Magellan Rx Management

Provider Manual

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1.0 Introduction

Magellan Rx Management, LLC (MRx), a Prime Therapeutics company, is the Pharmacy Benefit Manager (PBM) for the Plan. As the PBM, MRx will administer the point-of-sale (POS) system to process pharmacy claim transactions. The POS will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted.

After submission, MRx will respond to the pharmacy provider with information regarding member eligibility, the Plan allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable rejection messages. ProDUR messages will be returned in the DUR response fields. Other important related information will appear in the free-form message area.

In addition to POS claims, MRx will accept claims from approved providers via electronic batch on diskettes or through file transfer protocol (FTP). The format for an electronic media is NCPDP Batch version 1.2.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

1.1 MRx Pharmacy Program

This manual provides claims submission guidelines for the various pharmacy programs administered by MRx.

Important Plan coverage and reimbursement policies are available in this *Magellan Rx Management Provider Manual*. The MRx website contains a link to this document. Subsequent revisions to this document are available on each client's Web portal.

Please refer to Section 13.0 – Appendix D through Section 15.0 – Appendix F of this document to access client-specific links.

2.0 Pharmacy Relations

This *Provider Manual* addresses the following situations for participating pharmacies:

- Orientation of new participating pharmacies
- Updates of network activities
- Changes in state/federal regulatory contracting provisions
- Provide information to pharmacies on how to obtain information regarding benefits, eligibility, formulary, dispute, and appeals information.
- How to obtain a current copy of this manual and other documents that describe the relationship between MRx and participating pharmacies.

Should you have any questions, concerns, or suggestions on how to better serve your patients, please contact the Pharmacy Network team at the following:

Pharmacy Provider Relations Department
2900 Ames Crossing RD
Eagan, MN 55121

- Pharmacy Provider Relations: 888-277-5510, Option 1
- Department Fax Number: 877-823-6373
- Department Email: ProviderRelations@primetherapeutics.com

2.1 Enrolling as an Approved Pharmacy

The MRx Provider Network consists of contracted pharmacies. To enroll as a pharmacy provider, please follow the steps in Section 2.1.1 – Pharmacy Network Application and Disclosure Process.

2.1.1 Pharmacy Network Application and Disclosure Process

All pharmacies interested in participating in the MRx Pharmacy Network must submit the following:

- *Provider Application and Agreement*
- *Pharmacy Disclosure Form*

Please refer to Section 13.0 – Appendix D through Section 15.0 – Appendix F for client-specific information.

2.1.1.1 Instructions for Completing the Pharmacy Disclosure Form

Fill out all sections on the *Disclosure of Ownership and Control Interest Statement* upon request by MRx.

Note: Each pharmacy participating in the Group Purchasing Organization (GPO) or the Pharmacy Services Administration Organization (PSAO) MUST be monitored and reported to PBM by the PSAO entity on an annual basis and monitored against the List of Excluded Individuals and Entities (LEIE) maintained by the Office of Inspector General (OIG) and the System for Award Management (SAM) exclusion lists monthly. Any participating pharmacies or owners and their pharmacy confirmed as excluded must be removed from the PSAO Network immediately and reported to PBM upon removal. Return the completed form to PBM and fax to 1-888-656-4139.

2.1.2 Fraud, Waste, Abuse, and Program Integrity

MRx takes provider fraud, waste, and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. MRx has made a commitment to actively pursue all suspected cases of fraud, waste, and abuse and will work with law enforcement for full prosecution under the law.

Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their patients.

Our Policy

MRx has implemented a comprehensive compliance program to ensure ongoing compliance with all contractual and regulatory requirements. MRx's Compliance Program describes our comprehensive plan for the prevention, detection and reporting of fraud, waste, abuse, and overpayment across various categories of healthcare-related activities and operations. The elements of the Compliance Program include: [I] Written Policies and Procedures; [II] Designation of a Compliance Officer and a Compliance Committee; [III] Conducting Effective Training and Education; [IV] Developing Effective Lines of Communication; [V] Auditing and Monitoring; [VI] Enforcement Through Publicized Disciplinary Guidelines and Policies Dealing With Ineligible Persons; [VII] Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and [VIII] Whistleblower Protection and Non Retaliation policy.

MRx does not tolerate fraud, waste, or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste, and abuse programs to combat these problems. MRx's programs are wide-ranging and multi-faceted, focusing on prevention, detection, and investigation of all types of fraud, waste, abuse, and overpayment in government programs and private insurance.

- Our policies in this area reflect that both MRx and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid), federally funded contracts and private insurance. MRx complies with all

applicable laws, including the Federal False Claims Act, state false claims laws, applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded healthcare programs, e.g., Medicare Advantage, State Children's Health Insurance Program (SCHIP) and Medicaid, and other payers. Visit our website to review these policies. See the CMS Fraud-Prevention/Medicaid Program Integrity Educational Resource and the CMS Medicaid Program Integrity site for additional information.

What You Need to Do

Your responsibility is to:

- Comply with all federal and state laws and MRx requirements regarding fraud, waste, abuse, and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste, or abuse, and do not violate any federal or state law relating to fraud, waste, or abuse;
- Ensure that you provide and bill only for services to members that are medically necessary and consistent with all applicable requirements, regulations, policies, and procedures;
- Ensure that all claims' submissions—regardless of final claim status—are accurate, including any claims that are paid, reversed, denied, or rejected;
- Ensure that prescription record documentation is complete and accurate, and support services are billed by complying with MRx and other required record-keeping standards;
- Notify MRx immediately of any suspension, revocation, condition, limitation, qualification, or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;
- Cooperate with MRx's Audits and Investigations. MRx's expectation is that you will fully cooperate and participate with its fraud, waste, abuse, and overpayment audits and investigations. This includes, but is not limited to, permitting MRx or its subcontractors access to member prescription records and allowing MRx or its subcontractors to conduct on-site audits or reviews.
- Understand Fraud, Waste, Abuse and Overpayment:
  - *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. Fraud includes any act that constitutes fraud under applicable federal or state law.

- *Waste* means over-utilization of services or other practices that result in unnecessary costs.
- *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.
- *Overpayment* includes any amount that is not authorized to be paid by the healthcare program, whether paid because of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse, or mistake.

2.1.2.1 Reporting Suspected Fraud, Waste, Abuse, and Overpayments

MRx expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse, or overpayments. To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from MRx, you are obligated to report the overpayment and to return the overpayment to MRx.

Reports of suspected fraud, waste, or abuse may be made to MRx via one of the following methods:

- Special Investigations Unit Pharmacy Hotline: 1-800-349-2919
- Special Investigations Unit Hotline: 1-800-731-3269
- Special Investigations Unit email: fraudtiphotline@primetherapeutics.com
- Corporate Compliance Hotline: 1-612-777-5523
- Compliance Unit email: compliance@primetherapeutics.com

2.1.2.2 Pharmacy Audits

Audit Purpose and Policy

The Special Investigations Unit (SIU) provides oversight to the pharmacy audit program, which consist of mini-desk (claim check), desktop, onsite, and invoice audits.

Audits vs. Investigations

An *audit* is an objective and systematic assessment of how well a provider/program is performing as well as meeting expectations and applicable regulations. This is a routine process and can happen at any time. An *investigation* is usually undertaken in response to reports of misconduct. It is a process of detailed examination to achieve certain objectives. During an investigation, SIU may also interview the pharmacy, staff, or members, conduct

background checks, and conduct other analyses. When applicable, SIU may report findings to the applicable regulatory agency or client.

Claim Check (Mini Desk) Audits

A claim check (mini desk) audit is conducted by an auditor via email, fax, or mail. During each claim check (mini desk), we audit a small number of claims by reviewing the prescription record, labels, signature logs, and any other relevant documentation.

Desk Audits

A desk audit is conducted by an auditor via email, fax, or mail rather than in person. During each desk audit, we audit a larger number of claims and refills by reviewing the prescription records, labels, signature logs, and any other relevant documentation.

Instore Audits

An instore audit is conducted by an auditor in person at a pharmacy. During each onsite audit, we audit prescriptions and associated refills, conduct a compliance review that includes, but is not limited to, validation of proper licenses, review of regulatory practice requirements and general compliance training. We also review a sample of the signatures in the pharmacy's patient signature log, and validate licenses for out-of-state pharmacy permits, if applicable.

Invoice Audits

MRx or its third-party audit vendor may request invoice and purchase documentation from wholesalers, manufacturers, and distributors to ensure that the pharmacy had sufficient quantity of certain drugs to substantiate the claims submitted. Said documentation must be provided directly to the auditor by the wholesaler, manufacturer, or distributor—not the pharmacy. If shortages of supply are identified or where documentation is not supplied, all claims associated with the shortages identified are subject to overpayment recovery.

340B Audits

When applicable, MRx may conduct a review of claims submitted according to the requirements of the 340B Drug Pricing Program.

Access to Records

Please note that all claims submitted to MRx are subject to audit regardless of the final claim status. This includes claims that are paid, reversed, denied, and rejected. Pharmacies are expected to maintain and make available to MRx all appropriate documentation and records that support a claim or an element of a claim. This includes transaction logs and records, receipts of payment, and other records.

Documentation should not be altered or created in preparation for an audit. If a pharmacy is missing documentation, the pharmacy should contact the auditor or the MRx SIU and provide an explanation for the missing documentation.

Denying access to records or failure to respond to any audit request will be treated as a failure to comply with an audit. If a pharmacy fails to comply with an audit, MRx may recover any overpayments associated, implement disciplinary action, or terminate the pharmacy with cause from the national network.

Audit Process

All audits will be conducted in accordance with applicable contractual and regulatory requirements.

Audits will include the following steps:

- Advance notice will be provided to pharmacies (for on-site audits) unless suspected fraud has been identified. When suspected fraud has been identified, no advance notice is required. MRx and our vendors will work with pharmacies to make reasonable accommodations when scheduling on-site audits and to ensure minimal disruption to pharmacy operations during the audit process.
- A list of documentation required for the review will be provided (along with the required timeframe and submission method for desk audits).
- We will review the records to ensure their accuracy and compliance with regulatory and contractual requirements. When on-site we may also interview staff, review policies and procedures and other relevant documentation and will observe staff interactions with customers. Our audit staff comply with all applicable privacy regulations.
- Once records have been reviewed, a preliminary report of the findings is provided. It will include a detailed list of the discrepancies found, a reference to the contractual or regulatory requirement(s) in question, and guidelines for any opportunity to contest the initial findings. Some findings may not allow for submission of additional documentation due to their nature (e.g., wrong patient or prescriber selected).
- The audit will be closed, and a final report issued once the additional documentation has been reviewed or the time to submit additional documentation has closed. Any changes to the preliminary results based upon the review of additional documentation will be reflected in the final report.

Prescription Requirements

Pharmacies are expected ensure that all prescriptions billed and/or dispensed comply with all applicable state and federal laws. Hard copy prescriptions can include written prescriptions, facility orders, faxed, verbal or telephone orders, refill authorizations, transfers, and electronic prescriptions. Unless otherwise allowed by state and federal laws, electronic prescriptions

must document at a minimum system assigned user, date and time stamp, and authorization number. Pharmacies should not alter or generate prescriptions in response to an audit request or investigation.

Unless otherwise allowed by state or federal law, prescriptions should contain the following information:

- Prescription date
- Prescription number
- Member first name
- Member last name
- Member date of birth
- Member address (for controlled substances)
- Prescriber full name
- Prescriber NPI
- Prescriber phone number
- Prescriber DEA number (for controlled substances)
- Prescriber address (for controlled substances)
- Drug name and strength
- Quantity
- Specific directions for use – "Use as directed" is not allowed
- Substitution instructions from prescriber and/or refills authorized
- Transfer information if applicable

Compound Prescription Requirements

In addition to the above information a compound worksheet with detailed NDC, quantity and expiration dates of components is required for each compound claim.

Signature Logs

Pharmacies are expected to comply with all state and federal regulatory requirements related to signature logs. Unless otherwise specified by state or federal law, MRx will accept the following signature log documentation. All signature log documentation must tie back to the prescription-in-question as well as the specific date of service in cases of multiple refills. If you have questions about acceptable formats, please contact us at pharmacyaudit@primetherapeutics.com.

- Manual Signature Logs – typed or handwritten logs maintained to track in-pharmacy patient pick up displaying the member's actual physical signature and pick-up date;

- Delivery Manifests – a list of drugs that may contain multiple members to documentation shipped to a location with a signature line at the bottom and displaying the member's actual physical signature (not to be confused with "delivery confirmations");
- Delivery Confirmations – these are third-party delivery confirmations from UPS, FedEx, USPS, or other delivery companies that can be linked back to the prescription-in-question;
- Point of Sales – computer timestamps that document when the medication was processed at the pharmacy's register and released to the member.

Usual & Customary Pricing (U&C)

Just as with all claim elements, pharmacies are expected to enter accurate usual and customary (U&C) pricing for all claims submitted. The U&C charged by the pharmacy to the general public at the time of dispensing should be the same price as a cash paying customer for the same drug, including all prices associated with discounts, sales, loyalty programs, coupons, or other discounts. If the pharmacy alters the U&C price to increase claim payment without a true change of the cash price charged to the general public, it is considered a violation of the provider agreement. The pharmacy must be able to communicate the U&C price to MRx and supply proof of a cash prescription upon request. This could include, but not limited to, redacted transaction receipts or records. Failure to provide sufficient documentation may result in overpayment recovery, corrective action, and/or termination from the network.

Test Claims

Pharmacies must not submit test claims of prescriptions that were intended to be reversed; are false or nonexistent; contain "dummy" or false NPI or member cardholder ID numbers; or were never requested by the member or prescriber.

Return to Stock

Pharmacies should ensure that all prescriptions that were billed but not picked up by the member are returned to stock and the claim reversed within fourteen (14) business days of the claim submission. Failure to return prescriptions to stock may result in overpayment recovery.

Correct Days' Supply

Just as with all claim elements, pharmacists are expected to exercise professional judgement when entering days' supply for all claims submitted. If needed, the pharmacy should call the MRx helpdesk for override assistance.

Insulin and Diabetic Supplies

MRx SIU does not promote the breaking of insulin packages. Pharmacists should fill these prescriptions as written by the prescriber whenever possible and submit the correct days' supply. If a plan's limit is exceeded, call the MRx helpdesk to request an override. Pharmacies

should be mindful of potential refill too soon issues as a result of entering an incorrect days' supply.

Foot Baths, Nasal Rinses, and Other Drug Combinations Not Medically Accepted Indications for Off-Label Uses of Drugs

Foot baths, nasal rinses, and other drug combinations that are billed and dispensed as single ingredients to be mixed by the patient at home are not generally regarded as medically accepted indications (MAIs) and as such paid claims associated with these non-MAIs are subject to overpayment recovery.

Override and Submission Clarification Codes

Just as with all claim elements, pharmacies are expected to enter accurate override and submission clarification codes for all claims submitted. Pharmacies are expected to maintain and make available for audit if requested all relevant documentation and records to support the use of any override or submission clarification codes. Failure to provide sufficient documentation may result in overpayment recovery.

Use of Pre-Printed Prescription Forms

Pre-printed prescriptions are forms generated in advance by the pharmacy and provided to the prescriber for authorization. Pharmacies should never use pre-printed prescriptions where not permitted by federal or state regulation nor solicit a prescriber's authorization of a new fill of a medication without being expressly requested to do so by the member or prescriber. Claims associated with such prescription requests are subject to overpayment recovery.

Telemarketing and Soliciting Practices

Pharmacies shall not engage in deceptive marketing practices, such as cold call telemarketing, online or in-person soliciting, or recruitment practices to obtain member information for the purposes of billing claims without the member's explicit knowledge of each individual claim submitted. If the pharmacist or staff knows or suspects that a true patient-doctor relationship does not exist between the member and the prescriber, the pharmacy must confirm whether the patient-doctor relationship exists before dispensing. Pharmacies found to be engaged in deceptive or unethical marketing and billing practices will be subject to termination with cause from the network and/or overpayment recovery.

Medication Errors

Should a pharmacy fail to report a medication error and it is discovered during the audit process, the pharmacy is subject to additional disciplinary action, including corrective action or termination from the network. Please refer to 2.4 Medication Error Reporting for more information.

Disclosure of Ownership

Pharmacies are expected to comply with all state and federal laws related to ownership and potential conflicts of interest, including the Stark Law where applicable. As part of the credentialing process, pharmacies may be required to complete a *Disclosure of Ownership* form. The pharmacy must report to the Network Department any changes or new ownerships that occur outside of the credentialing cycle. Failure to disclose changes or additions to ownership can result in termination with cause from the Network.

Non-resident Permits

Pharmacies must ensure that they maintain the proper licensure for each state it operates, including in states where medications are mailed or delivered to the member. Failure to maintain proper non-resident permits can result in termination with cause from the Network.

Professional Judgement

Pharmacists are expected to exercise professional judgement when dispensing and comply with all state and federal regulations. For example, where quantities appear to exceed medically accepted indications (MAIs), pharmacists should consult with the authorizing prescriber.

Audit Violations

The following is a partial list of audit violations which could be perpetrated by a Network Pharmacy Provider resulting in claims being partially or fully recovered. For a full list, refer to Appendix G: Discrepancy Code List. In addition, legal or other action may be taken against the pharmacy, including immediate termination of the Provider Agreement:

- Incorrect day supply
- Billing brand, dispensing generic
- Undocumented substitution
- Invalid prescription transfer
- Missing, invalid, illegible, wrong, or ineligible prescription
- Billing for more than dispensed (pill shorting)
- Prescription missing patient name, doctor name/signature, directions for use, date written, strength, quantity, DEA number (CII-CV drugs), and other required elements
- Refill too soon or unauthorized refill
- Missing or incomplete/invalid signature log
- Wrong drug, prescriber, member, or pack size
- Exceeds/overfilled quantity
- Failed to respond to audit

- Member denied receiving prescription or prescriber denied authorizing prescription
- Inappropriate use of coupon codes
- Patient safety (dosage)
- Other state/federal laws not followed or miscellaneous discrepancies

2.1.2.3 Appeals of Audit Results

All audits include opportunities to appeal audit findings. **Pharmacies should review their contract and/or follow the instructions included in the final audit report for the submission of any appeals.** Be aware that appeal rights and timeframes may vary by state and contract. See Appendix G: Discrepancy Code List with acceptable appeal documentation. Once the audit is closed, appeals are only permitted as required by contract or regulation.

Should you have any questions pertaining to your audit results, please follow the instructions in your audit report or you may contact us in writing (please include a copy of your audit report). Please contact us within 30 days of the final audit letter date:

Special Investigations Unit, ATTN: MRxAudits

Fax: 877.290.1555

Email: pharmacyaudit@primetherapeutics.com

2.1.3 Right to Inspection by Government Entities

Provide that Plan, Department of Health and Human Services (DHHS) OIG, Office of the Comptroller of the Treasury, OIG, Medicaid Fraud Control Units (MFCU), and Department of Justice (DOJ), as well as any authorized state or federal agency or entity, shall have the right to evaluate through inspection, evaluation, review, or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including but not limited to:

- Medical records;
- Billing records;
- Financial records, and/or any records related to services rendered, quality, appropriateness, and timeliness of services; and/or
- Any records relevant to an administrative, civil, and/or criminal investigation and/or prosecution.

