs that are paid:
 - By an individual or another person, such as a family member, on behalf of the individual
 - On behalf of a low income subsidy person
 - Under a state pharmaceutical assistance program (SPAP)

Role of TrOOP Facilitator

The TrOOP Facilitator:

1. Helps the pharmacy identify a beneficiary's Medicare eligibility (E-1 Transaction)

2. Communicates with the primary plan to provide TrOOP information from “other payers,” enabling the plan to properly calculate TrOOP balances, and
3. Acts as a check and balance tool for CMS.

E-1 Transaction

- The TrOOP Facilitator helps the pharmacy identify a beneficiary’s Medicare eligibility through the pharmacy submission of an NCPDP E-1 transaction record.
- When Medicare beneficiaries can not identify their specific Medicare Plan or do not have their Medicare ID card with them, the pharmacy may send an E-1 transaction through their switch to the TrOOP Facilitator.
- **TrOOP Eligibility Verification:** CMS provides the required eligibility information to the PDP and to the TrOOP Facilitator to facilitate Eligibility Lookup. The TrOOP Facilitator matches the submitted beneficiary data to the enrollment data provided by CMS. The TrOOP facilitator then creates and sends a standard eligibility response and message back to the pharmacy.
 - **Accepted request** = there was a **MEDICARE ELIG (ELIGIBILITY) CHECK:** The primary and other insurance information was returned to the pharmacy in the message field,
OR
 - **Rejected request** = there was **no MEDICARE ELIG (ELIGIBILITY) CHECK:** No single match was found (possibly including reject codes, in case this will help the pharmacy obtain a patient match).
 - Included with either message is the Help Desk telephone number of the TrOOP facilitator or Medicare.
- TrOOP Eligibility Messaging should be returned in field 504-F4 (Message field) AFTER the processor message of **MEDICARE ELIG CHECK:** Field 504-F4 (Message field) is a 200-byte field. If additional bytes are needed, the Additional Message field 526-FQ should be used.
- *PRIMARY;BIN:123456;PCN:1234567890;GRP:123456789012345;ID:12345678901234567890;PC:001;PH:8001234567;&*
- Maximum message length is 100-byte and 101-byte ADDINS. If additional insurance is listed on the patient record, the message could be repeated with a different title (ADDINS:1). However, each individual insurance message should not be split between fields. For example if PRIMARY; and ADDINS:1 could not both fit in Message field 504-F4, PRIMARY should be entered in field 504-F4 in its entirety and ADDINS:1 should begin in position one of the Additional Message field (526-FQ)
- *PRIMARY;BIN:123456;PCN:1234567890;GRP:123456789012345;ID:12345678901234567890;PC:001;PH:8001234567;&*
- *ADDINS:1;BIN:123456;PCN:1234567890;GRP:123456789012345;ID:12345678901234567890;PC:001;PH:8001234567*

Role of the Pharmacy in Calculating a Beneficiary's True Out Of Pocket Costs

Although the Medicare Part D plan is responsible for the accurate calculation of TrOOP, the pharmacy plays an important role in ensuring that the process works properly.

- Pharmacies must be able to read and use the other coverage information sent by the primary payer in the Message fields 504-F4 and 526 FQ.
- Pharmacists must adjudicate claims in the proper order: Primary plan submitted, followed by any Secondary and Tertiary plan coverage. If a beneficiary has an SPAP plan, it is important to know the SPAP is always the payer of last resort.
- If the pharmacy reverses a primary Medicare Part D claim, then any other payer claims must also be reversed and in the appropriate order.

TrOOP Information Websites

For more information on TrOOP and the TrOOP Facilitator, visit the following websites: troopquestions@ndchealth.com and <http://medifacd.ndchealth.com>

9.14 Medicare Discount Card (PCA) Transition

- **November 15, 2005:** Enrollment in Prescription Drug Plans begins.
 - Discount Card Program Enrollment Applications will be processed through December 31, 2005.
 - \$600 Credit balances from 2004-2005 will roll over in 2006.
- **December 31, 2005:** Medicaid drug coverage ends for dual eligibles.
- **January 1, 2006:** Medicare Prescription Drug Plan, retiree options begin.
- **May 15, 2006:**
 - Medicare Discount Card program terminates May 15 or when beneficiaries enroll in a Medicare Part D program, whichever comes first.
 - Unused \$600 Credit balances expire on effective date of Part D plan or May 15, 2006, whichever comes first.
 - Last day to enroll in Medicare Part D for eligible beneficiaries to avoid late enrollment penalty!

If a discount card member enrolls in a Medicare Part D plan, CMS will process auto disenrollment from the Discount card.

9.15 Resources for More Information about Medicare Part D

More Information – For Health Care Professionals

- Toolkit and training materials for health care professionals
<http://new.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0557.pdf>
- Medicare Prescription Drug Coverage Information for Provider Page
<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

- Official U.S. government website for people with Medicare
<http://www.medicare.gov>

More Information – For All

- Visit www.medicare.gov
- Visit www.cms.hhs.gov
- Medicare Fact Sheets located at
<http://new.cms.hhs.gov/Partnerships/MMAOP/list.asp?filtertype=none&datefiltertype=-1&datefilterinterval=&datafiltertypename=Publication+Type&datafiltertype=4&datafiltervalue=&keyword=Supplemental+security+income&cmdFilterList=Refresh+List>
- Visit www.socialsecurity.gov
- Publications such as:
 - *Medicare & You* handbook
 - *Facts About Medicare Prescription Drug Plans*
- 1-800-MEDICARE
- Call Social Security at 1-800-772-1213
- SHIP 1-800-243-4636