When performed or requested, the evaluation, inspection, review, or request, shall be performed with the immediate cooperation of the Pharmacy. Upon request, the Pharmacy shall assist in such reviews, including the provision of complete copies of medical records. Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not bar disclosure of protected health information (PHI) to health oversight agencies, including but not limited to

OIG, MFCU, DHHS OIG and DOJ, so long as these agencies operate in compliance with applicable regulations. Provide that any authorized state or federal agency or entity, including, but not limited to, Plan, OIG, MFCU, OIG, DOJ, and the Office of the Comptroller of the Treasury may use these records and information for administrative, civil, or criminal investigations and prosecutions within the limitations set forth under HIPAA and Health Information Technology for Economic and Clinical Health (HITECH).

2.1.4 Monthly Screening Requirements and Exclusion from Participation in Government Health Care Programs

The following definitions shall apply for the Exclusion and Screening Requirements:

- "Exclusion Lists" means the US DHHS's OIG's List of Excluded Individuals/Entities (located at https://oig.hhs.gov/exclusions/index.asp) and the General Services Administration's List of Parties Excluded from Federal Programs (located at https://www.sam.gov/portal/public/SAM/)
- "Ineligible Persons" means any individual or entity who:
  - Is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended, or otherwise ineligible to participate in Federal health care programs, or in Federal procurement or non-procurement programs; OR
  - Has been convicted of a criminal offense that falls within the ambit of *42 U.S.C. § 1320(a)-7(a)*, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

The Pharmacy shall immediately notify the Pharmacy Network Vice President or Director should any pharmacist employed by the Pharmacy be sanctioned by the Federal OIG, the DHHS, or the Centers for Medicare & Medicaid Services (CMS). No pharmacists who have been excluded from participation in any government health care programs (Medicare, Medicaid, or other state or federal government health care programs) shall be permitted to participate in the Plan program unless they can document that Federal OIG, CMS, or DHHS has fully reinstated them as a participating provider. The Pharmacy shall immediately notify the PBM if it has been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the *Social Security Act* or is otherwise not in good standing with the Plan Program. Failure to notify the PBM shall constitute a material breach of the Agreement. Failure to provide the PBM with this information may also be cause for termination of the Pharmacy from participation in the Plan Program, and recoupment of any and all reimbursements made to the Pharmacy during the time period such excluded provider was providing Pharmaceutical Services to Plan enrollees.

The Pharmacy shall screen its employees, owners, officers, and managing agents and contractors initially, and on an ongoing monthly basis, to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care

programs (as defined in Section 1128B (f) of the *Social Security Act*) and are not employing or contracting with an individual or entity that has been excluded. The Pharmacy shall be required to immediately report to the PBM any exclusion information discovered. The Pharmacy shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Plan enrollees.

2.1.5 Compliance with Legal Regulations

Both the PBM and the Pharmacy agree to recognize and abide by all state and federal laws, rules, regulations, and guidelines applicable. The Agreement incorporates by reference the scope of the services provided or anticipated to be provided by the Agreement, including, but not limited to, the State Plan, *42 CFR § 431.107, 42 CFR 455 subpart B,* and Plan rules.

2.1.6 Incorporation by Reference of Federal and State Law/Regulation

By reference, the Agreement incorporates all applicable federal and state laws and regulations, and any applicable court orders or consent decrees; all revisions of such laws or regulations court orders or consent decrees shall automatically be incorporated into the Agreement as they become effective.

The Pharmacy shall be compliant with Section 6032 of the *Deficit Reduction Act of 2005 (DRA)* regarding policy development, employee training, and whistle blower protection related to The False Claims Act, *31 USCA § 3729-3733*, et seq.

2.1.7 HIPAA Compliance

In accordance with the HIPAA regulations, the Pharmacy shall at a minimum comply with the following requirements:

- As a party to this Agreement, the Pharmacy hereby acknowledges its designation as a covered entity under the HIPAA regulations.
- The Pharmacy shall comply with the transactions and code set, privacy, and security regulations of HIPAA. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.
- The Pharmacy shall transmit/receive from/to its provider, subcontractors, clearinghouses, and PBM all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by the PBM so long as the PBM's direction does not conflict with the law.
- The Pharmacy shall agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security, and all subsequent HIPAA standards, that it shall be in breach of the Pharmacy Network Agreement and shall then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet

the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between the PBM and the Pharmacy and between the Pharmacy and its providers and/or subcontractors to a halt, if for any reason the Pharmacy cannot meet the requirements of this Section, the PBM may terminate this Agreement in accordance with terms and termination as set forth in the Pharmacy Benefit Management Pharmacy Network Agreement.

- PHI data exchanged between the Pharmacy and the PBM is intended to be used only for the purposes of health care operations, payment, and oversight and its related functions. All PHI not transmitted for the purposes of health care operations and its related functions, or for purposes allowed under the HIPAA regulations shall be de-identified to protect the individual enrollee's PHI under the privacy act.
- Disclosures of PHI from the Pharmacy to the PBM shall be restricted as specified in the HIPAA regulations and shall be permitted for the purposes of health care operation, payment, and oversight; obtaining premium bids for providing health coverage; and modifying, amending, or terminating the group health plan. Disclosures to the PBM from the Pharmacy shall be as permitted and/or required under the law.
- The Pharmacy shall report to PBM within 48 hours of becoming aware of any use or disclosure of PHI in violation of the Agreement by the Pharmacy, its officers, directors, employees, subcontractors, or agents or by a third-party to which the Pharmacy disclosed PHI.
- The Pharmacy shall specify in its agreements with any agent or subcontractor of the Pharmacy that shall have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms, and conditions that apply to the Pharmacy pursuant to this Section.
- The Pharmacy shall make available to Plan enrollees the right to amend their PHI in accordance with the HIPAA regulations. The Pharmacy shall also make information available to enrollees, educating them of their rights and necessary steps in this regard in their Notice of Privacy Practices.
- The Pharmacy shall make an enrollee's PHI accessible to the Plan immediately upon request by Plan authorized staff.
- The Pharmacy shall make available to the PBM within 10 days of notice by the PBM to the Pharmacy, such information as in the Pharmacy's possession, and is required for the PBM to make the accounting of disclosures required by 45 CFR § 164.528. At a minimum, the Pharmacy shall provide the PBM with the following information:
  - The date of disclosure;
  - The name of the entity or person who received the HIPAA PHI, and if known, the address of such entity or person;
  - A brief description of the PHI disclosed;

- A brief statement of the purpose of such disclosure that includes an explanation of the basis for such disclosure; and
- If the request for an accounting of disclosures is submitted directly to the Pharmacy, the Pharmacy shall forward such request to PBM within two days. It shall be the PBM's responsibility to prepare and deliver any such accounting requested. Additionally, the Pharmacy shall institute an appropriate recordkeeping process and procedures and policies to enable the Pharmacy to comply with the requirements of this section; l) The Pharmacy shall make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the Secretary of DHHS for the purposes of determining compliance with the HIPAA regulations upon request.

- The Pharmacy shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which Pharmacy acknowledges and promises to perform, including, but not limited to, the following obligations and actions:
  - **Safeguards** – The Pharmacy agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the Pharmacy creates, receives, maintains, or transmits on behalf of PBM and/or Plan.
  - **Pharmacy's Agents** – The Pharmacy agrees to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of the PBM and/or Plan agrees to use reasonable and appropriate safeguards to protect the PHI.
  - **Notification of Security Incident** – The Pharmacy agrees to report to the PBM within 48 hours of becoming aware of any use or disclosure of the Plan enrollee's PHI or of any security incident of which the Pharmacy becomes aware.
- The Pharmacy shall implement all appropriate administrative, technical, and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of the Agreement, including but not limited to, confidentiality requirements in 45 CFR parts 160 and 164.
- The Pharmacy shall set up appropriate mechanisms to ensure minimum necessary access of its staff to PHI.
- The Pharmacy shall create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; enrollees' rights to amend, access, request restrictions; and the right to file a complaint.
- The Pharmacy shall provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights, and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter.

- The Pharmacy shall be allowed to use and receive PHI from the PBM and/or Plan where necessary for the management and administration of the Agreement and to carry out business operations.
- The Pharmacy shall be permitted to use and disclose PHI for the Pharmacy's own legal responsibilities.
- The Pharmacy shall adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Pharmacy employees and other persons performing work for said Pharmacy to have only minimum necessary access to personally identifiable data within their organization.
- The Pharmacy shall continue to protect PHI relating to individuals who are deceased.
- The Pharmacy must make available PHI in accordance with 45 CFR § 164.524.
- The Pharmacy must make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.

In accordance with HIPAA regulations, the Pharmacy shall adhere, at a minimum, to the following guidelines:

- The Pharmacy shall make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the HIPAA regulations.
- The Pharmacy shall adopt and implement policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight.
- The Pharmacy shall adopt a mechanism for resolving any issues of non-compliance as required by law.
- The Pharmacy shall establish similar HIPAA trading partner and business associate agreements with its subcontractors, trading partners, and business associates.

2.2 Credentialing and Quality Management

All Network Pharmacy Providers must comply with credentialing and quality management initiatives required by PBM. Network Pharmacy Provider agrees to provide PBM with documentation and other information which may be needed in connection with such initiatives. PBM may request copies of all documents required for the credentialing of a Network Pharmacy Provider at any time. Appropriate documents must be provided within 14 days of receipt of notification. MRx and Prime Therapeutics (Prime) follow non-discriminatory practices in the credentialing process. Participation in MRx's/Prime's Network(s) is not based on factors such as race, religion, gender/gender identity, color, national origin, age, or sexual orientation.

During credentialing, MRx/Prime reviews a pharmacy's location to determine if it is located in either a federally-defined or MRx/Prime-defined "heat" zone. "Heat" zones are designated by CMS or MRx/Prime as areas that have potential of high rates of fraud, waste, and abuse (FWA). Additional documentation may be requested for review during credentialing to include, but not be limited to, dispensing records and wholesaler reports. The Pharmacy's location may impact the Pharmacy's eligibility for network participation. Pharmacies must meet MRx's/Prime's credentialing criteria. Credentialing criteria are determined by MRx/Prime in its sole discretion to the extent not inconsistent with applicable law.

These criteria include, but are not limited to, dispensing criteria, billing thresholds for compound prescription drugs, non-FDA approved drugs, single ingredient drugs and products, and applicable clinical programming and reporting, as determined by MRx/Prime. MRx/Prime reserves the right to decline or terminate all Pharmacies under the same ownership or control when the Pharmacy is determined to be in violation of the Agreement, this Manual or applicable law.

2.2.1 Independent Pharmacy

The following documents are requested and validated during the initial credentialing process:

- Provider Credentialing Pharmacy Credentialing Application Form
- Disclosure Form
- Provider State license, including state license number. Must not expire in the next 30 days.
- Full Unrestricted Provider/Pharmacist Drug Enforcement Administration (DEA) license 2-5 including registrant number. Must not expire in the next 30 days.
- Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.
- Pharmacist in charge (PIC) License with no restrictions, limitations, or sanctions within the most recent three-years.
- Provider Federal Employee ID Number (EIN)
- Provider State Medicaid number

Recurring credentialing as required in the Plan contracts, or at a minimum every three years, is conducted and the following documents are requested from the Provider and validated:

- Disclosure Form
- Independent Pharmacy Recredentialing Form
- Provider State license, including state license number. Must not expire in the next 30 days.
- Full Unrestricted Provider/Pharmacist Drug Enforcement Administration (DEA) license 2-5 including registrant number. Must not expire in the next 30 days.

- Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.
- Pharmacist in charge (PIC) License with no restrictions, limitations, or sanctions within the most recent three-years
- Provider Federal Employee ID Number (EIN)
- Provider State Medicaid number

2.2.2 Pharmacy Services Administration Organization (PSAO)

For participants in the MRx network, recertification is conducted annually, and the following documents are requested from the PSAO within 14 days of receipt of the notification.

- Attestation of Compliance Form completed and signed.
- PSAO Store Affiliation Spreadsheet
  - Each pharmacy's state license number should be listed.
  - Each pharmacy's state license number should be active.
  - Each pharmacy's Full Unrestricted Provider/Pharmacist Drug Enforcement Administration (DEA) license 2-5 including registrant number should be listed.
  - Each pharmacy's DEA license number should be active.
- Insurance Certificate of Liability Attestation that attests that the organization ensures that all PSAO participating pharmacies have liability insurance – $1,000,000 per occurrence and $3,000,000 in aggregate and copies of said insurance will be provided upon request, when necessary. Must not expire in the next 30 days.

2.2.3 Pharmacy Chains

For participants in the MRx network, recertification is conducted annually, and the following documents are requested from the Chain within 14 days of receipt of the notification.

- Attestation of Compliance Form completed and signed.
- Chain Store Affiliation Spreadsheet
  - Each pharmacy's state license number should be listed.
  - Each pharmacy's state should be active.
  - Each pharmacy's Full Unrestricted Provider/Pharmacist Drug Enforcement Administration (DEA) license 2-5 including registrant number should be listed.
  - Each pharmacy's DEA license number should be active.
- Must submit Insurance Certificate of Liability – Policy shall be in an amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate per policy year. Must not expire in the next 30 days.

In addition, during initial Provider recruitment and recredentialing, the provider's information will be searched through federal level data, state level data, and data available from all publishing jurisdictions in the United States for all publish disciplinary and licensing boards for all published professions within those jurisdictions. All excluded or sanctioned providers will be reviewed to determine whether any new providers for Medicaid or Medicare networks managed by MRx are on the reviewed lists. The list will be provided by:

- The OIG (https://oig.hhs.gov/exclusions/exclusions_list.asp);
- General Services Administration (GSA) List of Parties Excluded from Federal Procurement Programs;
- State Medicaid Exclusions;
- DEA;
- Client Exclusions (if provided); and
- Numerous regulatory, licensing, and registration agencies.

2.3 Member Complaints

Member complaints regarding specific network pharmacies are investigated fully working with the pharmacy and member. Member complaints regarding pharmacies may result in a site visit. Appropriate action is taken if any evidence of poor quality that could affect the health safety of members is found. Pharmacies may be required to submit evidence of corrective actions.

2.4 Medication Error Reporting

Using MRx's approved form, network pharmacies shall report all medication dispensing errors to the Pharmacy Network team within 24 hours of identification of the event(s). Reports shall include any corrective actions taken and include any known outcomes. A medication error includes *near misses* where the error was caught before the medication(s) was dispensed to the member. Appropriate action is taken if any evidence of poor quality that could affect the health safety of members is found. Pharmacies may be required to submit evidence of corrective actions.

2.5 Pharmacy Dispute Process

These procedures are followed during any network pharmacy dispute of actions taken by MRx:

1. When a pharmacy corrective action and/or termination from the MRx Pharmacy Network is related to licensure sanctions, or ongoing government/state disbarment lists, there is no dispute allowed.
    a. The pharmacy may obtain and submit information related to the incident, but the termination will stand as in the notification to the pharmacy.
    b. Once all sanctions have been lifted, the pharmacy may reapply for network inclusion.

2. When a network pharmacy disputes any request or action from MRx as a consequence of MRx's quality/patient safety programs, the pharmacy has the right to submit additional information, or request clarification.
3. In cases where planned actions are expedited due to the potential severity to patient safety, the pharmacy must contact MRx immediately or prior to any action date identified in the correspondence sent to the pharmacy.
    a. The pharmacy's request will be acknowledged within eight business hours of receipt.
    b. MRx will provide a final written response within three business days.
    c. Business day equals at least nine hours a day during normal business days in the time zone for the particular service area, typically 0800 – 1900, but may vary based on client agreement.
4. For standard dispute timeframes (i.e., corrective action plans requested however no change in pharmacy privileges is under consideration), the pharmacy has seven business days to respond to MRx's report with a request for additional information or clarification.
    a. MRx will provide a final written response within seven business days of receipt of the additional information.
5. If the pharmacy still expresses dissatisfaction with MRx's findings, they may submit one appeal within ten calendar days of MRx's last determination.
    a. MRx will render a final decision within five business days of receipt of the appeal request.
    b. The final decision will be binding, and the corrective actions requested will stand.
6. The Network team shall document in writing all correspondence. Copies of all correspondence shall be maintained by the Network team and incorporated in any future credentialing process as appropriate.

2.6 Pharmacy Suspension Process

The following outlines MRx's network pharmacy suspension process:

1. When any MRx department or individual identifies any concerns or issues related to licensure sanctions, fraud, waste, and abuse audits, or ongoing government/state disbarment lists, the circumstances are fully investigated, and recommendations made as it relates to the status of a participating pharmacy in a MRx network.
2. MRx may recommend suspending or terminate a participating pharmacy that is found to be engaged in behavior or who is practicing in a manner that
    a. Poses a significant risk to the health, welfare, or safety of consumers; or
    b. Promotes fraud and abuse.

3. Investigation of circumstances due to the potential severity to patient safety or circumstances involving licensure sanctions or status on government/state disbarment lists, are expedited.
    a. Licensure sanctions – immediate action taken within one business day of identification of the sanctions.
    b. Disbarment list reviews – immediate action taken within one business day of identification of the sanctions.
    c. Significant risk to the health, welfare, or safety of consumers – immediate action taken within one business day of identification of the sanctions.
    d. Fraud and abuse – within three business days of final confirmed findings from fraud, waste, and abuse or other auditing processes.
    e. For all other situations such as potential trends identified through the ongoing quality monitoring program – within 10 business days of final review and analysis of all available data and recommendations from the Chief Medical Officer (CMO) and/or Quality Improvement Committee (QIC).
4. Pharmacies are provided access to a dispute resolution process.
5. The Network team shall document in writing all correspondence. Copies of all correspondence shall be maintained by the Network team and incorporated in any future credentialing process as appropriate.
6. When a decision has been made to suspend/terminate a pharmacy from the participating network, the following steps are taken:
    a. The pharmacy is notified in writing of the actions being taken and the rationale.
    b. As appropriate to the situation, additional verbal notification will be made.
    c. Appropriate coding changes to the Pharmacy Network tables are made to ensure no additional claims are processed during any suspension and/or following termination.
    d. The Member Web Portal tables for the *Find a Pharmacy* functionality are updated with any pharmacy network changes.
    e. A notice is posted to all member Web portals, noting the change in the pharmacy network.
    f. A claims review history is run to obtain all active member claims for the impacted pharmacy; and members are contacted, offered assistance to locate a new pharmacy, and facilitate transfer of any active prescriptions.
7. While the steps outlined above may involve the work of several departments, the overall responsibility rests with the Network team.

3.0 Billing Information

3.1 Claim Formats and Plan – Specific Values

Pharmacy claims may be submitted online by POS or paper using the following NCPDP standards:

- POS: NCPDP Version D.0
- Batch 1.2 (Contact the MRx EDI Help Desk at 1-800-924-6741.)
- Paper: Claims submitted (after the fact) All paper pharmacy claims must be submitted on a Universal Claim Form (UCF). The UCF may be obtained from NCPDP directly via the following website: http://www.ncpdp.org/products.aspx. Refer to Section 5.1 – Claim Format for further details on acceptable claim formats and specifications.

3.2 Magellan Rx Management (MRx) Website Pharmacy Portal

Announcements, provider forms, drug information, provider manuals, Medicaid policies, and bulletins will be posted on the website.

Please refer to Section 13.0 – Appendix D through Section 15.0 - Appendix F for client-specific information.

4.0 Call Center Services

A Pharmacy Support Center, Clinical Support Center, and Web Support Center are available to assist pharmacies, prescribers, and members.

4.1 Pharmacy Support Center

A toll-free number is provided for pharmacy support and is available 7 days a week, 24 hours a day, and 365 days a year. The Pharmacy Support Center responds to questions on coverage, claims processing, and Plan eligibility.

Examples of issues addressed by the Pharmacy Support Center staff include, but are not limited to, the following:

- **Questions on Claims Processing Messages** – If a pharmacy needs assistance with alert or denial messages, it is important to contact the Pharmacy Support Center at the time of dispensing drugs. Our staff can provide claim information on all error messages, including messaging from the ProDUR system.
- **Clinical Issues** – The Pharmacy Support Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. However, a second level of assistance is available if a pharmacist's question requires a clinical response. To address these situations, the Clinical Support Call Center will assist with initiating clinical prior authorizations (PAs).

4.2 Clinical Support Call Center

A toll-free number is provided for prescriber support and is available 7 days a week, 24 hours a day, and 365 days a year. The Clinical Support Center responds to questions about clinical PAs.

4.3 Web Support Call Center

A toll-free number is available for providers. This toll-free line is staffed Monday–Friday, 8:00 a.m.–8:00 p.m., Eastern Time (ET). The Web Support Call Center responds to questions concerning access to various Web applications, password management, navigation, and general questions.

Examples of issues addressed by the Web Support Call Center staff include, but are not limited to, the following:

- **Questions on changing passwords in the User Administration Console (UAC)** – If providers need assistance with changing their passwords or are if they are getting an alert that their password is locked out.
- **Questions on navigating the various Web applications** – If providers need assistance in navigating through various web applications, the Web Support Call Center can assist by explaining how to access the applications, log in, and maneuver the systems.

5.0 Program Setup

5.1 Claim Format

While Magellan Rx Management (MRx) strongly recommends claims submission by POS, paper claims, batch, and Web claims submission are also allowed. The following standard formats are accepted. Each is explained in subsequent sections.

Table 5.1.1 – Claim Formats Accepted by MRx

Billing Media	NCPDP Version	Comments
POS	Version D.0	Online POS and Web claims submission is preferred
Paper Claims	Universal Claim Form (D.0 UCF)	PUCF_D02PT for Standard Version D.0
Batch	NCPDP Batch 1.2	Contact MRx with questions regarding processing batch claims
Web Claims Submission	NCPDP D.0	

5.2 Point-of-Sale – NCPDP Version D.0

As part of claims processing, MRx uses an online POS system to provide submitters with real-time online information regarding the following:

- Plan eligibility
- Claim Status
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the MRx online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process as per the payer specifications listed in Section 10.0 – Appendix A – Plan D.0 Payer Specifications of this manual.

5.2.1 Supported POS Transaction Types

MRx has implemented the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1), reversals (B2), and re-bills (B3). Other transactions listed in *Table 5.2.1.1 – NCPDP Version D.0 Transaction Types Supported* are also supported.

- **Original Claims Adjudication (B1)** – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
- **Claims Reversal (B2)** – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- **Claims Re-Bill (B3)** – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 1Ø3) is equal to B3.
- The following fields must match the original paid claim for a successful transmission of a B2 (Reversal) or B3 (Re-bill):
  - Service Provider ID – NPI Number
  - Prescription Number
  - Date of Service (Date Filled)
  - National Drug Code (NDC)

Table 5.2.1.1 – NCPDP Version D.0 Transaction Types Supported

NCPDP D.0 Transaction Code	Transaction Name
B1	Billing
B2	Reversal
B3	Re-bill
E1	Eligibility Inquiry

5.2.2 Required Data Elements

A software vendor needs MRx's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The MRx Claims Processing system has program-specific field requirements; e.g., Mandatory, Situational, and Not Required. *Table 5.2.2.1 – Definitions of Field Requirements Indicators Used in Payer Specifications* lists abbreviations that are used throughout the payer specifications to depict field requirements. For additional information, refer to the Payer Specification Document on the Plan Portal.

Table 5.2.2.1 – Definitions of Field Requirements Indicators Used in Payer Specifications

Code	Description
M	MANDATORY Designated as MANDATORY in accordance with the *NCPDP Telecommunication Implementation Guide Version D.0.* The fields must be sent if the segment is required for the transaction.
R	REQUIRED Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	QUALIFIED REQUIREMENT "Required when" the situations designated have qualifications for usage ("Required if x," "Not required if y").

Claims are not processed without ALL the required (or mandatory) data elements.

Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not currently required may be required at a future date.

Claims are edited for valid format and valid values on fields that are not required.

If data are submitted in fields not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks result in claim denials.

- **Required Segments** – The transaction types implemented by MRx have NCPDP-defined request formats or segments. *Table 5.2.2.2 – Segments Supported for B1, B2, and B3 Transaction Types* lists NCPDP segments used.

Table 5.2.2.2 – Segments Supported for B1, B2, and B3 Transaction Types

Transaction Type Codes			
Segment	**B1**	**B2**	**B3**
Header	M	M	M
Patient	S	S	S
Insurance	M	S	M
Claim	M	M	M
Pharmacy Provider	S	N	S
Prescriber	M	S	M
COB/Other Payments	S	N	S
Worker's Comp	S	N	S
DUR/PPS	S	S	S

Transaction Type Codes			
Segment	**B1**	**B2**	**B3**
Pricing	M	S	M
Coupon	S	N	S
Compound	S	N	S
Prior Authorizations	S	N	S
Clinical	S	N	S
Facility	S	N	S
M = Mandatory	**S = Situational**	**N = Not Used**	

- **Payer Specifications** – A list of transaction types and their field requirements is available in Section 10.0 – Appendix A – Plan D.0 Payer Specifications. These specifications list B1 and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by MRx.
- **Program Setup** – *Table 5.2.2.3 – Important Required Values for Program Set Up* lists required values unique to Plan programs.

Table 5.2.2.3 – Important Required Values for Program Set Up

Fields	Description	Comments
BIN#		
Processor Control #		
Group	PLAN	
Provider ID #	NPI	10 bytes (numeric)
Cardholder ID #	Plan Assigned Number	Up to 20 bytes (numeric)
Prescriber ID #	NPI number	• 10 bytes (numeric) • An algorithm validation will be performed to verify NPI is valid.
Product Code	National Drug Code (NDC)	11 digits

5.3 Paper Claims

All paper pharmacy claims must be submitted on a *Universal Claim Form* (UCF, version PUCF_D02PT) to the following address unless noted on the member ID card or other Plan documentation provided by the member.

MRx Pharmacy Solutions
Attn: Paper Claims Department
Post Office Box 85042
Richmond, VA 23261-5042

Please refer to Section 13.0 – Appendix D through Section 15.0 - Appendix F for client-specific information.

Information is available at http://www.ncpdp.org/products.aspx regarding the UCF.

6.0 Service Support

6.1 Online Certification

The Software Vendor/Certification Number (NCPDP Field # 11Ø-AK) of the Transaction Header Segment is required for claims submission under NCPDP Version D.0; providers should submit the value that is assigned to them when being certified.

Magellan Rx Management (MRx) certifies software vendors, not an individual pharmacy's computer system. A pharmacy should contact its vendor or MRx to determine if the required certification has been obtained. For assistance with software vendor certification, contact MRx.

6.2 Solving Technical Problems

Pharmacies receive one of the following messages when the MRx POS system is unavailable (see *Table 6.2.1 – Host System Problem Messages and Explanations)*:

Table 6.2.1 – Host System Problem Messages and Explanations

NCPDP	Message	Explanation
90	Host Hung Up	Host disconnected before session completed.
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
93	Planned Unavailable	Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is Saturday, 11:00 p.m., ET–Sunday, 6:00 a.m., ET.
99	Host Processing Error	Do not retransmit claims.

MRx strongly recommends that a pharmacy's software has the capability to submit backdated claims. Occasionally, a pharmacy may also receive messages that indicate its own network is having problems communicating with MRx. If this occurs, or if a pharmacy is experiencing technical difficulties connecting with the MRx system, pharmacies should follow the steps outlined below:

- Check the terminal and communication equipment to ensure that electrical power and telephone services are operational.
- Call the telephone number that the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message).
- Contact the software vendor if unable to access this information in the system.
- If the pharmacy has an internal technical staff, forward the problem to that department, then the internal technical staff should contact MRx to resolve the problem.
- If unable to resolve the problem after following the steps outlined above, directly contact the MRx Pharmacy Support Center.

7.0 Online Claims Processing Edits

7.1 Paid, Denied, and Rejected Responses

After an online claim submission is made by a pharmacy, the POS system returns a message to indicate the outcome of the processing. If the claim passes all edits, a PAID message is returned with the allowed reimbursement amount. A claim that fails an edit and is REJECTED (or DENIED) also returns with an NCPDP rejection code and message. Refer to Section 11.0 – Appendix B – Point-of-Sale Reject Codes and Messages for a list of POS rejection codes and messages.

7.2 Duplicate Response

A duplicate disposition occurs when there is an attempt to submit a claim that has already gone through the adjudication process with either some or all the previous claim's information. An exact match on the following fields results in a duplicate disposition:

- Same Patient/Member
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number
- Same Fill Number

In situations where there are matches on some of the above data elements, Magellan Rx Management (MRx) returns an *NCPDP Error Code # 83 – Duplicate Paid Claim* to indicate a possible suspected duplicate.

There are situations where the provider sends the transaction request and MRx receives the request and processes the transaction. Then, due to communication problems or interruptions, the response is not received by the provider. In these cases, the provider should resubmit the transaction request. MRx responds with the same information as the first response, but the transaction response is marked as duplicate. For Reversal transactions, the following criteria may be used to determine a duplicate request when the system has a successful reversal already processed for the claim:

- Same Patient/Member
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number
- Same Fill Number

8.0 Program Specifications

8.1 Timely Filing Limits

Network pharmacy Providers are encouraged to submit all claims, electronically, at the time of dispensing prescriptions.

- Unless otherwise agreed in writing and to the extent permissible by applicable law, all claims must be submitted within 90 days from the date of fill.
  - Reversals and resubmits must occur within 90 days of the claim's original submission date or other time period as communicated by Magellan Rx Management (MRx) or required by applicable law.
  - All prescriptions not received by the Covered Person must be reversed, online, within fourteen (14) days from the date the claim was processed.
- **Claims that exceed the prescribed timely filing limit will deny and return NCPDP error code – 81*"Timely Filing Exceeded".***
- Requests for overrides on claims and adjustments billed past the timely filing limit, the pharmacy must contact Plan for consideration. Providers should contact the Pharmacy Support Center.

8.2 Mandatory Generic Requirements

- The MRx Plan may have a mandatory generic program where:
  - Multi-source brand products submitted with a **DAW code of '1,'** Physician requested brand be dispensed (Physician writes "Dispense as Written" on Rx when there is a generic equivalent available) may require a prior authorization to bypass the MAC pricing. Member may have to pay the cost difference between the brand rates versus the generic rate, plan option.
  - Multi-source brand products submitted with a **DAW code of '2,'** Member requests brand be dispensed. Member may have to pay the cost difference between the brand rates versus the generic rate, plan option.
- Exceptions to the mandatory generic policy may exist where MRx prefers a brand product over a generic.
- Enrollees are not charged their brand co-pay.

8.3 Dispensing Limits/Claim Restrictions

The Plan may have dispensing limits/claim restrictions. Please review the reject responses on the claim and contact the Pharmacy Support Center if further information is needed.

8.3.1 Days' Supply

The standard days' supply maximum is defined by the Plan. The Plan may allow for up to a 102-day supply at retail. Pharmacy must be participating in the MRx 90-day at retail network to participate. If pharmacy received a reject for days' supply, please contact the Pharmacy Support Center or refer to the MRx website to request a contract for participation.

8.3.2 Quantity

8.3.2.1 Minimum or Maximum Quantity Limits, Quantity per Day, Quantity Over Time, and Maximum Daily Dose.

All quantity limits are established by the Plan or plan specific. Please refer to the specific reject response or contact the Pharmacy Support Center for assistance.

8.3.3 Dollar Limit

All dollar limits are established by the Plan. Please refer to the specific reject response or contact the Pharmacy Support Center for assistance.

8.3.4 Minimum/Maximum Age Limits

All Age limits are established by the Plan. Please refer to the specific reject response or contact the Pharmacy Support Center for assistance.

8.3.5 Refills

- **DEA = 0**: Original plus up to 99 refills within 366 days from original Date Rx Written
- **DEA = 2**: No refills
- **DEA = 3–5**: Original plus 5 refills within 183 days from original Date Rx Written

8.4 Provider Reimbursement

8.4.1 Provider Reimbursement Rates

Provider Reimbursement rates including dispense fees, compounding fees, specialty drug reimbursement rates, or LTC rates are established by the specific fee schedules agreed to within the *MRx Pharmacy Solutions Participating Pharmacy Agreement,* which may be renegotiated or added to from time to time. Please refer to your signed pharmacy agreement or contact the MRx Pharmacy Networks Department at: providerrelations@primetherapeutics.com for a copy of most recent pharmacy contract.

8.5 Plan Co-Pays

The Plan determines their own co-pay structure for all categories of medications, including but not limited to:

- Preferred Brand;
- Non-Preferred Brand;
- Generic; and
- Specialty Medications.

Please refer the member to his or her Plan documents, member portal, or the paid claim response for applicable co-pay.

8.6 Prior Authorizations

8.6.1 Clinical PAs

The MRx Clinical Call Center will receive PA requests for products that have clinical edits for the MRx program. PA request(s) are made by the prescribing physician or the prescribing physician's agent (must be documented agent). Requests may be initiated by telephone, fax, mail, or WebPA. PA requests should not be completed by the pharmacy. PA requests submitted by the pharmacy and not the prescribing physician or prescribing physician's agent will be denied or subject to overpayment recovery.

8.6.2 Emergency Protocols

The Plan pays for an emergency supply of medications that require a clinical PA (formulary edits do not qualify) if a PA request has not been processed and it is after hours, a weekend, or a designated holiday. An example of when this may occur is when the prescriber is unavailable to provide sufficient information required to complete the prior authorization.

The appropriate PA process must be utilized during regular business hours. All the following conditions must be met for an emergency supply:

- The participant is Plan-eligible on the date of service.
- The medication requires clinical PA (Formulary edits do not qualify).
- The medication is not an excluded product for the Plan.
- The days' supply for the emergency period does not exceed days' supply parameters for the Plan.

8.6.3.1 Emergency Supply Override Process

- Claim denied for requiring a clinical PA. Non-formulary medications do not qualify.
- The dispensing pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply.
- In the dispensing pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for the day supply. For unbreakable packages, the full package can be dispensed.
- The Plan can determine their own Emergency Supply Override process. In the event an emergency dispensing of medication is required, refer to Plan specific documentation, or contact the MRx Pharmacy Support Center for override process.
- The enrollee is not charged a co-pay for the emergency supply.
  - Only one emergency supply is provided per drug (HSN) per member per year.
  - Recipients are not permitted to receive, nor will Plan pay for the remainder of the original prescription at any pharmacy unless the prescriber has received a clinical PA.

8.6.3.2 Pharmacy Override Summary

Table 8.6.3.2.1 – Pharmacy Override Summary

Pharmacy Override Summary		
Override Type	**Override NCPDP Field**	**Code**
Emergency Day Supply of Formulary Products requiring clinical edit.	Prior Authorization Type Code (Field # 461-EU)	8
	Prior Authorization Number (Field # 462-EV)	Eleven 8s
Filling the Remainder of an Emergency 3-Day Supply after a PA is obtained	Submission clarification Code (NCPDP Field # 42Ø-DK)	5
Hospice Patient	Patient Residence Field (NCPDP Field # 384-4X)	11
Pregnant Patient	Pregnancy Indicator Field (NCPDP Field # 335-2C)	2

8.6.3 Preferred Drug List (PDL)/PA/Quantity/Duration Lists

- All claims are interrogated against the Preferred Drug List (PDL), benefit requirements, and DUR criteria. A complete listing of PA criteria, step therapy requirements, quantity limits, and duration of therapy edits may be requested on the MRx website.
- All claims are interrogated for compliance with state and federal requirements.
- Prescriptions must be dispensed pursuant to the orders of a physician or legally authorized prescriber. Any subsequent refills may be dispensed not more than one year from the date the prescription was written (or earlier whenever legally dictated).
- Schedule 2 drugs (CIIs) may not be refilled; a new prescription is required for each fill.

- Controlled drugs other than CIIs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to five refills or six months, whichever comes first.
- Non-controlled drugs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to one year.

8.7 ProDUR Drug Utilization Review

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of MRx assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the MRx ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. MRx recognizes that the pharmacists use their education and professional judgments in all aspects of dispensing.

8.7.1 Drug Utilization Review Edits

The following ProDUR edits will deny for the Plan:

Early Refill (ER)

- Non-controlled Products Early Refill Tolerance: 75–85 percent

  For non-controlled products, the system will automatically check for an increase in dose and when an increase in dosage is detected, the system will not deny the current claim for early refill.
- Controlled Products Early Refill Tolerance: 85–95 percent

  The Call Center may assist in overriding this reject if one of the following conditions exists:
  - Dosage/Therapy change has occurred.
  - Patient is no longer taking the original dosage.
  - Dosage Time/Frequency Change has occurred.
  - Two strengths of the same drug are used to make strength of that medication not currently manufactured.

Therapeutic Duplication

ProDUR edits involving: Narcotic Analgesics, Sedative Hypnotics, Benzodiazepines, or Skeletal Muscle Relaxants require a telephone call to the Pharmacy Support Center to obtain an override.

Minimum/Maximum Daily Dosing (LD, HD)

- High Dose HD Only – tolerance at 225 percent

Drug-to-Gender (SX)

Severity level 1 interaction will deny and require a call to the Pharmacy Support Center for override consideration. Severity level 2 interactions will return ProDUR message.

Drug-to-Pregnancy Precautions (PG)

Drug to Geriatric Precautions (PA)

Drug to Pediatric Precautions (PA)

8.7.2 ProDUR Overrides

The following are the NCPDP interactive Professional Service, Result of Service, Reason for Service, and Submission Clarification codes. These codes may be used to override ProDUR denials at the POS. Override codes must be entered each time error occurs.