Express Scripts Glossary

Catastrophic Coverage: (Medicare)	Prescription coverage provided by Medicare after a beneficiary has reached the total drug expenditure limit (\$3,600 for 2006).
Copay	That portion of the total charge for each prescription drug which a Member is required to pay the Pharmacy in accordance with the Member's Prescription Drug Program, whether designated as a "copay" or "deductible" under the applicable Prescription Drug Program.
Coverage Gap	Under Medicare Part D, beneficiaries have a coverage gap of \$2,850 and are responsible for 100% of this cost.
Covered Drugs	Those prescription drugs, supplies and other items prescribed by an authorized, licensed medical practitioner that are covered by a Prescription Drug Program.
Cross Licensed Drugs	These drugs are included in the Single Source Brand category based on their patent protection.
DAW Code	These are "Dispense As Written" codes developed by the NCPDP, which may be revised from time to time.
Dual Eligibles (Full-benefit dual eligibles)	Beneficiaries who qualify for both Medicare and Medicaid. Medicare provides payment for acute health services. Medicaid covers Medicare premiums and cost-sharing.
Formulary	A list of FDA-approved prescription drugs and supplies developed by Express Scripts or a Plan Sponsor that are classified for purposes of benefit design and coverage decisions.
Generic Drugs	A "generic" drug is a prescription drug – whether identified by its chemical, proprietary, or non-proprietary name – which is pharmaceutically equivalent and interchangeable with a drug containing an identical amount of the same active ingredient(s) and approved by the FDA. The designation of a product as "generic" and/or subject to Maximum Allowable Cost (MAC) is determined by ESI, using data elements provided by First DataBank or other sources nationally recognized in the retail prescription drug industry.

Express Scripts Glossary *(Continued)*

HMO	A health maintenance organization or other managed care entity which typically is licensed to operate as such and may be the subject of federal and/or state laws that apply to, among other things, the provision of Pharmacy services to Members.
Identification Card	The printed Identification Card (ID) issued to the Member pursuant to the applicable Prescription Drug Program.
Long Term Care (LTC)	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Maximum Allowable Cost (MAC)	The maximum reimbursement to be paid for multi-source product as determined in ESI's sole discretion.
Medicare Part A	Beneficiary hospital/inpatient coverage
Medicare Part B	Beneficiary outpatient coverage
Medicare Part C	Medicare Advantage programs (MA), previously Medicare + Choice
Medicare Part D	The prescription drug plan program
Member	An individual and his or her eligible dependents to who benefits are available pursuant to a Prescription Drug Program.
Multi-Source Brand	A Drug with an expired patent that is now marketed by many different manufacturers. Multi-Source Drugs are classified by the FDA based on the drugs' therapeutic equivalence evaluations.
NCPDP	The National Council for Prescription Drug Programs is a non-profit ANSI-accredited Standards Development Organization consisting of over 1,230 members. These members represent various segments of the pharmacy community interested in electronic standardization within the pharmacy services sector of the healthcare industry.

Express Scripts Glossary *(Continued)*

Non-Covered Drugs	Prescription products that are not covered by plan Sponsors. Examples include products that are not covered in a closed Formulary plan, those used primarily for cosmetic purposes, for Member convenience, or that have marginal therapeutic value. Physicians are advised that if these products are prescribed, the Member will incur the full expense for these drugs. Refer to individual plan information and online messaging for specific reimbursement exclusions.
Over-the-Counter (OTC)	Products which do not require a prescription and are usually not covered (except insulin) by the Prescription Drug Program. If a prescription product is available in the identical strength, dosage form and active ingredient(s) as an OTC product, the prescription product will not be covered.
Pharmacy(ies)	A Pharmacy or Pharmacies owned or operated by Provider and licensed by the appropriate State Board of Pharmacy or other applicable regulatory authority. If Provider owns only one Pharmacy, then “Provider” and “Pharmacy” are used interchangeably in the Pharmacy Provider Agreement and this Pharmacy Network Manual.
Pharmacy Care Alliance	An alliance formed by the National Association of Chain Drug Stores (NACDS) in 2002 as a not-for-profit entity. Express Scripts, Inc. joined with NACDS in 2003 under the Pharmacy Care Alliance umbrella to create the Pharmacy Care Alliance (PCA) Prescription Drug Discount Card. The purpose of the Card is to help Medicare beneficiaries get the most from the new Medicare law authorizing prescription drug discounts to Medicare-eligible beneficiaries.
Pharmacy Network Manual	A written description of practices, policies, rules, and procedures provided by Express Scripts for Pharmacies dispensing Covered Drugs to Members. The Pharmacy Network Manual may be revised from time to time by Express Scripts in its sole discretion.
Pharmacy Provider Agreement	The PERx Managed Care Pharmacy Provider Agreement between Express Scripts and Provider.
Prescriber	A physician or other health care professional licensed to prescribe prescription drugs.

Express Scripts Glossary *(Continued)*

Prescription Drug Program	A Prescription Drug Program provided to a Sponsor pursuant to an agreement with Express Scripts pursuant to which Covered Drugs are available to Members in accordance with the terms of the program.
Single Source Brand	Drugs under patent protection that are usually marketed by only one manufacturer.
Sponsor	An HMO, managed care organization, insurance company, third party administrator, employer or other organization which provides or administers a Prescription Drug Program for Members.
Subsidy	Medicare Part D payments to plan sponsors from the federal government to encourage retention of employer-sponsored prescription benefits. Dual Eligible Beneficiaries qualify for a full subsidy.
Usual and Customary Retail Price (U&C)	The usual and customary retail price of a Covered Medication in a cash transaction at the Pharmacy dispensing the Covered Medication (in the quantity dispensed) on the date that it is dispensed, including any discounts or special promotions offered on such date.

Appendix A

Individual State Legal Requirements Applicable to HMOs or Managed Care Plans

General

The Provider Agreement provides that, where required by a Sponsor, the Provider Agreement will be subject to the Federal Health Maintenance Organization Act, 42 U.S.C. 300 et. seq., and the comparable laws and regulations of any applicable state. In addition, the Provider Agreement provides that provider must comply with this Provider Manual and all applicable laws, rules and regulations of governmental bodies having jurisdiction over pharmacies.

Various Sponsors have requested that the Provider Agreement conform to various state law requirements. As required by the terms of the Provider Agreement, and as described in the preceding paragraph, the Provider Agreement will be subject to the state laws described below, and such laws will take precedence over any conflicting provision in the Provider Agreement. The state laws described below will apply to a provider to the extent such provider is doing business in that state to which the particular law pertains, and only with respect to providers in those states who provide pharmacy services in connection with prescription drug programs maintained by Sponsors who are HMOs or similarly licensed organizations subject to such law.

The state laws described below do not represent an exhaustive overview of all of the laws which may apply when a Sponsor is an HMO or similarly licensed organization, and Express Scripts makes no representation that the following are the most current versions of such state laws. The following overview may be amended and updated from time to time to reflect changes in the law. In the event there is a conflict between the terms and conditions set forth below and the terms and conditions set forth in the Provider Agreement, the terms and conditions set forth below shall control.

GEORGIA

The following terms and conditions apply to pharmacy contracts entered into with Providers participating in Georgia's Medicaid and Peachcare for Kids programs.

- To the extent applicable, Provider has a right to an administrative review as provided in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS CHAPTER 500 (APPEALS) programs.

LOUISIANA

A time limit of 365 days is requested for the electronic submission of BlueCross and BlueShield of Louisiana.

MASSACHUSETTS

Section 1: Rules and Requirements

To the extent applicable with respect to Provider Agreements entered into by Providers and ESI, the following rules and requirements shall apply:

1. ESI shall not refuse to contract with or compensate for covered services a Pharmacy solely because such Pharmacy has in good faith:
 - a) communicated with or advocated on behalf of one or more of prospective, current or former Members regarding the provisions, terms or requirements of a Sponsor's Prescription Drug Program as they relate to the needs of such Members; or
 - b) communicated with one or more of prospective, current or former Members with respect to the method by which such Pharmacy is compensated by ESI for services provided to the Member.
2. Provider is not required to indemnify ESI 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 ESI based on ESI's management decisions, utilization review provisions or other policies, guidelines or actions.
3. Any incentive plan in the Pharmacy Provider Agreement that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract is null and void.
4. Neither ESI nor Provider has the right to terminate the Pharmacy Provider Agreement without cause.
5. ESI shall provide a written statement to Provider of the reason or reasons for such Provider's involuntary disenrollment from ESI's pharmacy network.
6. ESI shall notify Provider in writing of modifications in payments, modifications in covered services or modifications in ESI's 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 Provider, 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 ESI and Provider.

7. Provider shall not bill Members for charges for covered services other than for deductibles, copayments, or coinsurance.
8. Provider shall not bill Members for nonpayment by ESI of amounts owed under the Pharmacy Provider Agreement due to the insolvency of ESI. This requirement shall survive the termination of the Pharmacy Provider Agreement for services rendered prior to the termination of the Pharmacy Provider Agreement, regardless of the cause of the termination.
9. Provider shall comply with ESI and the Sponsor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
10. Within 45 days after the receipt by ESI of completed forms for payment to Provider, ESI shall (i) make payment, (ii) notify Provider in writing of the reason or reasons for nonpayment, or (iii) notify Provider in writing of what additional information or documentation is necessary to complete the forms for reimbursement. If ESI fails to comply with these requirements for any prescription drug claim relating to the dispensation of a Covered Medication, ESI shall pay, in addition to any reimbursement for services provided, interest on such benefits, which shall accrue beginning 45 days after ESI's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions relating to interest payments shall not apply to a claim that ESI is investigating because of suspected fraud.
11. Providers acknowledge that as part of the Sponsor's quality improvement program, an annual survey of Members may be conducted to assess satisfaction with access to covered health care services. This may include mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of Members.

NEW JERSEY

- N.J.A.C. 11:22-1.8(a) and (b). Internal and external appeals mechanisms required to be established pursuant to N.J.A.C. 11:22-1.8(a) and (b) by Sponsors who are considered "carriers" under New Jersey law are incorporated herein by reference and made a part of the Provider Agreement. The internal and external appeals mechanisms required to be established by each carrier under N.J.A.C. 11:22-1.8(a) and (b), are as follows:
 - (a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims but not including appeals pursuant to N.J.A.C. 8:38-8.5 through 8.7 and 8:38A 3.6 and 3.7.
 1. The internal review should be conducted by employees of the carrier who should be personnel other than those responsible for claims payment on a day-to-day basis and should be provided at no cost to the provider.

2. The internal review should be conducted and its results communicated in a written decision to the provider within 10 business days of the receipt of the appeal. The written decision should include:
 - (i) The names, titles and qualifying credentials of the persons participating in the internal review;
 - (ii) A statement of the participating provider's grievance;
 - (iii) The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;
 - (iv) A description of the evidence or documentation which supports the decision; and
 - (v) If the decision is adverse, a description of the method to obtain an external review of the decision.
- (b) Every carrier should offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process.
 1. The ADR mechanism should be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism should be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.
 2. The ADR mechanism, including the method to submit a claim through such mechanism, should be described in the participating provider contract and in the final internal decision denying or disputing the participating health care provider's claim, in full or in part.
 3. The decision of the ADR mechanism should be non-binding unless the parties agree otherwise.

ESI shall have no obligation to ensure that carriers comply with the aforementioned requirements regarding internal and external appeals.

- N.J.A.C. 11:4-37.4(c)(7). Provider agrees to maintain malpractice insurance at least in the amount determined sufficient for its anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.