Problem/Conflict Type: The following override codes may be used by providers in any condition where a provider-level override is allowed for ProDUR denials.

Professional Service Codes Allowed for Submission	Professional Service Code/Description	Result of Service Codes Allowed for Submission	Result of Service Code/Description	Reason for Service Code	Submission Clarification Code/Description (Listed as reference only, not required on claims)
All codes are allowed for all conflict types.	Select one: • **AS**/Patient Assessment • **CC**/Coordination of Care • **DE**/Dosing Evaluation/ Determination • **FE**/Formulary Enforcement • **GP**/Generic Product Selection • **M0**/Prescriber Consulted • **MA**/Medication Administration • **MR**/Medication Review	All codes are allowed for all conflict types.	Select one: • **1A**/filled as is, false positive • **1B**/filled prescription as is • **1C**/filled, with different dose • **1D**/filled, different direction • **1E**/filled, with different drug • **1F**/filled, different quantity • **1G**/filled, Prescriber approved • **1H**/brand-to-generic change • **1J**/Rx-to OTC change	ER DD TD SX	Select one: • 01/No Override • 02/Other Override • 03/Vacation supply • 04/Lost prescription • 05/Therapy change • 06/Starter Dose • 07/Medically necessary

Professional Service Codes Allowed for Submission	Professional Service Code/Description	Result of Service Codes Allowed for Submission	Result of Service Code/Description	Reason for Service Code	Submission Clarification Code/Description (Listed as reference only, not required on claims)
	• **PH**/Patient Medication History • **PM**/Patient Monitoring • **P0**/Patient Consulted • **PE**/Patient Education /Instruction • **PT**/Perform Laboratory Test • **RO**/Physician Consulted Other Source • **RT**/Recommended Laboratory Tests • **SC**/Self Care Consultation • **SW**/Literature Search/Review • **TC**/Payer/Processor Consulted • **TH**/Therapeutic Product Interchange		• **1K**/filled, different dosage form • **2A**/prescription not filled • **2B**/not filled – direction clarified • **3A**/recommendation accepted • **3B**/recommendation not accepted • **3C**/discontinued drug • **3D**/regimen changed • **3E**/therapy changed • **3F**/therapy chg – cost inc accepted • **3G**/drug therapy unchanged • **3H**/follow-up report • **3J**/Patient referral • **3K**/instructions understood • **3M**/compliance aid provided • **3N**/medication administered		

All ProDUR alert messages appear at the end of the claim's adjudication transmission.

Alerts appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.

Format	Field Definitions
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. • 1 = Your Pharmacy • 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. • 1 = First Databank • 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. • 0 = No Value • 1 = Same Prescriber • 2 = Other Prescriber

8.8 Retro DUR

All standard retrospective DUR (RetroDUR) programs adhere to current standards of drug-based screening elements for medications that have limited clinical documentation supporting combination use, carry high-risk warnings for concomitant drug therapy, identify overuse, identify underuse or sub-therapeutic dosing of medication, suggest possible fraud, and abuse potential or offer other opportunities to improve patient care.

The MRx RetroDUR systems logic identifies and profiles members, pharmacy providers, prescribers, and disease states. Program-specific historical data are used to identify trends of interest and variables that can be used as reliable predictors of subsequent outcomes. After interventions are made to either pharmacy providers or prescribers, follow-up ensures that members receive quality care, as well as cost-effective and therapeutically sound treatment. MRx clinical staff detects therapeutically inappropriate treatment trends that are then targeted for intervention.

MRx's RetroDUR programs include the standard member exception-based program, as well as pharmacy provider, prescriber, and disease state profiling. The RetroDUR system is supported by a fully-integrated data warehouse of both pharmacy and medical data, including diagnosis, procedure, hospital, and laboratory claims data when available.

Criteria are revised as therapeutic problems are identified and/or eliminated and new drug products are released. The program promotes therapeutic appropriateness of medications by checking for, but not limited to, early refills, brand versus generic utilization, drug-to-drug

interactions, and therapeutic duplication. These RetroDUR edits detect potential adverse drug consequences of incorrect drug utilization. The RetroDUR system detects excessive use of medication and insufficient daily doses by comparing drugs selected for review to the submitted daily doses and the duration of therapy. This RetroDUR edit detects errors in dosage and duration and monitors member compliance. Clinical abuse or misuse can be determined so remedial strategies can be introduced to improve quality of care and conserve program funds.

MRx's standard Therapeutic Criteria Catalog contains medically accepted standards of practice that have been identified and are continually updated to reflect current medical literature. The criteria are designed to reduce the incidence of drug therapy failure and drug-induced illness. The system detects drug-to-diagnosis contraindications, treatment failure, adverse reactions, and iatrogenic effects by evaluating drug, diagnostic, and laboratory procedural information, when available. Other factors, such as the patient's age, gender, location, co-morbidities, and those members receiving mental health and/or substance abuse treatment, are also incorporated into criteria as medically relevant.

MRx also has the ability to develop criteria that look for opportunities to improve adherence to established and new evidence-based guidelines – for example, a criterion that looks for members with diabetes who could benefit from initiation of an angiotensin converting enzyme inhibitor (ACEI) to reduce the risk of diabetic complications.

The appropriate medical references are documented for each therapeutic criterion. When new criteria are developed, the information regarding approved dosage forms, approved indications, doses, duration of therapy, adverse reactions, and drug interactions is collected and carefully evaluated. These criteria are translated into sophisticated computer algorithms and entered into the Therapeutic Criteria Catalogue for additional analysis by team members. Extensive automated testing is then performed using broad patient populations. The resulting exception profiles are then evaluated, and changes are made, as necessary.

MRx will use these tools to evaluate the level and quality of care provided to the program's members and to identify possible overpayment as a result of inappropriate utilization.

MRx's DUR Program shall include policies and/or procedures that address criteria for:

- Identifying the drug use that is outside the standard of practice;
- Evaluating the available drug submission data:
  - Comparing between optimal (based on best available science)/appropriate and actual use in order to address discrepancies;
  - Coordinating intervention when treatment alternatives are warranted; and
  - Evaluating the effectiveness of the drug utilization management program; and
- Timeliness of the reviews;
- Disclosure of the clinical oversight process to the Plans; and
- Disclosure of the clinical oversight process to prescribers, upon request.

8.9 Special Participant Conditions

Please refer to Section 13.0 - Appendix D through Section 15.0 – Appendix F for client-specific information.

8.9.1 Lock-In

A member may be locked into a prescriber, pharmacy provider, or both; the Plan guidelines will vary. Refer to the rejection code on the claim and contact the Pharmacy Support Center.

- Enrollees may be locked into a designated pharmacy. Claims submitted for these individuals will deny NCPDP EC 50 – "Non-matched Pharmacy Number" with an additional supplemental message when the claim is submitted by an unauthorized pharmacy. In the event of an emergency, contact the MRx Pharmacy Support Center for override consideration.

8.10 Compound Claims

All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be submitted on the claim. At least one item in the compound must be a covered drug. *If an excluded or non-PDL agent is included in the compound, the claim will reject for "invalid compound."* The pharmacy may place an **8** in the submission clarification code field and resubmit the claim; however, be advised that any component of a compound requiring a PA will necessitate an approval prior to receiving payment from the Plan Pharmacy Program.

Important Notes:

- The Claim Segment Product ID (i.e., National Drug Code [NDC]) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
- A non-blank space value is expected in the Claim Segment Product ID field for field validation. The pharmacy submits a single zero in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected if a single zero is not submitted as the Product ID.
- A Submission Clarification Code value of "8" only allows a claim to continue processing if at least one ingredient is covered. Non-rebateable ingredients will process with the submission clarification code; but only rebateable ingredients are eligible for reimbursement.
- The Compound Type, NCPDP Field # 996-G1, is required to be submitted on all compound claims. If this field is not submitted, the claim will reject.

- Each multi-ingredient compound claim counts as one claim towards the Brand Rx fill limits, if applicable.
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- If total cost is not equal to the sum of the ingredients' cost, the claim will deny.
- Multiple instances of an NDC within a compound will not be allowed.
- Duplicate edits are applied regardless of the compound status of the claim.

8.10.1 Fields Required for Submitting Multi-Ingredient Compounds

On Claim Segment

- Enter **Compound Code** (NCPDP Field # 4Ø6-D6) of "2."
- Enter **Product Code/NDC** (NCPDP Field # 4Ø7-D7) as "0" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter **Product/Service ID Qualifier** (NCPDP Field # 436-E1) as "00" to identify the product as a multi-ingredient compound.
- Enter **Quantity Dispensed** (NCPDP Field # 442-E7) of entire product.
- Enter **Gross Amount Due** (NCPDP Field # 43Ø-DU) for entire product.
- **Submission Clarification Code** (NCPDP Field # 42Ø-DK) = Value "8" will only be permitted for POS (not valid for paper claims) and should be used only for compounds.

On Compound Segment

- **Compound Dosage Form Description Code** (NCPDP Field # 45Ø-EF)
- **Compound Dispensing Unit Form Indicator** (NCPCP Field # 451-EG)
- **Compound Route of Administration** (NCPCP Field # 452-EH)
- **Compound Ingredient Component Count** (NCPCP Field # 447-EC) (Maximum of 25)

For Each Line Item

- **Compound Product ID Qualifier** (NCPCP Field # 488-RE) of "00"
- **Compound Product ID** (NCPDP Field # 489-TE)
- **Compound Ingredient Quantity** (NCPDP Field # 448-ED)
- **Compound Ingredient Cost** (NCPDP Field # 449-EE)

8.11 Partial Fills

In those cases where a pharmacy provider does not dispense the full amount per the prescriber's directions because of a drug shortage, the pharmacy provider should submit the claim as a partial fill and indicate as such on the claim transaction.

- Standard NCPDP fields required for partial fills will be supported and required.
- The dispense fee will be paid on the initial fill.
- The co-payment, if applicable, will be collected on the initial fill.
- Partial fills cannot be use with Multi-Ingredient Compound claims.
- Partial fills may not be transferred from one Pharmacy to another.
- Two Partial fill transactions may not be submitted on the same day; the Service Date must be different for each of the partial transactions and the completion transaction.

9.0 Coordination of Benefits

Typically, the Magellan Rx Management (MRx) Plan is the primary payer. In the event they are the secondary payer, please follow the subsequent guidelines. Coordination of benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments, and thus, prevention of duplicate payments.

Third-party liability (TPL) refers to:

- An insurance plan or carrier;
- A program; and
- A commercial carrier.

The plan or carrier can be:

- An individual;
- A group;
- Employer-related;
- Self-insured; and
- A self-funded plan.

The program can be Medicare, which has liability for all or part of an enrollee's medical or pharmacy coverage.

The terms *third-party liability* and *other insurance* are used interchangeably to mean any source other than the Plan that has a financial obligation for health care coverage.

Please refer to Section 13.0 – Appendix D through Section 15.0 – Appendix F for client-specific information.

9.1 COB General Instructions

9.1.1 COB Process

The MRx COB process does require a match on Other Payer ID and submission of the Other Payer Date.

- Online COB (cost avoidance) is required. COB edits will be applied when TPL exists for the enrollee and claim DOS.
- The Plan is always the payer of last resort. Providers must bill all other payers first and then bill the Plan. This requirement also applies to compounds.
- COB processing requires that the Other Payer Amount Paid, Other Payer ID, Other Payer Date, and Other Payer Patient Responsibility be submitted on the claim to the Plan.

Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.

- System returns Other Payer details in "COB Response Segment" (items returned are subject to information received on the recipients COB records):
  - Other Payer Coverage Type
  - Other Payer ID Qualifier
  - Other Payer ID
  - Other Payer Processor Control Number (PCN)
  - Other Payer Cardholder ID
  - Other Payer Group ID
  - Other Payer Person Code
  - Other Payer Help Desk Phone Number
  - Other Payer Patient Relationship Code
  - Other Payer Benefit Effective Date
  - Other Payer Benefit Termination Date
- Reimbursement will be calculated to pay the lesser of the Plan allowed amount or the Other Payer Patient Responsibility as reported by the primary carrier, less the third-party payment.

- Plan co-payments will also be deducted for participants subject to Plan co-pay. In some cases, this may result in the claim billed to the Plan being paid at $0.00.

  Note: MRx will not send a negative amount in the Amount Paid field if the TPL and co-payment are greater than the Plan allowable.

- Co-pay Only Claims, Other Coverage Code = 8, are not allowed.

Following are values and claim dispositions based on pharmacist submission of the standard NCPDP TPL codes. Where applicable, it has been noted which Other Coverage Code (NCPDP Field # 308-C8) should be used based on the error codes received from the primary.

Table 9.1.1.1 – TPL Codes

NCPDP Field #308-C8	When to Use	Submission Requirements/Responses
O – Not Specified	OCC 0 is allowed; submit when member does not have TPL.	Claim will reject with a 41 error if member record has TPL. Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be submitted to TPL and then resubmitted with proper OCC and COB required fields.

NCPDP Field #308-C8	When to Use	Submission Requirements/Responses
1 – No Other Coverage	OCC 1 is allowed; This code can be used when the pharmacy cannot determine the valid TPL identity.	• Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be submitted to TPL and then resubmitted to the Plan with proper OCC and COB required fields. • Verify TPL information provided. • When the enrollee has TPL on file and the OCC 1 is submitted, the claim will continue to reject for NCPDP 41.
2 – Exists Payment Collected	OCC 2 is used when any positive amount of money is collected from another payer. Submit the amount collected from the other primary payer(s) (TPL), along with the date the claim was adjudicated to the primary payer (TPL) in order override the TPL denial.	Paid claim and completed COB segment inclusive of the following fields: • Other Payer Amount Paid (Field # 431-DV) that is > $0 • Other Payer Amount Paid Qualifier (Field # 342-HC) must be a valid value. • Other Payer-Patient Responsibility Amount Submitted (Field # 352-NQ) if ≥ $0 • Other Payer Date (Field # 443-E8) that is compliant with timely filing. • Other Payer ID (Field # 340-7C) that is valid. • Other Payer ID Qualifier (Field # 339-6C) that is valid. Claims submitted without required COB fields will reject with NCPDP specific reject codes.
3 – Exists Claim Not Covered	OCC 3 is used when the Plan beneficiary has TPL, but the particular drug is not covered by the other plan(s).	Requires submission of: • Other Payer Date (Field # 443-E8) • Other Payer ID (Field # 340-7C) • Other Payer ID Qualifier (Field # 339-6C) The reject code generated after billing the other insurer(s) should be submitted in the "Other Payer Reject Code (472-6E) field. Claim will pay only if the following Other Payer Reject codes submitted are: 60, 61, 63, 65, 66, 67, 68, 69, 70, 3Y Claims submitted without required COB fields will reject with NCPDP specific reject codes.

NCPDP Field #308-C8	When to Use	Submission Requirements/Responses
4 – Exists Payment Not Collected	OCC 4 is used when a patient's TPL is active, but there is no payment collected from the primary insurer (i.e., the beneficiary has not met their primary payer's deductible obligation, plan capitation, etc.). OCC 4 should also be used if the total cost of the claim is less than the patient's TPL co-pay requirement and the primary insurance plan made no payment.	Paid claim; also requires submission of: • Other Payer Amount Paid (Field # 431-DV) that = $0 • Other Payer Amount Paid Qualifier (Field # 342-HC) • Other Payer-Patient Responsibility Amount Submitted (Field # 352-NQ) this is = $0 • Other Payer Date (Field # 443-E8) that is valid. • Other Payer ID (Field # 340-7C) that is valid. • Other Payer ID Qualifier (Field # 339-6C) Claims submitted without required COB fields will reject with NCPDP specific reject codes.
8 – Claim Billing for a Co-pay	OCC 8 is not accepted	

10.0 Appendix A: Plan D.0 Payer Specification

For client-specific payer specification documents, please refer to Section 13.0 – Appendix D through Section 15.0 – Appendix F.

11.0 Appendix B: Point-of-Sale Reject Codes and Messages

The following table lists the rejection codes and explanations, possible B1, B2, B3 fields that may be related to denied payment, and possible solutions for pharmacies experiencing difficulties. All edits may not apply to this program. Pharmacies requiring assistance should call the Magellan Rx Management (MRx) Pharmacy Support Center. Please refer to Section 13.0 – Appendix D through Section 15.0 - Appendix F for client-specific information.

11.1 Version D.0 Reject Codes for Telecommunication Standard

All edits may not apply to this program.