- N.J.A.C. 11:4-37.4(c)(17). Provider agrees that in no event, including, but not limited to, nonpayment by Sponsor or ESI, payment by Sponsor or ESI that is other than what Provider believed to be in accordance with the reimbursement provision of the Provider Agreement or is otherwise inadequate, insolvency of Sponsor or ESI, or breach of the Provider Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person (other than Sponsor or ESI) acting on behalf of the Member for services provided pursuant to the Provider Agreement. The Provider Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage. Nor does the Provider Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that Sponsor may not cover or continue to cover a specific service or services.
- N.J.A.C. 8:38A-4.15(a). The Provider Agreement shall be construed to be consistent with the laws of the State of New Jersey regarding confidentiality of information and shall not be construed to cause Provider to violate his or her professional licensing standards, including, but not limited to, N.J.S.A. 45: 14B-31 et seq.
- N.J.A.C. 8:38A-4.15(b)1-11.
 - If the Provider Agreement is terminated prior to its renewal date, ESI shall give Provider at least 90 days prior written notice prior to termination.
 - Provider may not be terminated or penalized because of filing a complaint or appeal, as permitted.
 - Provider's participation in a hearing shall not be deemed to be an abrogation of the Provider's legal rights.
 - Provider may not be terminated or penalized for acting as an advocate for a Member in seeking appropriate, medically necessary health services.
 - Provider shall not receive financial incentives for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitation arrangements between ESI and Provider, provided that capitation shall not be used as the sole method of reimbursement to Provider if Provider primarily provides supplies rather than services.
 - Provider shall not discriminate in its treatment of Members.
 - Patient information shall be kept confidential, but ESI and Provider shall engage in timely and appropriate communication of patient information, so that both Provider and

ESI may perform their respective duties efficiently and effectively for the benefit of Members.

- The internal provider complaint and grievance procedure of Sponsor is incorporated into and made a part of the Provider Agreement and may be used by Provider.
- Provider shall have a right to communicate openly with a Member about all diagnostic testing and treatment options.
- The Provider Agreement shall not be construed to impose obligations or responsibilities upon Provider which require Provider to violate New Jersey's statutes or rules governing licensure of Provider if Provider is to comply with the terms of the Provider Agreement.
- Governing Law. The governing law with respect to providers subject to the aforementioned rules shall be the State of New Jersey.
- Limitation of Liability Exemption. Notwithstanding anything to the contrary in the Provider Agreement, the ESI limitation of liability exemption set forth in Section 4(B) of the Provider Agreement shall not be construed to exempt ESI from liability for acts or conduct of ESI.
- Notification of Changes. Notwithstanding anything to the contrary in the Provider Agreement, ESI will provide Provider with at least thirty (30) days' notice of any changes to the Provider Agreement.
- Independent Parties. Section 9(G) should be construed to read that it is not the intent of either party to create an agency relationship, and neither party does in fact deem such a relationship.

NEW YORK

Definitions

"Health Maintenance Organization" or "HMO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more HMOs. "IPA" may also include, for purposes of this Agreement, one or more pharmacies licensed or otherwise authorized to contract with other unaffiliated pharmacies in an intermediary capacity.

“Provider” shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed and/or certified as required by applicable federal and state law.

General Terms and Conditions

1. This Agreement is subject to the approval of the New York State Department of Health as to form and, if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least 30 days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the HMO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, HMO shall notify and/or submit a copy of such material amendment to the county departments of social services (LDSS) as may be required by the Agreement between the LDSS and the HMO.
3. If this agreement is between HMO and an IPA or hospital provider or a management authority contractor, any assignment of this agreement is **conditioned on** the prior approval of the Commissioner of Health.
4. Provider or, if the agreement is between HMO and IPA, IPA agrees, and shall require IPA’s providers to agree, to comply fully and abide by the rules, policies and procedures that the HMO has established or will establish including:
 - quality improvement/management;
 - utilization management, including but not limited to, pre-certification procedures, referral process or protocols, and reporting of clinical encounter data;
 - member grievances;
 - provider credentialing.
5. The provider or, if the agreement is between HMO and IPA, IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If Provider is a primary care practitioner, Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when Provider is unavailable. Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The HMO or IPA which is a party to this agreement agrees that nothing within this agreement is intended to, or shall be deemed to, transfer liability for the HMO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and all amendments thereto.
9. To the extent the HMO enrolls individuals covered by the Medical Assistance Program, this agreement incorporates the pertinent provisions of the model contract between HMO and the local Department of Social Services as if set forth fully herein.
10. The parties to this agreement agree to comply with all applicable requirements of the Americans with Disability Act.

Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the HMO or IPA, insolvency of the HMO or IPA, or breach of this agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the HMO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or county Medicaid Managed Care contract, or the State Family Health Plus contract, and this agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, provider agrees that, during the time an enrollee is enrolled in the HMO, he/she/it will not bill the County Department of Social Services or the New York State Department of Health for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the agreement between the HMO and the county department of social services or the Family Health Plus contract. This provision shall not prohibit the provider from collecting copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that provider shall have advised the enrollee that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the provider has not been given a list of covered services by the HMO, and/or provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the HMO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this

- agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.
2. Coordination of Benefits (COB). To the extent otherwise permitted in this agreement, Provider may participate in collection of COB on behalf of the HMO, with COB collectibles accruing to the HMO or to provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, provider shall maintain and make available to the HMO records reflecting collection of COB proceeds by provider and amounts paid directly to enrollees by third party payers, and amounts thereof, and HMO shall maintain or have immediate access to records concerning collection of COB proceeds.
 3. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan Regulations contained in 42 CFR §417.479 and 42 CFR § 434.70 into any contracts between the provider or IPA and other persons or entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

Records; Access

1. Pursuant to authorization by the enrollee, Provider will make enrollee's medical records and other personally identifiable information including encounter data available to the HMO, and IPA (if applicable), with appropriate consent/ authorization obtained by the HMO as necessary, for purposes, including preauthorization, concurrent review, quality assurance, provider claims processing and payment. Provider will also make enrollee medical records available to DOH for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals and as otherwise required by state law. Providers shall provide copies of such records to DOH at no cost. Providers expressly acknowledge that he/she/it shall also provide to the HMO and the State, on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid reimbursable services the provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, Comptroller of the State of New York and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for six (6) years or, if administratively possible, six (6) years from age of majority, or such longer period as specified elsewhere within this agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The HMO and Provider agree that the HMO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consents from such Enrollees at the time that service is rendered or at the earliest opportunity, for disclosure of medical records to the HMO, to an IPA or to third parties. If the Agreement is between an HMO and an IPA, the HMO agrees as provided above and the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a Provider, Provider agrees to obtain consent from Enrollee if the Enrollee has not previously signed a consent for disclosure of medical records.

Termination and Transition

1. Any termination of this agreement, if this agreement is between HMO and an IPA or institutional network providers, or between an IPA and an institutional provider, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 60 days after receipt of notice by either party, provided, however, that termination, by HMO may be effected on less than 60 days notice provided HMO demonstrates, to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.
2. If this agreement is between HMO and a health care professional, HMO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. HMO shall provide the health care professional 60 days notice of its decision to not renew this agreement.
3. If this agreement is between an HMO and an IPA, in the event either party gives notice of termination of the agreement the parties agree, and the IPA's providers agree that the IPA providers shall continue to provide care to the HMO's enrollees pursuant to the terms of this agreement for 180 days following the effective date of termination, or until such time as the HMO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. Provider agrees that, except as otherwise required by statute or regulation, in the event of HMO or IPA insolvency or termination of this contract for any reason, during the period covered by the paid enrollee premium services pursuant to the subscriber or county Medicaid Managed Care contract, or

the State Family Health Plus contract, to an enrollee confined in an inpatient facility on the effective date of insolvency or other event causing termination, or receiving a course of treatment in progress, shall continue until medically appropriate discharge or transfer, or completion of the course of treatment, whichever first occurs.

Provider further agrees that, in the case of Medicaid Managed Care, Family Health Plus and Child Health Plus, during the time an enrollee is enrolled in the HMO, the Provider will not bill the county Department of Social Services or the New York State Department of Health for Covered Services within the Medicaid Managed Care, Family Health Plus or Child Health Plus benefit package as set forth in the agreement between the HMO and the county or New York State or the Child Health Plus subscriber contract. *For purposes of this clause the term Provider shall include IPA and IPA's contracted providers if this Agreement is between HMO and an IPA.* This provision shall survive termination of this agreement.

5. To the extent that the provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the HMO, or an IPA that has contracts with one or more HMOs that have such contracts with the State or a county, notwithstanding any other provision herein, retains the option to immediately terminate this agreement when the provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this agreement, provider agrees, and, where applicable, IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this agreement, the parties to this agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation 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.

IPA-Specific Provisions

1. To the extent that an IPA is otherwise authorized by this agreement to perform pre-authorization of services and concurrent utilization review, the standards employed by the IPA shall be those of the HMO or approved by the HMO. All denials of services, and all determinations on appeals of such denials, shall be made by HMO, or a management contractor which is a registered utilization review agent, pursuant to a written management agreement between the HMO and a management contractor approved by the Department of Health. Where the IPA's determination on concurrent review is inconsistent with the results of the HMO's own concurrent review, the HMO's review and determination shall control.
2. Any reference to IPA quality assurance (QA) activities within this agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

PENNSYLVANIA

Pursuant to rules adopted by the Pennsylvania Department of Health, the following terms are hereby incorporated within every network agreement ("Agreement") between your pharmacy(ies) and Express Scripts, Inc. ("ESI") for the provision of pharmaceutical care and services to ESI Plan Sponsors that are Pennsylvania HMOs. To the extent any provision of the Agreement is inconsistent with the following, this Addendum will control.

(1) Hold Harmless. In no event, including but not limited to, non-payment by ESI or the Plan Sponsor, the insolvency of Plan Sponsor or ESI, or breach of this Agreement, shall the Pharmacy bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against a Member or persons other than the Plan Sponsor acting on behalf of such Member for the Covered Medications provided hereunder. This provision does not prohibit collecting supplemental charges or co-payments in accordance with the terms of the applicable agreement between the Plan Sponsor and the Member. This provision shall survive the termination of this Agreement for those Covered Medications provided prior to such termination, regardless of the cause of the termination, and shall be construed for the benefit of the Member. Any modification, addition or deletion to this provision shall become effective no earlier than 15 days after the appropriate state regulatory authorities have received written notification of the proposed changes and such changes shall otherwise comply with all state laws and regulations. This hold harmless language supersedes any written or oral agreement currently in existence, or entered into at a later date, between Pharmacy, ESI and the Member, or persons acting in their behalf.