Table 11.1.1 – Point-of-Sale Reject Codes and Messages

Reject Code	Explanation	Field Number Possibly in Error
ØØ	"M/I" Means Missing/Invalid	
Ø1	M/I BIN	1Ø1
Ø2	M/I Version Number	1Ø2
Ø3	M/I Transaction Code	1Ø3
Ø4	M/I Processor Control Number	1Ø4
Ø5	M/I Pharmacy Number	2Ø1
Ø6	M/I Group Number	3Ø1
Ø7	M/I Cardholder ID Number	3Ø2
Ø8	M/I Person Code	3Ø3
Ø9	M/I Birth Date	3Ø4
1C	M/I Smoker/Non-Smoker Code	334
1E	M/I Prescriber Location Code	467
1Ø	M/I Patient Gender Code	3Ø5
11	M/I Patient Relationship Code	3Ø6
12	M/I Patient Location	3Ø7
13	M/I Other Coverage Code	3Ø8
14	M/I Eligibility Clarification Code	3Ø9
15	M/I Date of Service	4Ø1
16	M/I Prescription/Service Reference Number	4Ø2
17	M/I Fill Number	4Ø3
19	M/I Days' Supply	4Ø5

Reject Code	Explanation	Field Number Possibly in Error
2C	M/I Pregnancy Indicator	335
2E	M/I Primary Care Provider ID Qualifier	468
2Ø	M/I Compound Code	4Ø6
21	M/I Product/Service ID	4Ø7
22	M/I Dispense as Written (DAW)/Product Selection Code	4Ø8
23	M/I Ingredient Cost Submitted	4Ø9
25	M/I Prescriber ID	411
26	M/I Unit of Measure	6ØØ
28	M/I Date Prescription Written	414
29	M/I Number Refills Authorized	415
3A	M/I Request Type	498-PA
3B	M/I Request Period Date-Begin	498-PB
3C	M/I Request Period Date-End	498-PC
3D	M/I Basis of Request	498-PD
3E	M/I Authorized Representative First Name	498-PE
3F	M/I Authorized Representative Last Name	498-PF
3G	M/I Authorized Representative Street Address	498-PG
3H	M/I Authorized Representative City Address	498-PH
3J	M/I Authorized Representative State/Province Address	498-PJ
3K	M/I Authorized Representative Zip/Postal Zone	498-PK
3M	M/I Prescriber Phone Number	498-PM
3N	M/I Prior Authorized Number Assigned	498-PY
3P	M/I Authorization Number	5Ø3
3R	Prior Authorization Not Required	4Ø7
3S	M/I Prior Authorization Supporting Documentation	498-PP
3T	Active Prior Authorization Exists Resubmit at Expiration of Prior Authorization	
3W	Prior Authorization in Process	
3X	Authorization Number Not Found	5Ø3
3Y	Prior Authorization Denied	
32	M/I Level of Service	418
33	M/I Prescription Origin Code	419

Reject Code	Explanation	Field Number Possibly in Error
34	M/I Submission Clarification Code	42Ø
35	M/I Primary Care Provider ID	421
38	M/I Basis of Cost	423
39	M/I Diagnosis Code	424
4C	M/I Coordination of Benefits/Other Payments Count	337
4E	M/I Primary Care Provider Last Name	57Ø
4Ø	Pharmacy Not Contracted with Plan on Date of Service	None
41	Submit Bill to Other Processor or Primary Payer	None
5C	M/I Other Payer Coverage Type	338
5E	M/I Other Payer Reject Count	471
5Ø	Non-Matched Pharmacy Number	2Ø1
51	Non-Matched Group ID	3Ø1
52	Non-Matched Cardholder ID	3Ø2
53	Non-Matched Person Code	3Ø3
54	Non-Matched Product/Service ID Number	4Ø7
55	Non-Matched Product Package Size	4Ø7
56	Non-Matched Prescriber ID	411
58	Non-Matched Primary Prescriber	421
6C	M/I Other Payer ID Qualifier	422
6E	M/I Other Payer Reject Code	472
6Ø	Product/Service Not Covered for Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7
61	Product/Service Not Covered for Patient Gender	3Ø2, 3Ø5, 4Ø7
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 32Ø
63	Institutionalized Patient Product/Service ID Not Covered	
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 416
65	Patient Is Not Covered	3Ø3, 3Ø6
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6
67	Filled Before Coverage Effective	4Ø1
68	Filled After Coverage Expired	4Ø1
69	Filled After Coverage Terminated	4Ø1
7C	M/I Other Payer ID	34Ø

Reject Code	Explanation	Field Number Possibly in Error
7E	M/I DUR/PPS Code Counter	473
7Ø	Product/Service Not Covered	4Ø7
71	Prescriber Is Not Covered	411
72	Primary Prescriber Is Not Covered	421
73	Refills Are Not Covered	4Ø2, 4Ø3
74	Other Carrier Payment Meets or Exceeds Payable	4Ø9, 41Ø, 442
75	Prior Authorization Required	462
76	Plan Limitations Exceeded	4Ø5, 442
77	Discontinued Product/Service ID Number	4Ø7
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5
8C	M/I Facility ID	336
8E	M/I DUR/PPS Level of Effort	474
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424
81	Claim Too Old	4Ø1
82	Claim Is Post-Dated	4Ø1
83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7
84	Claim Has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2
85	Claim Not Processed	None
86	Submit Manual Reversal	None
87	Reversal Not Processed	None
88	DUR Reject Error	
89	Rejected Claim Fees Paid	
9Ø	Host Hung Up	Host Disconnected Before Session Completed
91	Host Response Error	Response Not in Appropriate Format to Be Displayed
92	System Unavailable/Host Unavailable	Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period
95	Time Out	Refer to *Solving Technical Problems* for additional information

Reject Code	Explanation	Field Number Possibly in Error
96	Scheduled Downtime	Refer to *Solving Technical Problems* for additional information
97	Payer Unavailable	Refer to *Solving Technical Problems* for additional information
98	Connection to Payer Is Down	Refer to *Solving Technical Problems* for additional information
99	Host Processing Error	Do Not Retransmit Claim(s)
AA	Patient Spend Down Not Met	
AB	Date Written Is After Date Filled	
AC	Product Not Covered Non-Participating Manufacturer	
AD	Billing Provider Not Eligible to Bill This Claim Type	
AE	QMB (Qualified Medicare Beneficiary) – Bill Medicare	
AF	Patient Enrolled Under Managed Care	
AG	Days' Supply Limitation for Product/Service	
AH	Unit Dose Packaging Only Payable for Nursing Home Recipients	
AJ	Generic Drug Required	
AK	M/I Software Vendor/Certification ID	11Ø
AM	M/I Segment Identification	111
A9	M/I Transaction Count	1Ø9
BE	M/I Professional Service Fee Submitted	477
B2	M/I Service Provider ID Qualifier	2Ø2
CA	M/I Patient First Name	31Ø
CB	M/I Patient Last Name	311
CC	M/I Cardholder First Name	312
CD	M/I Cardholder Last Name	313
CE	M/I Home Plan	314
CF	M/I Employer Name	315
CG	M/I Employer Street Address	316
CH	M/I Employer City Address	317

Reject Code	Explanation	Field Number Possibly in Error
CI	M/I Employer State/Province Address	318
CJ	M/I Employer Zip Postal Zone	319
CK	M/I Employer Phone Number	32Ø
CL	M/I Employer Contact Name	321
CM	M/I Patient Street Address	322
CN	M/I Patient City Address	323
CO	M/I Patient State/Province Address	324
CP	M/I Patient Zip/Postal Zone	325
CQ	M/I Patient Phone Number	326
CR	M/I Carrier ID	327
CW	M/I Alternate ID	33Ø
CX	M/I Patient ID Qualifier	331
CY	M/I Patient ID	332
CZ	M/I Employer ID	333
DC	M/I Dispensing Fee Submitted	412
DN	M/I Basis of Cost Determination	423
DQ	M/I Usual and Customary Charge	426
DR	M/I Prescriber Last Name	427
DT	M/I Unit Dose Indicator	429
DU	M/I Gross Amount Due	43Ø
DV	M/I Other Payer Amount Paid	431
DX	M/I Patient Paid Amount Submitted	433
DY	M/I Date of Injury	434
DZ	M/I Claim/Reference ID	435
EA	M/I Originally Prescribed Product/Service Code	445
EB	M/I Originally Prescribed Quantity	446
EC	M/I Compound Ingredient Component Count	447
ED	M/I Compound Ingredient Quantity	448
EE	M/I Compound Ingredient Drug Cost	449
EF	M/I Compound Dosage Form Description Code	45Ø
EG	M/I Compound Dispensing Unit Form Indicator	451

Reject Code	Explanation	Field Number Possibly in Error
EH	M/I Compound Route of Administration	452
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453
EK	M/I Scheduled Prescription ID Number	454
EM	M/I Prescription/Service Reference Number Qualifier	445
EN	M/I Associated Prescription/Service Reference Number	456
EP	M/I Associated Prescription/Service Date	457
ER	M/I Procedure Modifier Code	459
ET	M/I Quantity Prescribed	46Ø
EU	M/I Prior Authorization Type Code	461
EV	M/I Prior Authorization Number Submitted	462
EW	M/I Intermediary Authorization Type ID	463
EX	M/I Intermediary Authorization ID	464
EY	M/I Provider ID Qualifier	465
EZ	M/I Prescriber ID Qualifier	466
E1	M/I Product/Service ID Qualifier	436
E3	M/I Incentive Amount Submitted	438
E4	M/I Reason for Service Code	439
E5	M/I Professional Service Code	44Ø
E6	M/I Result of Service Code	441
E7	M/I Quantity Dispensed	442
E8	M/I Other Payer Date	443
E9	M/I Provider ID	444
FO	M/I Plan ID	524
GE	M/I Percentage Sales Tax Amount Submitted	482
HA	M/I Flat Sales Tax Amount Submitted	481
HB	M/I Other Payer Amount Paid Count	341
HC	M/I Other Payer Amount Paid Qualifier	342
HD	M/I Dispensing Status	343
HE	M/I Percentage Sales Tax Rate Submitted	483
HF	M/I Quantity Intended to Be Dispensed	344
HG	M/I Days' Supply Intended to Be Dispensed	345

Reject Code	Explanation	Field Number Possibly in Error
H1	M/I Measurement Time	495
H2	M/I Measurement Dimension	496
H3	M/I Measurement Unit	497
H4	M/I Measurement Value	499
H5	M/I Primary Care Provider Location Code	469
H6	M/I DUR Co-Agent ID	476
H7	M/I Other Amount Claimed Submitted Count	478
H8	M/I Other Amount Claimed Submitted Qualifier	479
H9	M/I Other Amount Claimed Submitted	48Ø
JE	M/I Percentage Sales Tax Basis Submitted	484
J9	M/I DUR Co-Agent ID Qualifier	475
KE	M/I Coupon Type	485
M1	Patient Not Covered in This Aid Category	
M2	Recipient Locked In	
M3	Host PA/MC Error	
M4	Prescription/Service Reference Number/Time Limit Exceeded	
M5	Requires Manual Claim	
M6	Host Eligibility Error	
M7	Host Drug File Error	
M8	Host Provider File Error	
ME	M/I Coupon Number	486
MZ	Error Overflow	
NE	M/I Coupon Value Amount	487
NN	Transaction Rejected at Switch or Intermediary	
PA	PA Exhausted/Not Renewable	
PB	Invalid Transaction Count for This Transaction Code	1Ø3, 1Ø9
PC	M/I Claim Segment	111
PD	M/I Clinical Segment	111
PE	M/I COB/Other Payments Segment	111
PF	M/I Compound Segment	111
PG	M/I Coupon Segment	111

Reject Code	Explanation	Field Number Possibly in Error
PH	M/I DUR/PPS Segment	111
PJ	M/I Insurance Segment	111
PK	M/I Patient Segment	111
PM	M/I Pharmacy Provider Segment	111
PN	M/I Prescriber Segment	111
PP	M/I Pricing Segment	111
PR	M/I Prior Authorization Segment	111
PS	M/I Transaction Header Segment	111
PT	M/I Workers' Compensation Segment	111
PV	Non-Matched Associated Prescription/Service Date	457
PW	Non-Matched Employer ID	333
PX	Non-Matched Other Payer ID	34Ø
PY	Non-Matched Unit Form/Route of Administration	451, 452, 6ØØ
PZ	Non-Matched Unit of Measure to Product/Service ID	4Ø7, 6ØØ
P1	Associated Prescription/Service Reference Number Not Found	456
P2	Clinical Information Counter Out of Sequence	493
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions	447
P4	Coordination of Benefits/Other Payments Count Does Not Match Number of Repetitions	337
P5	Coupon Expired	486
P6	Date of Service Prior to Date of Birth	3Ø4, 4Ø1
P7	Diagnosis Code Count Does Not Match Number of Repetitions	491
P8	DUR/PPS Code Counter Out of Sequence	473
P9	Field Is Non-Repeatable	
RA	PA Reversal Out of Order	
RB	Multiple Partials Not Allowed	
RC	Different Drug Entity Between Partial and Completion	
RD	Mismatched Cardholder/Group ID – Partial to Completion	3Ø1, 3Ø2
RE	M/I Compound Product ID Qualifier	488

Reject Code	Explanation	Field Number Possibly in Error
RF	Improper Order of Dispensing Status Code on Partial Fill Transaction	
RG	M/I Associated Prescription/Service Reference Number on Completion Transaction	456
RH	M/I Associated Prescription/Service Date on Completion Transaction	457
RJ	Associated Partial Fill Transaction Not on File	
RK	Partial Fill Transaction Not Supported	
RM	Completion Transaction Not Permitted with Same "Date of Service" As Partial Transaction	4Ø1
RN	Plan Limits Exceeded on Intended Partial Fill Values	344, 345
RP	Out of Sequence "P" Reversal on Partial Fill Transaction	
RS	M/I Associated Prescription/Service Date on Partial Transaction	457
RT	M/I Associated Prescription/Service Reference Number on Partial Transaction	456
RU	Mandatory Data Elements Must Occur Before Optional Data Elements in a Segment	
R1	Other Amount Claimed Submitted Count Does Not Match Number of Repetitions	478, 48Ø
R2	Other Payer Reject Count Does Not Match Number of Repetitions	471, 472
R3	Procedure Modifier Code Count Does Not Match Number of Repetitions	458, 459
R4	Procedure Modifier Code Invalid for Product/Service ID	4Ø7, 436, 459
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436
R6	Product/Service Not Appropriate for This Location	3Ø7, 4Ø7, 436
R7	Repeating Segment Not Allowed in Same Transaction	
R8	Syntax Error	
R9	Value in Gross Amount Due Does Not Follow Pricing Formulae	43Ø
SE	M/I Procedure Modifier Code Count	458
TE	M/I Compound Product ID	489

Reject Code	Explanation	Field Number Possibly in Error
UE	M/I Compound Ingredient Basis of Cost Determination	49Ø
VE	M/I Diagnosis Code Count	491
WE	M/I Diagnosis Code Qualifier	492
XE	M/I Clinical Information Counter	493
ZE	M/I Measurement Date	494

12.0 Appendix C: State Regulatory Requirements

This section provides the State Regulatory Requirements for which Magellan Rx Management (MRx) may represent over time based on the MRx Pharmacy Solutions Participating Pharmacy Agreement.

12.1 Medicare Part D

MEDICARE PART D ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Medicare Part D Addendum ("Medicare Addendum") applies to the extent that Pharmacy is a downstream entity to Part D Sponsors and PBM and provides delegated pharmacy services set forth in the Agreement and this Part D Addendum to Part D Members.

1. **DEFINITIONS**. All capitalized terms shall have the meaning set forth in the Agreement. The following terms have the following meanings:

   "Clean Claim" shall have the meaning set forth in 42 CFR 423.520.

   "CMS" means the Centers for Medicare and Medicaid Services.

   "Home Infusion Pharmacy" means a pharmacy under contract with PBM that certifies its capabilities to meet the requirements set forth in 42 CFR 423.120(a)(4).

   "Indian Tribe, Tribal Organization or Urban Indian Organization Pharmacy" or "I/T/U Pharmacy" shall have the meaning of the term "I/T/U Pharmacy" set forth in 42 CFR 423.100.

   "Medicare Worker" means any person involved in the delivery or administration of services to Part D Members, including any officer, employee, temporary employee, volunteer, or consultant of Pharmacy.

   "Medicare Laws" means the Social Security Act, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, any applicable regulations (including but not limited to those under 42 CFR Part 423), the CMS Medicare Prescription Drug Benefit Manual (the "Manual"), and any and all related guidance, instructions, or other requirements issued by CMS.

   "Medicare Part D" means the Medicare Prescription Drug Benefit program authorized by Part D of Title XVIII of the Social Security Act.

   "Medicare Part D Pharmacy Network" means PBM's network of participating pharmacies made available to Part D Sponsors for the benefit of Part D Members. A Medicare Part D Pharmacy Network is a Pharmacy Network.

"Long Term Care Pharmacy" or "LTC Pharmacy" shall have the meaning of the term "long term care network pharmacy" set forth in 42 CFR 423.100.

"Part D Cost Share" means the amount that a Part D Member is required to pay for a Part D Drug under a Part D Plan, whether as copayment, coinsurance, deductible, or other amount.

"Part D Drug" shall have the meaning set forth in 42 CFR 423.100. A Part D Drug is a Covered Drug.

"Part D Member" means a Part D Eligible Individual as set forth in 42 CFR 423.4 and who is a Covered Person under a Part D Sponsor's Part D Plan.

"Part D Plan" shall have the meaning set forth in 42 CFR 423.4. A Part D Plan is a Benefit Plan.

"Part D Sponsor" means a Plan Sponsor under contract with CMS to provide a Part D Plan to Part D Members.

2. **SCOPE OF ADDENDUM**

2.1 Participation in Part D Networks. PBM will identify Pharmacy as a participant in PBM's Medicare Part D Pharmacy Networks, provided however, that nothing in this Medicare Addendum will require a Part D Sponsor to include Pharmacy in any Medicare Part D Pharmacy Network.

2.2 Services. This Medicare Addendum applies only to Pharmacy's provision of services to Part D Members. Pharmacy will provide services to Part D Members in accordance with the terms set forth herein.

3. **PHARMACY OBLIGATIONS**

3.1 Claim Submission. Pharmacy will submit all claims for Part D Drugs dispensed to a Part D Member through the electronic point of sale system provided by PBM, except as otherwise specified in this Addendum or any Schedule hereto. Pharmacy will follow PBM's instructions provided through such system, including the collection of the applicable Part D Cost Share. Pharmacy will submit a claim to PBM whenever a Part D Member presents his or her Medicare identification card, or the information on such card is on file with Pharmacy, unless the Part D Member expressly requests that Pharmacy not submit such claim.

3.2 Cost Sharing Amounts. Pharmacy will collect the Part D Cost Share communicated by PBM to Pharmacy, including any such amounts due from a Part D Member that qualifies for a low-income subsidy. Pharmacy will not waive any such Part D Cost Share amount.

3.3 Negotiated Prices. Pharmacy will extend the negotiated prices for Part D Drugs (i.e., the amount of reimbursement under this Agreement) to Part D Members even if no benefits are payable to the Part D Member because of the application of any Part D Cost Share. In such instance, Pharmacy will collect from the Part D Member no more than the negotiated price, even if such price is less than the amount of the Part D Cost Share.

3.4 Hold Harmless. Pharmacy will not charge or otherwise seek to hold responsible any Part D Member for any amount relating the dispensing of a Part D Drug, except for Part D Cost Share and any costs Pharmacy is required to incur to collect such Part D Cost Share (e.g., fee relating to a returned check). In no event will Pharmacy hold a Part D Member responsible for payment of any amount that is the obligation of PBM or a Part D Sponsor. This limitation applies even in the event that PBM does not compensate Pharmacy for its services under this Agreement for any reason.

3.5 Equivalent Drugs. Pharmacy will, after the Part D Drug is dispensed at the point of sale, inform the Part D Member of any differential between the price of that drug and the price of the lowest priced generic version of that Part D Drug that is therapeutically equivalent and bioequivalent and available at Pharmacy, if one exists for the Part D Member's prescription.

3.6 Appeals Notices. Pharmacy will provide to each Part D Member whose prescription cannot be covered under the Part D Plan at the point of sale, as indicated in the transaction response, the standardized notice, and instructions on how the Part D Member may contact the Part D Sponsor and the Part D Member's right to receive, upon request, a coverage determination, including information about the exceptions process.

3.7 Vaccines. Pharmacy may provide and administer vaccines if permitted by applicable state law. Pharmacy represents and warrants that it will comply with all applicable laws and regulations relating to the sale, dispensing, and administration of such vaccines (including any licensing requirements), and that all Medicare Workers involved in the sale, dispensing, or administration of any vaccines are appropriately licensed and have undergone all required training and education relating to the provision of such services.

3.8 Monitoring. Pharmacy acknowledges that PBM and/or Part D Sponsors will monitor and evaluate the Pharmacy's performance of its services to Part D Members on an ongoing basis.

3.9 Delegation. In the event PBM approves Pharmacy's subcontracting/delegation of services hereunder, Pharmacy's delegated services will be memorialized in a written and signed agreement that requires such delegate to comply with all applicable provisions of this Agreement (including specifically this Medicare Addendum), and

that all services will be performed in a manner consistent with this Agreement, the Part D Sponsor's commitments to CMS, and Medicare Laws. In the event such delegate fails to perform its services in such a manner, then CMS, the Part D Sponsor, or PBM may suspend, revoke, or otherwise terminate such delegation upon written notice to Pharmacy. Pharmacy will not perform any services from a location outside of the United States, nor delegate any services that are to be performed outside of the United States, without PBM's written consent.