- (2) Member records shall be kept confidential by ESI and the Provider in accordance with 40 P.S § 991.2131 and all applicable State and Federal laws and regulations, which include:
- (i) The Department of Health, the Insurance Department, and, when necessary, the Department of Public Welfare, shall have access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Article XXI, this chapter and other laws of the Commonwealth.
 - (ii) Records are only accessible to Department of Health employees or agents with direct responsibilities under subparagraph (i) above.
- (3) Pharmacy shall participate in and abide by the decisions of ESI's or the Plan Sponsor's, as appropriate, quality assurance, UR and enrollee complaint and grievance systems.
- (4) Pharmacy shall adhere to State and Federal laws and regulations.
- (5) ESI and Pharmacy shall comply with any applicable prompt payment requirements of claims consistent with the requirements of 40 P. S. § 991.2166 and 31 Pa. Code § 154.18 (relating to prompt payment of claims).
- (6) Neither party shall be permitted to terminate the Agreement contract without cause upon less than 60 days prior written notice.
- (7) Pharmacy shall be provided at least thirty (30) days prior written notice of any changes to contracts, policies or procedures affecting Providers or the provision or payment of health care services to Members, unless the change is required by law or regulation.
- (8) This Agreement shall include no incentive reimbursement system for Pharmacists which weighs utilization performance as a single component more highly than quality of care, Member services and other factors collectively.
- (9) This Agreement shall include no financial incentive that compensates a Pharmacist for providing less than medically necessary and appropriate care to a Member.
- (10) Pharmacy acknowledges and agrees that nothing contained in this Agreement limits the following:
- (i) The authority of the Sponsor to ensure the Pharmacy's participation in and compliance with the Plan Sponsor's quality assurance, utilization management, UM, complaint and grievance systems and procedures and limits;
 - (ii) The Department of Health's authority to monitor the effectiveness of the Sponsor's system and procedures or the extent to which the plan adequately monitors any function delegated to ESI, or to require the Plan Sponsor to take prompt corrective action regarding quality of care or consumer grievances and complaints; and

(iii) The Plan Sponsor's authority to sanction or terminate a Pharmacy found to be providing inadequate or poor quality care or failing to comply with the Plan Sponsor's systems, standards or procedures as agreed to by ESI.

(11) Pharmacy acknowledges and agrees that any delegation by the Plan Sponsor to ESI for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to the Plan Sponsor's oversight and monitoring of ESI performance.

(12) Pharmacy acknowledged and agreed that the Plan Sponsor, upon failure of ESI to properly implement and administer the systems, or to take prompt corrective action after identifying quality, enrollee satisfaction or other problems, may terminate its contract with ESI, and that as a result of the termination, Pharmacy's participation may also be terminated.

(13) Pharmacy and ESI further acknowledge and agree that this Agreement does not contain provisions permitting ESI or the Plan Sponsor to sanction, terminate or fail to renew a Pharmacy's participation for any of the following reasons:

- (i) Discussing the process that the Plan Sponsor or any entity contracting with the Plan Sponsor uses or proposes to use to deny payment for a health care service;
- (ii) Advocating for medically necessary and appropriate health care services for a Member, including information regarding the nature of the treatment, the risks of the treatment, the alternative treatments or the availability of alternative therapies, consultation or tests;
- (iii) discussing the decision of any Plan Sponsor to deny payment for a health care service;
- (iv) filing a grievance on behalf of and with the written consent of a Member, or helping a Member to file a grievance;
- (v) taking another action specifically permitted by sections 2113, 2121 and 2171 of Act 68.

(14) Pharmacy and ESI acknowledge that this Agreement does not contain any provision permitting the Plan Sponsor to penalize or restrict Pharmacy from discussing any of the information health care providers are permitted to discuss under section 2113 of the act or other information the Pharmacy reasonably believes is necessary to provide to a Member full information concerning the health care of the Member.

TEXAS

The following terms and conditions apply to pharmacy contracts entered into with Providers in Texas on or after August 16, 2003, and, on a prospective basis only, to existing contracts renewed on and after such date, to the extent such pharmacies are servicing entities subject to Senate Bill 418 enacted during the 78th Regular Legislative Session in Texas.

- To the extent applicable, Provider will be reimbursed in accordance with the prompt payment rules set forth in § 21.2801.
- Notwithstanding anything in the Pharmacy Provider Agreement to the contrary, Provider will not be restricted under the terms of the Pharmacy Provider Agreement from contracting with insurers, preferred provider plans, preferred provider organizations, or HMOs.
- Prior to ESI's termination of the Pharmacy Provider Agreement, Provider shall be afforded with the right to request a review from the insurer in accordance with, and to the extent required by, 28 TAC § 3.3703(a)(8). Termination shall also be in compliance with 28 TAC § 11.901(4), to the extent applicable.
- Notwithstanding anything in the Pharmacy Provider Agreement to the contrary, Provider shall not be required to hold harmless ESI for any tort liability resulting from acts or omissions of ESI.
- To the extent applicable, Provider shall comply with Insurance Code Article 3.70-3C §4, which relates to Continuity of Care.
- In the event Provider voluntarily terminates the Pharmacy Provider Agreement, ESI shall notify the insurer so insurer may comply with Insurance Code Article 3.70-3C § 6(e)(2).
- Any notice of termination by ESI shall include Provider's right to request a review by insurer in accordance with, and to the extent required by 28 TAC § 3.3706(c).
- Provider shall be entitled to request from ESI all information reasonably necessary to determine that Provider is being compensated in accordance with the Pharmacy Provider Agreement. Such request shall be handled in accordance with 28 TAC § 3.3703(a)(20) and 28 TAC § 11.901(10). All information provided by ESI shall be considered confidential and proprietary to ESI, and Provider shall be prohibited from disclosing such information to any third party, unless required by law.
- Provider will hold Members harmless for payment of the cost of covered health care services in the event ESI fails to pay Provider for health care services. ESI will not engage in any retaliatory action, including termination of or refusal to renew a contract, against Provider because Provider has, on behalf of a Member, reasonably filed a complaint against ESI or has appealed a decision of ESI.

To the extent required by Texas law, Provider must post in its office a notice to Members on the process for resolving complaints with the applicable HMO. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

Appendix B

Medicare + Choice Addendum

In accordance with the terms of the Pharmacy Provider Agreement (the “Agreement”) between Express Scripts, Inc. (“ESI”) and the provider named in the Agreement (“Provider”) the terms of this Addendum to the Pharmacy Network Manual are hereby incorporated into the Agreement between the parties, effective on and after January 1, 2000. The provisions of this Addendum apply to Medicare+Choice Benefit Plans.