3.10 Professional Judgment and Clinical Practices. Pharmacy will review DUR messages received from PBM through the point-of-sale system and use professional judgment as to whether any action is required. Pharmacy will provide patient counseling to Part D Members when appropriate and in a culturally competent manner and will ensure effective communications with Members with disabilities regarding their treatment options. Nothing in this Agreement is to be construed as a restriction on Pharmacy, acting lawfully, from advising or advocating on behalf of a Part D Member about the Part D Member's health status, medical care, treatment options, risks, benefits, consequences of treatment or non-treatment, or the opportunity to refuse treatment.

3.11 Electronic Prescribing. Pharmacy will support and comply with applicable electronic prescription standards developed or adopted by CMS.

3.12 Marketing. Pharmacy will not distribute or otherwise display information comparing the benefits of different Part D Plans unless Pharmacy displays such information from all Part D Plans in its service area.

4. PBM OBLIGATIONS

4.1 Point of Sale. PBM will communicate to Pharmacy the amount of any Part D Cost Share due from the Part D Member through the electronic point of sale system.

4.2 Clean Claims. PBM will issue, mail, or otherwise transmit payment of Clean Claims under this Agreement within fourteen (14) days of receipt of an electronically submitted Clean Claim, and within thirty (30) days of receipt for Clean Claim submitted otherwise. Pharmacy acknowledges that payment is subject to PBM's receipt of funds for such claims from the applicable Part D Sponsor.

5. COMPENSATION

5.1 Fee Schedule. Pharmacy will accept as payment in full for Part D Drugs dispensed under this Medicare Addendum to Part D Members, the amounts set forth in any applicable Fee Schedule attached to or otherwise made a part of this Agreement.

5.2 Pricing Source. A prescription drug pricing standard used by PBM under this Medicare Addendum is Medi-Span's Prescription Pricing Guide. PBM will also utilize

a prescription drug pricing standard, maximum allowable cost (MAC), which is not publicly available. For MAC pricing, PBM will disclose all individual drug prices to be updated to Pharmacy in advance of their use for reimbursement of claims. PBM will update the pricing standards referenced in this section not less frequently than once every seven (7) days, beginning with an initial update on January 1 of each year to accurately reflect the market price of acquiring Part D Drugs.

6. **RECORDS AND AUDIT**

6.1. Records Maintenance. Pharmacy will keep and maintain accurate records of all services and transactions relating to services to Part D Members for a period of least ten (10) years from the termination of the Agreement, or the date that any audit is completed, whichever is later. Pharmacy will maintain original prescription records for the greater of three (3) years or the period required by applicable state law and may thereafter transfer such records to an electronic format to satisfy the requirements of the preceding sentence.

6.2 Audit. Pharmacy will permit DHHS, the Comptroller, CMS, PBM, and Part D Sponsors, or (in each case) their designees or authorized representatives, to audit, examine, inspect, and/or evaluate all books and records, contracts, computers or other electronic systems, including any medical records, relating to the delivery or administration of services under the Medicare Part D program for a period of ten (10) years after the termination of the Agreement, or the date on which any audit is completed, whichever is later.

7. **COMPLIANCE PROVISIONS**

7.1 Compliance With Law. Pharmacy will comply with all applicable laws and regulations, including all Medicare Laws, and minimum standards for pharmacy practice established by the states. Pharmacy will provide services in a manner consistent with the Part D Sponsor's contractual commitments to CMS. Without limiting the generality of the foregoing, Pharmacy will comply with the transition of care policies of Part D Sponsors. Pharmacy will further comply with any and all federal and state privacy and security requirements, including but not limited to those set forth under HIPAA and the privacy and security provisions set forth in 42 CFR 423.136, which require that for any medical records or other health and enrollment information, Pharmacy will (a) abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information of Part D Members (and with respect to information that identifies a particular Part D Member, Pharmacy will have procedures that specify for what purposes the information is used within the organization, and to whom and for what purposes it discloses the information outside the organization); (b) ensure that medical information is released only in accordance with applicable

federal or state law; (c) maintain the records and information in an accurate and timely manner; and (d) ensure timely access by Part D Members to the records and information that pertain to them.

7.2 Compliance Program.

a. General. Pharmacy will establish and maintain an effective compliance program in accordance with 42 CFR 423.504(b)(4)(vi) and Chapter 9 of the Manual, as applicable. Without limiting the generality of the foregoing, Pharmacy will (a) establish, maintain, and distribute written policies, procedures, and a code/standards of conduct that demonstrate the Pharmacy's commitment to comply with all applicable laws (or establish, maintain, and distribute those supplied by PBM), (b) require all Medicare Workers to undergo all necessary compliance and fraud, waste, and abuse training within ninety (90) days of hire and annually thereafter, (c) have effective lines of communication relating to, and promptly report to PBM, any actual or suspected noncompliance with Medicare Laws or other laws that relate to the delivery or administration of services to Part D Members, including but not limited to the charging of an incorrect Cost Share, failure to provide required notices to Part D Members, or any act of fraud, waste, or abuse, (d) take appropriate disciplinary actions against Medicare Workers and others for noncompliant or unethical behavior, and (e) cooperate with PBM regarding any necessary corrective actions for the remediation of any noncompliance.

b. Exclusion. In addition, Pharmacy represents and warrants that neither it, nor any Medicare Worker is excluded or otherwise ineligible to participate in federal healthcare programs. Prior to hiring of any Medicare Worker and then monthly thereafter, Pharmacy will ensure that no Medicare Worker is so excluded or ineligible by reviewing the DHHS OIG List of Excluded Individuals and the System for Award Management. Pharmacy will notify PBM immediately if it or any Medicare Worker becomes excluded. On a time frequency reasonably prescribed by PBM, Pharmacy will obtain an attestation from all Medicare Workers that they are free from any conflict of interest in the delivery or administration of benefits under the Medicare Part D program.

c. Certification. Pharmacy will provide to PBM reasonable evidence, including through periodic certifications, of its compliance with this Medicare Addendum, including but not limited to this Section 7.

8. TERMINATION

In addition to any other provision of the Agreement, PBM may terminate this Agreement, or this Medicare Addendum, in its discretion, if Pharmacy violates any of the terms of this Addendum, including but not limited to its failure to comply with any Medicare Law. CMS, a

Part D Sponsor, or PBM (acting for such Part D Sponsor) may suspend, revoke, or otherwise terminate this Medicare Addendum upon written notice to Pharmacy if any determine that Pharmacy has not performed satisfactorily.

9. **GENERAL PROVISIONS**

9.1 Federal Funds. Pharmacy acknowledges that the claims information it submits to PBM will be used by Part D Sponsors to satisfy their reporting and other obligations to CMS, to seek funds and/or reimbursement from CMS, and/or perform plan financial reconciliation with CMS. Accordingly, Pharmacy certifies that such information is accurate, truthful, and complete.

9.2 Applicability to Other Pharmacies. In the event Pharmacy is a Home Infusion Pharmacy, I/T/U Pharmacy, or LTC Pharmacy, Pharmacy will comply with the terms of any applicable Schedule to this Addendum.

In the event of a conflict between the Agreement and this Medicare Addendum, the terms of this Medicare Addendum will control.

MEDICARE PART D ADDENDUM

SCHEDULE A (HOME INFUSION PHARMACY)

This Schedule A (Home Infusion Pharmacy) to the Medicare Part D Addendum is hereby attached to and incorporated into the Participating Pharmacy Agreement between PBM and Pharmacy, for the purpose of permitting Pharmacy to be a downstream entity to Part D Sponsors and PBM and to provide infusion services to Part D Members.

Pharmacy agrees the following terms:

1. Pharmacy will deliver home-infused drugs in a form that can be administered in a clinically appropriate fashion, including in a Part D Member's place of residence.
2. Pharmacy will provide infusible Part D Drugs for both short-term acute care and long-term chronic care therapies.
3. Pharmacy will ensure that its professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing home infusion Part D Drugs to a Part D Member in his/her place of residence.
4. Pharmacy will provide delivery of home infusion drugs within twenty-four (24) hours of discharge from an acute care setting, or later if so prescribed.

MEDICARE PART D ADDENDUM

SCHEDULE B (LONG TERM CARE PHARMACY)

This Schedule B (Long Term Care Pharmacy) to the Medicare Part D Addendum is hereby attached to and incorporated into the Participating Pharmacy Agreement between PBM and

Pharmacy, for the purpose of permitting Pharmacy to be a downstream entity to Part D Sponsors and PBM to provide long term care pharmacy ("LTC") services to Part D Members in the LTC setting.

Pharmacy agrees the following terms:

1. **Comprehensive Inventory and Inventory Capacity**. Pharmacy will provide a comprehensive inventory of plan formulary drugs commonly used in the long-term care setting. In addition, Pharmacy must provide a secured area for physical storage of drugs, with necessary added security as required by federal and state law for controlled substances.
2. **Pharmacy Operations and Prescription Orders**. Pharmacy will provide services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to LTC residents, including but not limited to the performance of drug utilization review (DUR). In addition, the Pharmacy's pharmacists will conduct DUR to routinely screen for allergies and drug interactions, to identify potential adverse drug reactions, to identify inappropriate drug usage in the LTC population, and to promote cost effective therapy in the LTC setting. Pharmacy will also be equipped with and use pharmacy software and systems sufficient to meet the needs of prescription drug ordering and distribution to an LTC facility. Further, Pharmacy will provide written copies of its pharmacy procedures manual to PBM upon request and said manual will be available at each LTC facility nurses' unit. Pharmacy will provide ongoing in-service training to assure that LTC facility staff is proficient in Pharmacy's processes for ordering and receiving of medications. Pharmacy is responsible for return, destruction and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by the applicable state Board(s) of Pharmacy. Pharmacy will dispose of controlled substances and out of date substances in accordance with state and federal guidelines.
3. **Special Packaging**. Pharmacy will have the capacity to provide specific drugs in units of use packaging, bingo cards, cassettes, unit dose or other special packaging commonly required by LTC facilities. Pharmacy will have access to, or arrangements with, a vendor to furnish supplies and equipment including but not limited to labels, auxiliary labels, and packing machines for furnishing drugs in such special packaging required by the LTC setting.
4. **IV Medications**. Pharmacy will have the capacity to provide intravenous (IV) medications to the LTC resident Part D Members as ordered by a qualified medical professional. Pharmacy will have access to specialized facilities for the preparation of IV prescriptions (clean room). Additionally, Pharmacy will have access to or arrangements with a vendor to furnish special equipment and supplies as well as IV trained pharmacists and technicians as required to safely provide IV medications.
5. **Compounding/Alternative Forms of Drug Composition**. Pharmacy will be capable of providing specialized drug delivery formulations as required for some LTC resident Part D Members. Specifically, Part D Member LTC residents unable to swallow or ingest

medications through normal routes may require tablets split or crushed or provided in suspensions or gel forms, to facilitate effective drug delivery.

6. **Pharmacist On-call Service**. Pharmacy will provide on-call, 24-hour-per-day, 7-day-a-week service with a qualified pharmacist available for handling calls after hours and to provide medication dispensing available for emergencies, holidays, and after hours of normal operations.

7. **Delivery Service**. Pharmacy will provide for delivery of medications to the LTC facility up to 7 days each week (up to 3 times per day) and in-between regularly scheduled visits. Emergency delivery service will be available 24 hours a day, 7 days a week. Specific delivery arrangements will be determined through an agreement between Pharmacy and the LTC facility. Pharmacy will provide safe and secure exchange systems for delivery of medication to the LTC facility. In addition, Pharmacy will provide medication cassettes, or other standard delivery systems, which may be exchanged on a routine basis for automatic restocking. Pharmacy acknowledges that delivery of medication to carts is a part of routine "dispensing."

8. **Emergency Boxes**. Pharmacy will provide "emergency" supply of medications as required by the LTC facility in compliance with state requirements.

9. **Emergency Log Books**. Pharmacy will provide a system for logging and charging medication used from emergency/first dose stock. Further, Pharmacy will maintain a comprehensive record of a resident's medication order and drug administration.

10. **Miscellaneous Reports, Forms and Prescription Ordering Supplies**. Pharmacy will provide reports, forms, and prescription ordering supplies necessary for the delivery of quality pharmacy care in the LTC setting. Such reports, forms and prescription ordering supplies may include, but will not necessarily be limited to, provider order forms, monthly management reports to assist the LTC facility in managing orders, medication administration records, treatment administration records, interim order forms for new prescription orders, and boxes/folders for order storage and reconciliation in the LTC facility.

11. **Short Cycle Dispensing**.

    a. Pharmacy will dispense solid oral doses of brand name drugs, as defined in 42 CFR 423.4, to Part D Members residing in LTC facilities in no greater than 14-day increments at a time. Pharmacy will permit the use of uniform dispensing techniques for Part D Drugs dispensed to Part D Members residing in LTC facilities under the preceding sentence as defined by each of the LTC facilities in which such Part D Members reside. Pharmacy will collect and report information, in a form and manner specified by CMS, on the dispensing methodology used for each dispensing event described herein, and on the nature and quality of unused brand and generic drugs, as

defined in 42 CFR 423.4, dispensed by Pharmacy to Part D Members residing in an LTC facility, except that such reporting is not required if Pharmacy dispenses both brand and generic drugs, as defined in 42 CFR 423.4, in no greater than 7-day increments.

b. The provision of Section 11 above do not apply to (i) solid oral doses of antibiotics or solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance, and (ii) LTC pharmacies when they service intermediate care facilities for the mentally retarded (ICFs/IID) and institutes for mental disease (IMDs) as defined in 42 CFR 435.1010 and for I/T/U Pharmacies as defined in 42 CFR 423.100.

c. Regardless of the total number of incremental dispensing events, the total Part D Cost Share for a Part D Drug to which the dispensing requirements under this Section 11 apply must be no greater than the total Part D Cost Share that would be imposed for such Part D Drug if the requirements of this Section 11 did not apply. Pharmacy will credit PBM for any unused medications in accordance with the Agreement and to the maximum extent permitted by applicable law.

12. **Transition Supply**. Pharmacy accepts delegation of transition notice responsibilities to Part D Members residing in an LTC facility to the extent permitted by CMS requirements. Pharmacy will (a) maintain a fully functional electronic communication process with PBM for receipt of transition notices in a format acceptable to PBM, (b) ensure delivery of the notice to the applicable Part D Member (or his/her authorized representative) within three (3) business days of the fill, and (c) maintain a process that demonstrates such notices have been provided to Part D Members (or their authorized representatives) within such 3-business day period.

13. **Submission of Claims**. Pharmacy will submit all claims for Part D Drugs provided to Part D Members to PBM within ninety (90) days after the drug was provided to such Part D Member.

14. **Rebates**. If required by CMS or requested by PBM as necessary to satisfy any legal or contractual obligation to a Part D Sponsor, Pharmacy will disclose to PBM the amount of access and/or performance rebates or other price concessions it receives that are designed to or are likely to influence or impact utilization of Part D Drugs. Access and/or performance rebates refers to rebates that manufacturers provide that are designed to prefer, protect, or maintain that manufacturer's product selection by the pharmacy or to increase the volume of that manufacturer's products dispensed by the pharmacy under a formulary or otherwise. Pharmacy will provide such data for all Part D Drugs, at an NDC level and will work with PBM to report such data at a Part D Sponsor level.

MEDICARE PART D ADDENDUM

SCHEDULE C – INDIAN HEALTH ADDENDUM

1. **Purpose of Indian Health Addendum; Supersession**.

The purpose of this Indian Health Addendum is to apply special terms and conditions to the Participating Pharmacy Agreement ("Agreement") by and between Magellan Pharmacy Solutions, Inc. ("PBM") and the Pharmacy identified in the Agreement (referred to in this Indian Health Addendum as "Provider") for administration of Medicare Prescription Drug Benefit program at pharmacies and dispensaries of Provider authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and implementing regulations in Parts 403, 411, 417, 422, and 423 of Title 42, Code of Federal Regulations. To the extent that any provision of the Agreement or any other addendum thereto is inconsistent with any provision of this Indian Health Addendum, the provisions of this Indian Health Addendum shall supersede all such other provisions.

2. **Definitions**.

For purposes of the Agreement, any other addendum thereto, and this Indian Health Addendum, the following terms and definitions shall apply:

a. The term "Part D Plan Sponsor" means a nongovernmental entity that is certified under 42 CFR 417.472, 42 CFR Part 423 or 42 CFR Part 422 as meeting the requirements and standards that apply to entities that offer Medicare Part D plans.

b. The terms "Part D Plan" means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in 42 CFR 423.272, 42 CFR 422.502 or 42 CFR 417.472 and that is offered by a PDP sponsor that has a contract with the Centers for Medicare and Medicaid Services that meets the contract requirements under subpart K of 42 CFR Part 423 or subpart K of 42 CFR Part 422.

c. The term "Provider" means the Indian Health Service (IHS) and all pharmacies and dispensaries operated by the IHS, or an Indian tribe, tribal organization or urban Indian organization which operates one or more pharmacies or dispensaries and is identified by name in Section 1 of this Indian Health Addendum.

d. The term "Centers for Medicare and Medicaid Services" means the agency of that name within the U.S. Department of Health and Human Services.

e. The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act ("IHCIA"), 25 USC §1661.

f. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603.

g. The term "tribal organization" has the meaning given than term in Sec. 4 of the IHCIA, 25 USC §1603.

h. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603.

i. The term "Indian" has the meaning given to that term in Sec. 4 of the IHCIA, 25 USC §1603.

j. The term "dispensary" means a clinic where medicine is dispensed by a prescribing provider.

3. **Description of Provider**.

The Provider identified in Section 1 of this Indian Health Addendum is (check appropriate box):

☐ IHS operated health care facilities located within the geographic area covered by the Provider Agreement, including hospitals, health centers and one or more pharmacies or dispensaries ("IHS Provider"). Where an IHS Provider operates more than one pharmacy or dispensary all such pharmacies and dispensaries are covered by this Addendum.

☐ An Indian tribe that operates a health program, including one or more pharmacies or dispensaries, under a contract or compact with the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 USC §450 et seq.

☐ A tribal organization authorized by one or more Indian tribes to operate a health program, including one or more pharmacies or dispensaries, under a contract or compact with the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 USC §450 et seq.

☐ An urban Indian organization that operates a health program, including one or more pharmacies or dispensaries, under a grant from the Indian Health Service issued pursuant to Title V of the IHCIA.

4. **Deductibles; Annual Out-of-Pocket Threshold**.

The cost of pharmaceuticals provided at a pharmacy or dispensary of Provider or paid for by the Provider through a referral to a retail pharmacy shall count toward the deductible and the annual out-of-pocket threshold applicable to an IHS beneficiary enrolled in a Part D Plan.

5. **Persons eligible for services of Provider**.

a. The parties agree that the IHS Provider is limited to serving eligible IHS beneficiaries pursuant to 42 CFR Part 136 and section 813(a) and (b) of the IHCIA, 25 USC §1680(a) and (b), who are also eligible for Medicare Part D services pursuant to Title XVIII, Part D of the Social Security Act and 42 CFR Part 423. The IHS Provider may provide

services to non-IHS eligible persons only under certain circumstances set forth in IHCIA section 813(c) and in emergencies under section 813(d) of the IHCIA.

b. The parties agree that the persons eligible for services of the Provider who is an Indian tribe or a tribal organization or a Provider who is an urban Indian organization shall be governed by the following authorities:

   i. Title XVIII, Part D of the Social Security Act and 42 CFR Part 423;

   ii. IHCIA sections 813, 25 USC §1680c;

   iii. 42 CFR Part 136; and

   iv. The terms of the contract, compact or grant issued to the Provider by the IHS for operation of a health program.

c. No clause, term or condition of the Agreement or any addendum thereto shall be construed to change, reduce, expand, or alter the eligibility of persons for services of the Provider under the Part D Plan that is inconsistent with the authorities identified in subsection (a) or (b).

6. **Applicability of other Federal laws**.

Federal laws and regulations affecting a Provider include but are not limited to the following:

a. An IHS provider:

   i. The Anti-Deficiency Act 31 U.S.C. § 1341;

   ii. The Indian Self Determination and Education Assistance Act ("ISDEAA"); 25 USC § 450 et seq.;

   iii. The Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671-2680;

   iv. The Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;

   v. The Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 CFR Part 5b;

   vi. Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2;

   vii. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164; and

   viii. The IHCIA, 25 U.S.C. § 1601 et seq.

b. A Provider who is an Indian tribe or a tribal organization:

   i. The ISDEAA, 25 USC §450 et seq.;

   ii. The IHCIA, 25 USC §1601, et seq.;

   iii. The FTCA, 28 USC §§2671-2680;

   iv. The Privacy Act, 5 USC §552a and regulations at 45 CFR Part 5b;

v. The HIPAA and regulations at 45 CFR parts 160 and 164; and

vi. Sec. 206(e)(3) of the IHCIA, 25 USC § 1624e(e)(3), regarding recovery from tortfeasors.

c. A Provider who is an urban Indian organization:

i. The IHCIA, 25 USC §1601, et seq.;

ii. The Privacy Act, 5 USC §552a and regulations at 45 CFR Part 5b;

iii. The HIPAA and regulations at 45 CFR parts 160 and 164; and

iv. Sec. 206(e)(3) of the IHCIA, 25 USC §1621e(e)(3), regarding recovery from tortfeasors, as made applicable to urban Indian organizations by Sec. 206(i) of the IHCIA.

7. **Non-taxable entity**.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a PBM or a Part D Plan Sponsor to collect or remit any Federal, State, or local tax.

8. **Insurance and indemnification**.

a. As an IHS provider, FTCA coverage obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. § 2671-2680. Nothing in the Agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the Plan will be held harmless from liability.

b. A Provider which is an Indian tribe or a tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the Federal Tort Claims Act (FTCA) pursuant to Federal law (Pub. L. 101-512, Title III, §314, as amended by Pub. L. 103-138, Title III, §308 (codified at 25 USC §450 F note); and regulations at 25 CFR Part 900, Subpart M. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Pub. L. 104-73, (codified at 42 USC §233(g)-(n)) and regulations at 42 CFR Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Further, nothing in the Agreement or any addendum thereto shall be interpreted to authorize or obligate Provider or any employee of such Provider to operate outside of the scope of employment of such employee, and Provider shall not be required to indemnify PBM or the Part D Plan Sponsor.

9. **Licensure**.

   a. States may not regulate the activities of IHS-operated pharmacies nor require that the IHS pharmacists be licensed in the State where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a pharmacy or dispensary of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the Agreement, IHS pharmacists shall hold state licenses in accordance with applicable federal law, and that the IHS facilities where the pharmacies and dispensaries are located shall be accredited in accordance with federal statutes and regulations. During the term of the Agreement, the parties agree to use the IHS facility's Drug Enforcement Agency (DEA) number consistent with federal law.

   b. Federal law (Sec. 221 of the IHCIA) provides that a pharmacist employed directly by a Provider that is an Indian tribe or tribal organization is exempt from the licensing requirements of the state in which the tribal health program is located, provided the pharmacist is licensed in any state. Federal law (Sec. 408 of the IHCIA) further provides that a health program operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law. The parties agree that these federal laws apply to the Agreement and any addenda thereto. This provision shall not be interpreted to alter the requirement that a pharmacy hold a license from the Drug Enforcement Agency.

   c. To the extent that any directly hired employee of an urban Indian Provider is exempt from State regulation, such employee shall be deemed qualified to perform services under the Agreement and all addenda thereto, provided such employee is licensed to practice pharmacy in any State. Federal law (Sec. 408 of the IHCIA) provides that a health program operated by an urban Indian organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law. This provision shall not be interpreted to alter the requirement that a pharmacy hold a license from the Drug Enforcement Agency.

10. **Provider Eligibility for Payments**.

To the extent that the Provider is exempt from State licensing requirements, the Provider shall not be required to hold a State license to receive any payments under the Agreement and any addendum thereto.

11. **Dispute Resolution**.

a. **For IHS Provider**. In the event of any dispute arising under the Agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the Agreement or any addendum thereto to the contrary, IHS shall not be required to submit any disputes between the parties to binding arbitration.

b. **For Tribal and Urban Providers**. In the event of any dispute arising under the Agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Any dispute hereunder that cannot be resolved by and between the parties in good faith shall be submitted to the dispute resolution procedure pursuant to the Agreement.

12. **Governing Law**.

The Agreement and all addenda thereto shall be governed and construed in accordance with Federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and Federal law, Federal law shall prevail. Nothing in the Agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to State law to any greater extent than State law is already applicable.

13. **Pharmacy/Dispensary Participation**.

The Agreement and all addenda thereto apply to all pharmacies and dispensaries operated by the Provider. A pharmacy is required to use a National Provider Identifier (NPI) number.

14. **Acquisition of Pharmaceuticals**.

Nothing in the Agreement and all addenda thereto shall affect the Provider's acquisition of pharmaceuticals from any source, including the Federal Supply Schedule and participation in the Drug Pricing Program of Section 340B of the Public Health Service Act. Nor shall anything in such agreement and all addenda thereto require the Provider to acquire drugs from the Part D Plan Sponsor or from any other source.

15. **Drug Utilization Review/Generic Equivalent Substitution**.

Where the Provider lacks the capacity to comply with the information technology requirements for drug utilization review and/or generic equivalent substitution set forth in the Agreement, the Provider and PBM agree that the Provider shall comply with PBM and/or Part D Plan Sponsor's drug utilization review and/or generic equivalent substitution policies and procedures through an alternative method. Nothing in this paragraph shall be interpreted as waiving the applicability of the drug utilization review and/or generic equivalent substitution policies and procedures adopted by Part D sponsor in accordance with 42 CFR.§§ 423.153(b) and (c), as approved by CMS, to covered Part D drugs dispensed by the Provider to enrollees in

the Part D Plan[s]. As specified at 42 CFR. §423.132(c)(3), the requirements related to notification of price differentials is waived for the Provider.

16. **Claims**.

The Provider may submit claims to PBM by telecommunication through an electronic billing system or by calling a toll-free number for non-electronic claims; in the case of the latter, Provider shall submit a confirmation paper claim.

17. **Payment Rate**.

Claims from the provider shall be paid at rates that are reasonable and appropriate.

18. **Information, Outreach, and Enrollment Materials**.

    a. All materials for information, outreach, or enrollment prepared for the Part D Plan shall be supplied by PBM or the Part D Plan Sponsor to Provider in paper and electronic format at no cost to the Provider.

    b. All marketing or informational material listing a provider as a pharmacy must refer to the special eligibility requirements necessary for service to be provided, consistent with the eligibility requirements as described in this Indian health addendum in paragraphs 5(a) for IHS providers and 5(b) for tribal and urban providers.

19. **Hours of Service**.

The hours of service of the pharmacies or dispensaries of Provider shall be established by Provider. At the request of PBM or the Part D Plan Sponsor, Provider shall provide written notification of its hours of service.

20. **Endorsement**.

An endorsement of a non-Federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-Federal entity under this agreement.

21. **Sovereign Immunity**.

Nothing in the Agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

12.2 Alabama

ALABAMA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Alabama Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, managed care organizations, insurers, or carriers under Alabama law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Alabama law, PHARMACY agrees:
    a. That in no event, including but not limited to, non-payment, PBM's or Plan Sponsor's insolvency, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons, or persons other than PBM or Plan Sponsor acting on behalf of Covered Persons for services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles, and coinsurances on PBM's or Plan Sponsor's behalf made in accordance with the terms of the Benefit Plan between Plan Sponsor and Covered Persons. Ala. Code § 27-21A-3; Ala. Admin. Code r. 482-1-080-.05(2)(c); 420-5-6.10(2)(q)(1).
    b. PHARMACY further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons, or persons on their behalf. Ala. Admin. Code r. 420-5-6.10(2)(q)(1).
    c. PHARMACY may not change, amend, or waive any provision of this Agreement without prior written consent of PBM. Any attempts to change, amend, or waive the Agreement are void. Ala. Admin. Code r. 420-5-6.10(2)(q)(1).
2. This Agreement shall not establish reimbursement rates or procedures that result in reimbursement rates for services rendered to Covered Persons covered by Plan Sponsor which are less than the usual and customary rates paid by consumers not covered by a third-party plan for the same or similar services. Ala. Code § 34-23-115.
3. PHARMACY shall be compensated at the rate and frequency set forth in the Agreement and any related attachments. Ala. Code § 34-23-112.
4. PHARMACY agrees to resolve all disputes, controversies and claims in the manner set forth in the Agreement and any related attachments. Ala. Code § 34-23-112.

5. PHARMACY agrees to participate in Plan Sponsor's enrollee grievance procedures. Ala. Admin. Code r. 420-5-6-.10(2)(j).
6. PHARMACY agrees to participate in pharmacy audits in the manner detailed in the Agreement. To the extent of a direct conflict between the terms of the Agreement and the Alabama Pharmacy Audit Integrity Act codified at Alabama Code §§ 34-23-180 et seq., the provisions of the Alabama Pharmacy Audit Integrity Act shall control. Ala. Code §§ 34-23-184 to 34-23-187.
7. PHARMACY shall provide PBM and the Alabama Department of Insurance with written verification that PHARMACY is registered with the Alabama State Board of Pharmacy in accordance with Ala. Code § 27-45-20.
8. **IF A PROVIDER REQUESTS PAYMENT UNDER A HEALTH INSURANCE PLAN FROM A HEALTH INSURER OR ITS CONTRACTED VENDOR OR A REGIONAL CARE ORGANIZATION BE MADE USING ACH ELECTRONIC FUNDS TRANSFER, THAT REQUEST MUST BE HONORED. FURTHERMORE, SUCH A REQUEST MAY NOT BE USED TO DELAY OR REJECT A TRANSACTION, OR ATTEMPT TO ADVERSELY AFFECT THE PROVIDER.** Ala. Code § 27-1-17.1

12.3 Alaska

ALASKA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Alaska Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of medical service corporations, managed care insurance plans, health maintenance organizations, and insurers under Alaska law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health care insurer, PHARMACY agrees:
    a. That PHARMACY shall be responsible for providing Covered Drugs as communicated via the POS system or otherwise, as set forth in the Agreement. Alaska Stat. § 21.07.010(a)(1).

b. That PHARMACY shall be compensated at the rate set forth in the Agreement and any related attachments. Alaska Stat. § 21.07.010(a)(2).

c. That the Agreement may be terminated as set forth in the Agreement and any related attachments. Notwithstanding anything to the contrary in the Agreement, a provision that allows for discretionary termination by either party shall apply equally to both PHARMACY and PBM. Alaska Stat. § 21.07.010(a)(3).

d. In the event of a dispute between PHARMACY and PBM, a fair, prompt, and mutual dispute resolution process shall be used consisting of the following:

   i. The parties shall hold an initial meeting at which all parties are present or represented by individuals with authority regarding the manners in dispute. The meeting shall be held within 10 working days after PBM receives written notice of the dispute or gives written notice to PHARMACY, unless the parties otherwise agree in writing to a different schedule;

   ii. If, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties. Each party shall bear its proportionate share of the cost of mediation, including the mediator's fees;

   iii. The parties shall negotiate in good faith in the initial meeting and in mediation;

   iv. If, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law. Alaska Stat. § 21.07.010(a)(4).

e. PHARMACY shall not be penalized, or PHARMACY's contract terminated by PBM because PHARMACY acts as an advocate for a Covered Person in seeking appropriate, medically necessary health care services. Alaska Stat. § 21.07.010(a)(5).

f. PHARMACY shall be free to communicate openly with a Covered Person about all appropriate diagnostic testing and treatment options. Alaska Stat. § 21.07.010(a)(6).

g. Terms used in the Agreement and this Addendum shall have the meaning set forth in the Glossary of Terms attached to the Agreement. Alaska Stat. § 21.07.010(a)(7).

h. Notwithstanding anything to the contrary in the Agreement, PHARMACY shall not be required to indemnify or hold harmless PBM or Plan Sponsor for PBM's or Plan Sponsor's own acts or conduct. Alaska Stat. § 21.07.010(c).

2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a medical service corporation under Alaska law, PHARMACY agrees:

a. That PHARMACY shall provide Covered Drugs to Covered Persons and that the obligation to furnish these services shall be a direct obligation of the PHARMACY to the Covered Persons as well as to PBM and Plan Sponsor;

b. That PHARMACY shall be compensated for services rendered in accordance with the terms of the Agreement and any related attachments and that PHARMACY may not request or receive compensation for services that is not in accord with those terms;

c. That compensation for services may be prorated and settled under the circumstances and in the manner referred to in Alaska Stat. § 21.87.300;

d. That, if PHARMACY withdraws from the Agreement, the withdrawal may not be effective as to a Covered Person's contract in force on the date of the withdrawal until the termination of the Covered Person's contract or the next anniversary of the Covered Person's contract, whichever date is earlier; and Alaska Stat. § 21.87.140.

12.4 Arizona

ARIZONA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Arizona Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health care services organization, hospital and medical service corporation, insurers, or carriers under Arizona law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PBM shall not restrict or prohibit PHARMACY's good faith communication with its patients concerning the patients' health care or medical needs, treatment options, health care risks or benefits. Ariz. Rev. Stat. §§ 20-118(A), 20-827(B), 20-1061(B)(1).
2. PBM shall not terminate the Agreement or refuse to renew the Agreement with PHARMACY solely because PHARMACY in good faith does any of the following:
    a. Advocates in private or in public on behalf of a patient.
    b. Assists a patient in seeking reconsideration of a decision made by PBM and/or Plan Sponsor to deny coverage for Covered Drugs.
    c. Reports a violation of law to an appropriate authority.

Ariz. Rev. Stat. §§ 20-118(B), 20-827(B), 20-1061(B)(2).

3. To the extent PHARMACY provides Covered Drugs to Covered Persons of a hospital, medical, dental, or optometric service corporation or a health care services organization under Arizona law, PBM will not make or withhold a specific payment from PHARMACY as an inducement to deny, reduce, limit, or delay medically necessary care that is covered by a Covered Person's Benefit Plan for a specific disease or condition. Ariz. Rev. Stat. §§ 20-833(D), 20-1061(C).

4. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health care services organization under Arizona law, PHARMACY agrees:

    a. In the event that PBM or Plan Sponsor fails to pay for covered services as set forth in the Covered Person's evidence of coverage or contract, the Covered Person shall not be liable to PHARMACY for any amounts owed by PBM and/or Plan Sponsor, and PHARMACY shall not bill or otherwise attempt to collect from the Covered Person any amount owed by PBM and/or Plan Sponsor. Ariz. Rev. Stat. § 20-1072(A).

    b. PHARMACY, and any agent, trustee, or assignee of PHARMACY shall not maintain an action at law against a Covered Person to collect any amounts owed by PBM and/or Plan Sponsor for which the Covered Person is not liable to PHARMACY under the preceding subparagraph. Ariz. Rev. Stat. § 20-1072(C).

    c. PHARMACY shall not charge Covered Persons more than the amount contracted for under the Agreement. Ariz. Rev. Stat. § 20-1072(F).

    d. In the event that Plan Sponsor is declared insolvent, PHARMACY shall provide services to Covered Persons at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after Plan Sponsor is declared insolvent, until the earliest of the following:

        i. The duration of the contract period under the Covered Person's Benefit Plan or for 60 days from the date of insolvency is declared, whichever is longer;

        ii. If the Covered Person is confined on the date of insolvency in an inpatient facility until his or her discharge;

        iii. A notification from the receiver pursuant to Ariz. Rev. Stat. 20-1069(F) or a determination by the court that Plan Sponsor cannot provide adequate assurance it will be able to pay PHARMACY's claims for covered services that were rendered after the Plan Sponsor is declared insolvent;

        iv. A determination by the court that the insolvent Plan Sponsor is unable to pay PHARMACY's claims for covered services that were rendered after the Plan Sponsor is declared insolvent;

v. A determination by the court that continuation of services would constitute undue hardship to PHARMACY;

vi. A determination by the court that Plan Sponsor has satisfied its obligations to all Covered Persons under its Benefit Plans.

Ariz. Rev. Stat. §§ 20-1074(B); 20-1069(A).

5. Notwithstanding anything to the contrary in the Agreement, where the Agreement provides for a defined length of time to adjust or request adjustment of the payment of a claim, PHARMACY and PBM and Plan Sponsor shall each have the same length of time to adjust or request adjustment of the payment of a claim. Ariz. Rev. Stat. § 20-3102(I).

6. PHARMACY agrees to participate in audits as set forth in the Agreement and the MRx Provider Manual. PBM has established an audit appeal process which can be found at Section 2 of the Provider Manual. Ariz. Rev. Stat. § 20-3323(C).

12.5 Arkansas

ARKANSAS ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Arkansas Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organization, hospital or medical service corporation, insurers, or carriers under Arkansas law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Arkansas law, PHARMACY agrees:

   a. In the event PBM and/or Plan Sponsor fails to pay for services as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by PBM and/or Plan Sponsor. PHARMACY, or its agent, trustee, or assignee shall not maintain an action at law against Covered Persons to collect sums owed by PBM and/or Plan Sponsor nor make any statement, either written or oral, to any Covered Person that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by PBM and/or Plan Sponsor. Ark. Code Ann. §§ 23-76-118(b)(1)(A), 23-76-119(c)(1), (3)(A).

b. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY shall continue to provide Covered Drugs for the duration of the period after the insolvency for which premium payment has been made or until Covered Person's discharge from an inpatient facility, whichever is longer. Ark. Code Ann. § 23-76-118(c)(2).