1. Definitions. For purposes of this Addendum:

“Medicare+Choice Member” means any employee, purchaser, enrollee, beneficiary or other person who is covered by the Medicare+Choice Benefit Plan of a Medicare+Choice Sponsor. “Member” as defined in the Agreement includes a Medicare+Choice Member. “Medicare+Choice Benefit Plan” means a Benefit Plan issued, sponsored or administered by Sponsors pursuant to their contracts with the Health Care Financing Administration (“HCFA”).

“Medicare+Choice Sponsor” means any Sponsor that arranges for the provision of Covered Medications to Medicare+Choice Members pursuant to a Medicare+Choice contract with HCFA.

2. Federal Audit Rights. Provider agrees, and shall cause Pharmacies to agree, to maintain records, documents and any other information relating to Medicare+Choice Sponsor’s Medicare+Choice Members for a period of 6 years or such longer period required by law. Further, Provider agrees, and shall cause Pharmacies to agree, to allow the United States Department of Health and Human Services and the Comptroller General or their designees, the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation and other records of Provider and Pharmacies, their subcontractors or transferees, as are reasonably necessary to verify the nature and extent of the costs of the pharmacy services provided to Medicare+Choice Members, for a period of up to six years or for such additional period of time as may be required under Medicare regulation section 422.502(e)(4). Provider agrees, and shall cause each Pharmacy to agree, to ensure the availability of its premises, physical facilities and equipment, and records relating to Medicare+Choice Members and any additional relevant information that HCFA may require.

3. Member Records. Provider agrees, and shall cause Pharmacies to agree, to (a) take necessary actions to safeguard the privacy of information that identifies a particular Medicare+Choice Member, (b) maintain Medicare+Choice Member records in an accurate and timely manner, and (c) ensure timely access of Medicare+Choice Members to the records and information that pertains to them.

Provider further agrees, and shall cause Pharmacies to agree, that information from, or copies of, Medicare+Choice Member records may be released only to authorized individuals. Provider must ensure, and cause Pharmacies to ensure, that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders or subpoenas. Provider agrees, and shall cause Pharmacies to agree, to abide by all applicable Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and patient information.

- 4. Non-discrimination.** Provider agrees, and shall cause Pharmacies to agree, to provide pharmacy services and Covered Medications to all Medicare+Choice Members without regard to race, ethnicity, religion, sex, color, national origin, age, sexual orientation, source of payment, physical or mental health status, or disability.

Provider shall not, and shall ensure that Pharmacies shall not, deny, limit or condition the furnishing of pharmacy services to Medicare+Choice Members on the basis of any factor that is related to health status, including, but not limited to, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, or disability.

- 5. Quality of Care.** Provider agrees, and shall cause Pharmacies to agree, to provide pharmacy services and Covered Medications to all Medicare+Choice Members in a manner consistent with professionally recognized standards of care in the community in which such pharmacy is providing services.

Provider agrees, and shall cause Pharmacies to agree, to provide pharmacy services and Covered Medications in a manner consistent with applicable Medicare+Choice Sponsor standards for timely access to care.

Provider agrees, and shall cause Pharmacies to agree, to comply with applicable Medicare+Choice Sponsor medical policies, quality assurance and performance improvement programs, and medical management programs, including, but not limited to, providing access to medical records and cooperating with Medicare+Choice Sponsor's data collection activities necessary to meet Medicare+Choice Sponsor's obligations under its contract with HCFA, to the extent that such policies and procedures apply to pharmacy services and Covered Medications provided by Provider and Pharmacies.

- 6. Nonrecourse.** In no event, including, but not limited to, non-payment by ESI for Covered Medications rendered to Medicare+Choice Members by Provider or Pharmacies, insolvency of ESI, or breach by ESI of any term or condition of this Agreement, shall Provider or any Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare+Choice Member or persons acting on behalf of the Medicare+Choice Member for Covered Medications eligible for reimbursement under this Agreement. This provision does not prohibit Provider or Pharmacy from collecting from the Medicare+Choice Member Copayments, Coinsurance Charges,

Deductibles, Ancillary Charges or other charges for services not covered under the Medicare+Choice Benefit Plan. This provision does not prohibit Provider or Pharmacy and a Medicare+Choice Member from agreeing to continue pharmacy services solely at the expense of the Medicare+Choice Member, as long as Provider or Pharmacy has clearly informed the Medicare+Choice Member that the specific pharmacy service or services may not be covered or continue to be covered by the Medicare+Choice Benefit Plan.

In the event of Medicare+Choice Sponsor's insolvency or other cessation of operations or termination of the Medicare+Choice Sponsor's contract with HCFA, Provider shall continue, and shall cause Pharmacies to continue, to provide Covered Medications to Medicare+Choice Members as required by applicable Medicare laws and regulations and all other applicable Federal and State laws relating to insolvency or other cessation of operations or termination. This provision shall (a) apply to all Covered Medications rendered while this Agreement is in force; (b) with respect to Covered Medications rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of Medicare+Choice Members; and (d) supersede any oral or written agreement, existing or subsequently entered into, between Provider or any Pharmacy and a Medicare+Choice Member or person acting on a Medicare+Choice Member's behalf, that requires the Medicare+Choice Member to pay for Covered Medications. Notwithstanding the preceding, ESI shall not be liable for payment to Provider in the event, for any reason, Medicare+Choice Sponsor does not provide funds for payment for Covered Medications.

- 7. Application of Federal Laws and Medicare+Choice Policies.** Provider agrees, and shall cause Pharmacies to agree, that to the extent it or they provide pharmacy services under Medicare+Choice Benefit Plans, it or they are subject to any and all applicable Medicare laws and regulations and HCFA instructions and all Federal laws relating to entities that receive Federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975 and the Americans with Disabilities Act, to the extent such laws apply to the services being provided. Provider acknowledges, and shall cause Pharmacies to acknowledge, that payments received by Provider under the Agreement for services provided to Medicare+Choice Members may consist, in whole or in part, of Federal funds; and that Provider and Pharmacies are subject to the laws and regulations that are applicable to individuals receiving Federal funds.

Provider agrees, and shall cause Pharmacies to agree, that any services provided by Provider or Pharmacies to Medicare+Choice Members will be consistent with and will comply with Medicare+Choice Sponsor's Medicare+Choice contractual obligations.

- 8. Accuracy of Data.** Provider agrees, and shall cause Pharmacies to agree, to provide to the applicable Medicare+Choice Sponsor and ESI, data relating to pharmacy services and Covered Medications provided in connection with Medicare+Choice Benefit Plans issued by Medicare+Choice Sponsor, which is accurate, complete and truthful to the best of the Provider and Pharmacy's knowledge, information and belief. To the extent required by Medicare+Choice Sponsor, Provider agrees, and shall

cause Pharmacies to agree to certify in writing that all such data is accurate, complete and truthful to the best of the Provider's and Pharmacy's knowledge, information and belief.

- 9. Independent Quality Review.** Provider agrees, and shall cause Pharmacies to agree, to cooperate with an independent quality review and improvement organization's activities pertaining to provision of pharmacy services and Covered Medications to Medicare+Choice Members.
- 10. Notification of Provider Termination.** To the extent Provider or ESI is permitted to terminate Provider's participation in a Medicare+Choice Sponsor's programs without cause, any such termination shall require at least 60 days' advance written notice, or any longer period required under the Agreement, by the party taking such action.
- 11. Medicare, Medicaid Status and Other State and Federal Programs.** Provider represents that neither it, its owners, its Pharmacies, Provider's or Pharmacy's pharmacists, its other health care professionals, or others involved in the provision of services under the Agreement, whether employed by or under contract with Provider or any Pharmacy, are excluded from participation in the Medicare, Medicaid or other state or federal health care benefit programs. Provider agrees to notify ESI, in writing, within 10 days of any exclusion from any of such programs or of any suspension, revocation, condition, limitation, qualification, criminal, disciplinary, or other restriction on Provider, any Pharmacy, Provider's or Pharmacy's pharmacists or other health care professionals employed by or under contract with Provider or any Pharmacy, which affects its and/or their eligibility to provide Covered Medications to Members. ESI shall terminate the Agreement, in its entirety or with respect to Medicare+Choice Benefit Plans, immediately upon written notice to Provider in the event of Provider, its owners, any Pharmacy, Provider's or Pharmacy's pharmacists, other health care professionals, or others involved in the provision of services under the Agreement employed by or under contract with Provider or any Pharmacy, losing its and/or their eligibility to provide Covered Medications to Members under any such programs. In the event loss of such eligibility is limited to a specific Pharmacy, ESI may alternatively terminate that Pharmacy, in its entirety or with respect to Medicare+Choice Benefit Plans, upon written notice to Provider.
- 12. Appeals and Grievances.** Provider agrees, and shall cause Pharmacies to agree, to adhere to Medicare+Choice Sponsor's and Medicare's procedures for appeals, grievances and expedited appeals for Medicare+Choice Members, including gathering and forwarding information in a timely manner to ESI to forward to Medicare+Choice Sponsor as necessary, to the extent such procedures apply to pharmacy services and Covered Medications.
- 13. Medicare+Choice Sponsor's Obligations.** Medicare+Choice Sponsor has the obligation to provide information necessary for Provider and Pharmacies to comply with applicable requirements under Medicare+Choice programs and Medicare+Choice Sponsor is ultimately responsible to HCFA for the rendering of all services under its Medicare+Choice Benefit Plans.

- 14. Prompt payment.** Provider shall be paid promptly for Covered Medications, in the timeframe for payment set forth in the Agreement.
- 15. Medicare+Choice Sponsor Policies and Procedures.** Provider agrees, and shall cause Pharmacies to agree, to comply with any applicable Medicare+Choice Sponsor policies and procedures necessary for performing its responsibilities under the Agreement, including providing information and data as necessary for Medicare+Choice Sponsor to meet its obligations under its contract with HCFA.
- 16. Conflict of Terms.** To the extent there is a conflict between the provisions of this Addendum and any terms, conditions and provisions of the Agreement, or any Amendments or other Addenda thereto, the provisions of this Addendum shall govern as they apply to the Medicare+Choice program. All other terms, conditions and provisions of the Agreement remain unchanged.

Appendix C

TRICARE Refund Recoveries

ESI will immediately offset overpayments to pharmacies caused by pharmacy-initiated reversals by balancing the amounts against the next available remittance. ESI will continue to offset subsequent remittances until the full reversal amount has been recovered. In the event the pharmacy or chain does not have sufficient TRICARE activity to fully recover the outstanding balance within 60 days of the reversal initiation, ESI will notify the pharmacy or chain of the outstanding balance so payment can be forwarded directly to ESI.

In the event ESI does not receive payment in full (either through further offset or by check) within 30 days of ESI's notification, the following recoupment actions are required under the TRICARE Retail Pharmacy program contract and the Federal Claims Collection Act.

1. ESI will continue to apply all payments of future claims to the overpayment until the amount is recouped.
2. If amounts are not recouped, ESI will refer the overpayment to Office of General Counsel, TRICARE Management Activity (TMA) for collection which will result in liability to the pharmacy for added administrative costs and fees, and may result in an adverse credit rating report after sufficient notification is provided.

If you believe that a recoupment action is improper or incorrect, you have the right to request reconsideration. Your written request, stating specific reasons why you feel the action is incorrect or improper, should be received within 90 days of the date on the original demand letter.

If you wish to appeal this decision, please submit your request in writing to:

Express Scripts, Inc.
P.O. Box 60903
Phoenix, AZ 85082-0903