2. To the extent PHARMACY provides Covered Drugs to Covered Persons of an insurer under a minimum basic benefit policy, PHARMACY agrees that Covered Persons shall have no obligation to make payment for any medical service rendered by PHARMACY that is determined not to be medically necessary. Ark. Code Ann. § 23-98-109(a)(3)(C).

3. PHARMACY shall, without restriction or penalty, be free to disclose to Covered Persons any health care information that PHARMACY deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by PBM and/or Plan Sponsor. Ark. Code Ann. § 23-99-407.

4. In the event the Agreement is terminated, PHARMACY agrees to continue to provide Covered Drugs to Covered Persons until a current episode of treatment for an acute condition is completed or until the end of 90 days, whichever occurs first. During this period of continuing care, PHARMACY shall be deemed to be a participating provider for purposes of reimbursement, utilization management, and quality of care and shall be bound by those corresponding provisions of the Agreement. Ark. Code Ann. § 23-99-408.

12.6 California

CALIFORNIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This California Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health care service plans, health maintenance organizations, and insurers under California law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PBM shall not terminate the Agreement or otherwise penalize PHARMACY principally for advocating for appropriate health care. Cal. Bus. & Prof. Code § 510; Cal. Ins. Code § 10120.5.

2. PBM may sell, lease, transfer, or convey to Plan Sponsors, including workers' compensation and automobile insurers, and other contracting agents, PBM's Pharmacy Network. PBM and Plan Sponsors actively encourage Covered Persons' use of Pharmacy Network providers by, among other things, providing information to Covered Persons in the form of provider directories, the use of toll-free telephone numbers and/or internet web site addresses supplied directly to Covered Persons advising them of the existence of the Pharmacy Network. Neither PBM nor Plan Sponsors shall be required to actively encourage Covered Persons to use network providers when obtaining medical care in the case of an emergency. PHARMACY acknowledges that it has received a summary of all Plan Sponsors currently eligible to utilize PHARMACY's contracted rate pursuant to the Agreement and shall hereafter be entitled to a summary within 30 calendar days of PBM's receipt of PHARMACY's written request. Upon execution of the Agreement and a subsequent renewal or amendment, PHARMACY may decline to be included in a network that is sold, leased, transferred, or conveyed to Plan Sponsors that do not actively encourage the Plan Sponsor's Covered Persons to use network providers when obtaining medical care. PHARMACY's election under this provision shall be binding on PBM and any other contracting agent that buys, leases, or otherwise obtains the network. PHARMACY shall not be excluded from a network that is sold, leased, transferred, or conveyed to Plan Sponsors that actively encourage their Covered Persons to use network providers when obtaining medical care, based upon PHARMACY's refusal to be included in a network that is sold, leased, transferred, or conveyed to Plan Sponsors that do not actively encourage their Covered Persons to use network providers when obtaining medical care. Cal. Bus. & Prof. Code § 511.1(b); Cal. Health & Safety Code § 1395.6; Cal. Ins. Code § 10178.3.

3. In the event PBM sells, leases, or transfers its Pharmacy Network, the rights and obligations of PHARMACY shall be governed by the Agreement between PBM and PHARMACY. Cal. Bus. And Prof. Code § 511.3; Cal. Health & Safety Code § 1375.7(c).

4. PHARMACY acknowledges that PBM has disclosed in an electronic or paper format: (a) information regarding claims processes including directions for the electronic transmission, physical delivery and mailing of claims, all claim submission requirements, instructions for confirming PBM's receipt of claims; and a phone number for claims inquiries and filing information; and (b) information regarding provider dispute processes including the identity of the office responsible for receipt and resolution of disputes, directions for the electronic transmission, physical delivery, and mailing of disputes, all claim dispute requirements, the timeframe for acknowledgment of receipt of a dispute, the phone number for dispute inquiries and filing information, and directions for filing substantially similar multiple claim disputes and other disputes.

   PHARMACY acknowledges it has received in electronic form: (a) information as to the amount of payment PHARMACY shall receive for each service provided under the Agreement, including any fee schedules or other factors or units used in determining the

fees for each service and (b) detailed payment policies and rules and nonstandard coding methodologies, if applicable, used to adjudicate claims. PHARMACY shall hereafter be provided information regarding fee schedules and reimbursement information annually on or before the Agreement's anniversary date and upon written request.

PBM shall provide at least 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to this provision. Cal. Bus. & Prof. Code § 511.4; Cal. Ins. Code § 10133.66; 28 Cal. Code Reg. § 1300.71(l)-(o).

5. To the extent required by law, PBM or Plan Sponsor, as applicable, will disclose to PHARMACY the processes that PBM or Plan Sponsor, as applicable, uses in providing utilization review or utilization management functions to authorize, modify, or deny health services under Benefit Plans provided by Plan Sponsors. Cal. Health & Safety Code §§ 1363.5, 1367.01(b).

6. To the extent PBM or a Plan Sponsor conducts economic profiling with respect to PHARMACY, to the extent required by law, PBM shall provide PHARMACY with economic profiling information related to PHARMACY upon PHARMACY's written request. To the extent required by law, PBM or Plan Sponsor, as applicable, shall honor such requests until 60 days after termination of the Agreement. Cal. Health & Safety Code § 1367.02(c); Cal. Ins. Code § 10123.36.

7. Notwithstanding anything to the contrary in the Agreement, including the pharmacy manual, PHARMACY shall have 90 days from the date of service to submit all claims for Prescription Drug Benefits provided to Eligible Persons to PBM, except as required by any state or federal law or regulation. Cal. Ins. Code § 10133.66(a); 28 Cal. Code Reg. §1300.71(b)(1).

8. Nothing in the Agreement shall be construed to prohibit, restrict, or limit PHARMACY from advertising. PBM may, however, require that each advertisement contain a disclaimer that PHARMACY's services may be covered for some, but not all, Benefit Plans or Plan Sponsors utilizing PBM's services, and that Benefit Plans and Plan Sponsors may cover some, but not all of PHARMACY's services. This provision shall not prohibit or limit provisions in the Agreement intended to protect service marks, trademarks, trade secrets, or other confidential information or property. Cal. Bus. & Prof. Code § 512; Cal. Health & Safety Code § 1395.5; Cal. Ins. Code § 10127.4.

9. Neither PBM nor Plan Sponsor shall make payment to PHARMACY directly, in any type or form, as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a Covered Person or groups of Covered Persons with similar medical conditions. Cal. Health & Safety Code § 1348.6; Cal. Ins. Code § 10175.5.

10. PBM values its relationships with contracted pharmacies and strives to address and resolve PHARMACY concerns efficiently, fairly, and cost-effectively. Whenever possible, PBM resolves issues raised by PHARMACY at the time of the initial contact. However, if the issue cannot be resolved informally, PBM offers a process for PHARMACY to use to resolve its grievances. A description of PBM's pharmacy grievance process is set forth in the Provider Manual. Cal. Health & Safety Code § 1367(h)(1); Cal. Ins. Code § 1023.137. The pharmacy grievance process shall allow for a submission deadline of at least 365 days to the extent required by 28 Cal. Code Reg. § 1300.71.38(d).

11. If PBM and PHARMACY agree that PHARMACY shall accept, as payment under the Agreement, the lowest payment rate charged by PHARMACY to any patient or third party, that provision shall not be deemed to apply to, or take into consideration, any cash payments made to PHARMACY by individual patients who do not have any private or public form of health care coverage for the service rendered by PHARMACY. Cal. Health & Safety Code § 1371.22; Cal. Ins. Code § 10126.5.

12. PHARMACY shall adhere to regulations adopted by the California Department of Managed Health Care to assure Covered Persons have access to health services in a timely manner. PHARMACY agrees to provide reporting as directed by PBM to ensure compliance with timely access standards. Cal. Health & Safety Code § 1367.03(f)(1).

13. PBM shall neither request reimbursement for overpayment nor reduce the level of payment to PHARMACY based solely on the allegation that PHARMACY has entered into a contract with a licensed health care service plan for participation in a benefit plan approved by the California Department of Managed Health Care. Cal. Health & Safety Code §1371.2

14. Notwithstanding anything in the Agreement to the contrary, PBM, Plan Sponsor, and PHARMACY are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, each other. Nothing in this provision shall preclude a finding of liability based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. Cal. Health & Safety Code § 1371.25.

15. If PBM terminates the Agreement for reasons other than medical disciplinary cause, fraud, or criminal activity, PHARMACY agrees, upon request, to continue to provide Covered Drug services to Covered Persons who at the time of the Agreement's termination were receiving services from PHARMACY for the following conditions: (a) an acute condition; (b) a serious chronic condition; (c) a pregnancy; (d) a terminal illness; (e) the care of a newborn child between birth and 36 months; or (f) performance of a procedure that is authorized by Plan Sponsor to occur within 180 days of the Agreement's termination.

    For purposes of this provision, an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires

prompt medical attention and that has a limited duration. PHARMACY shall continue to provide Covered Drugs for the duration of the acute condition.

A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. PHARMACY shall continue to provide Covered Drugs to a Covered Person with a serious chronic condition for the period of time necessary to complete a course of treatment and to arrange for the safe transfer to another provider, as determined by PBM and Plan Sponsor in consultation with the Covered Person and PHARMACY, and consistent with good professional practice. Continued services for a serious chronic condition shall not exceed 12 months from the date the Agreement was terminated or 12 months.

A pregnancy refers to the three trimesters of pregnancy and the immediate postpartum period. PHARMACY shall continue to provide Covered Drugs for the duration of a Covered Person's pregnancy.

A terminal illness means an incurable or irreversible condition that has a high probability of causing death within one year or less. PHARMACY shall continue to provide Covered Drugs for the duration of a Covered Person's terminal illness, which may exceed 12 months from termination of the Agreement.

PHARMACY shall continue to provide Covered Drugs for the care of a newborn child between birth and age 36 months for a period not to exceed 12 months from the Agreement's termination.

PHARMACY shall complete a procedure that is authorized by PBM or Plan Sponsor as part of a documented course of treatment and has been recommended and documented by PHARMACY to occur with 180 days of the Agreement's termination.

PHARMACY agrees that in rendering Covered Drugs during the continuation periods outlined above, PHARMACY shall be subject to the same contractual terms and conditions that were imposed upon PHARMACY prior to termination of the Agreement, including reimbursement rates.

Cal. Health & Safety Code § 1373.96; Cal. Ins. Code § 10133.56

16. Upon termination of the Agreement, Plan Sponsor shall be liable under the same contractual terms and conditions in effect prior to termination for Covered Drugs rendered by PHARMACY to a Covered Person who retains eligibility under the Benefit Plan or by operation of law under the care of PHARMACY at the time of termination until the services being rendered to the Covered Person by PHARMACY are completed, unless PBM or Plan Sponsor makes reasonable and medically appropriate provision for the assumption of such

services by a participating provider. 10 Cal. Code Reg. § 2240.2(d); 28 Cal. Code Reg. § 1300.67.4(10); 1300.67.8(e).

17. PHARMACY acknowledges that Covered Persons' copayments, when based upon a percentage of the fee for services rendered, shall be calculated exclusively from the negotiated rate under the Agreement. PHARMACY shall not charge or collect copayment amounts greater than those calculated in accordance with this provision. Cal. Health & Safety Code § 1373.18; Cal. Ins. Code §§ 10133.2, 10133.3.

18. PBM shall not require that in-person contact occur between PHARMACY and Covered Persons before payment is made for Covered Drugs appropriately provided through telehealth as that term is defined in subdivision (a) of Section 2290.5 of the California Business and Professions Code and provided all other terms and conditions imposed by the Agreement and by Plan Sponsor are met. Cal. Health & Safety Code § 1374.13; Cal. Ins. Code § 10123.85.

19. Except for applicable co-payments and deductibles, PHARMACY shall not invoice or balance bill a Covered Person for the difference between PHARMACY's billed or customary charges and the reimbursement paid by Plan Sponsor or PBM for any Covered Drug. PHARMACY agrees that in the event PBM or Plan Sponsor fails to pay for Covered Drugs, the Covered Person shall not be liable to PHARMACY for any sums owed by PBM or Plan Sponsor. Neither PHARMACY nor its agent, trustee, or assignee may maintain any action at law against a Covered Person to collect sums owed by PBM or Plan Sponsor. Cal. Health & Safety Code §§1358.10(e)(1)(E); 1379; 28 Cal. Code Reg. § 1300.67.8(e), 1300.71(g)(4).

20. PHARMACY shall report to PBM all surcharge and copayment moneys paid by Covered Persons directly to PHARMACY. Cal. Health & Safety Code § 1385.

21. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY agrees to continue to provide Covered Drugs to Covered Persons until the effective date of a Covered Person's coverage in a successor plan pursuant to either open enrollment or the allocation process but in no event longer than 45 days in the event of allocation or 30 days in the case of open enrollment, whichever is greater. Cal. Health & Safety Code §§1394.7(e), 1394.8

22. Nothing in the Agreement shall be construed to require PHARMACY to accept additional patients if, in PHARMACY's reasonable professional judgment, accepting additional patients would endanger patients' access to, or continuity of, care. Cal. Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(b).

23. PHARMACY shall be required to comply with any quality improvement or utilization management programs or procedures of PBM or Plan Sponsor provided that such programs and procedures were disclosed to PHARMACY at least 15 days prior to PHARMACY's execution of the Agreement. PBM and Plan Sponsor may, however, make a change to the quality improvement or utilization management programs or procedures at

any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, subject to the provisions of the paragraph immediately below. Cal. Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(b).

24. PBM may make material changes to the Agreement upon at least 45 business days' prior notice of the change to PHARMACY. PHARMACY shall have the right to terminate the Agreement prior to implementation of the change. Cal Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(c). Notwithstanding the foregoing, if the Agreement provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families Program, PBM may make a material change to the Agreement if: (i) PHARMACY is given a minimum of 90 business days' notice of the change; (ii) PHARMACY has the right to negotiate and agree to the change within 30 business days of the notice; (iii) PHARMACY may terminate the Agreement within 90 business days from receipt of the notice; and (iv) The material change becomes effective 90 business days from the date of the notice if PHARMACY does not exercise its right to negotiate the change or to terminate the Agreement. Cal. Health & Safety Code § 1375.7(b)(1)(C).

25. PHARMACY shall maintain and retain for at least two years such records and provide such information to PBM and Plan Sponsor and to the Director of the California Department of Managed Health Care as may be necessary to demonstrate compliance by Plan Sponsor with California law. This provision survives termination of the Agreement, whether by rescission or otherwise. 28 Cal. Code Reg. § 1300.67.8(b).

26. The respective Directors of the California Department of Managed Health Care and Department of Insurance may request information from PHARMACY required under Article 6.2, Chapter 2.2, Division 2 of the Health and Safety Code, under Article 4.5, Chapter 1, Part 2, Division 2 of the California Insurance Code, or under the Patient Protection and Affordable Care Act. Cal. Health & Safety Code § 1385.05; Cal. Ins. Code § 10181.5.

27. Upon demand, PHARMACY shall grant PBM and Plan Sponsor access at reasonable times to the books, records and papers of PHARMACY relating to the services provided to Covered Persons, to the cost thereof, and to payments received by PHARMACY from Covered Persons (or from others on their behalf). 28 Cal. Code Reg. § 1300.67.8(c).

28. PHARMACY agrees to participate in audits as set forth in the Provider Manual. PBM has established an audit appeal process which can be found in the Provider Manual. PBM has established an appeals process to appeal final audit findings related to California PHARMACIES. California PHARMACIES shall have at least 30 days from the delivery of the final audit report to appeal an unfavorable audit finding to PBM. PBM shall provide a written determination of the appeal to PHARMACY and will append this determination to the final audit report. If the parties are not satisfied with the appeal or determination, the parties may seek relief under the terms of the Agreement. Cal. Bus. & Prof. Code § 4438(b)(2).

29. Nothing in the Agreement shall be construed to require PHARMACY to permit access to patient information in violation of federal or state laws concerning patient information. Cal. Health & Safety Code § 1375.7(b).

30. Nothing in the Agreement shall be construed to require PHARMACY to waive any provision of Division 2, Chapter 2.2 of the California Health & Safety Code, or sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations relating to claims processing and payment. Cal. Health & Safety Code § 1375.7(b)(4); 28 Cal. Code Reg. § 1300.71(p)

31. PHARMACY agrees that nothing in the Agreement as presented to PHARMACY required or permitted PHARMACY to assume financial risk for the following items: (a) injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects; (b) injectable medications or blood products used for hemophilia; (c) injectable medications related to transplant services; (d) adult vaccines; (e) self-injectable medications; or (f) injectable medication or medication in an implantable dosage form costing more than $250.00 per dose. To assume financial risk for the above listed items, PHARMACY must request to do so in writing at the time of negotiating or renewing the Agreement. Cal. Health & Safety Code § 1375.8.

32. PHARMACY shall not collect surcharges for Covered Drugs. If PBM or Plan Sponsor receives notice of any such surcharge, it shall take appropriate action as provided under the Agreement. 28 Cal. Code Reg. § 1300.67.8(d).

33. To the extent required by law, PHARMACY shall display in a prominent place in each patient reception and waiting area a notice informing Covered Persons how to contact Plan Sponsor, file a complaint with Plan Sponsor, obtain assistance from the Department of Managed Health Care, and seek an independent medical review. The notice shall be in the form and displayed in the manner required by law.

34. Informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department, and seek an independent medical review are available in non-English languages through the Department of Insurance's website. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, California 95814. 28 Cal. Code Reg. § 1300.67.04 (c)(2)(D)(ii).

35. PHARMACY shall comply with each plan's language assistance program standards, as communicated to PHARMACY in writing from time to time and shall cooperate with PBM and Plan Sponsor by providing any information necessary to assess compliance. Cal. Health & Safety Code § 1367.04(f);10 Cal. Code Reg. § 2538.3(d); 28 Cal. Code Reg. §§ 1300.67.04(c)(2)(E) and 1300.67.04(e)(4),

36. PHARMACY agrees that if its retail price for a prescription drug is less than a Covered Person's copayment, PHARMACY shall charge Covered Person no more than the retail price. 28 Cal. Code Reg. § 1300.67.24(c)(1).

37. PHARMACY shall not make any additional charges for rendering services provided pursuant to the Agreement except as provided for in the Covered Person's agreement with the Plan Sponsor. Cal. Admin. Code tit. 10, § 2240.4(a).

38. PHARMACY's primary consideration shall be the quality of services rendered to Covered Persons. Cal. Admin. Code tit. 10, § 2240.4(a).

39. PHARMACY shall not discriminate against any Covered Person on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such Covered Person of any complaint, grievance, or legal action against PHARMACY. Cal. Admin. Code tit. 10, § 2240.4(a).

40. Immediately upon cancellation or amendment of the Agreement, PHARMACY shall send a notice of such cancellation or amendment, the text thereof, and the effective date thereof to Health Plan Registrar, Office of the Attorney General, 3580 Wilshire Boulevard, Los Angeles, California 90010, California Attorney General. 11 Cal. Code Reg. § 536.

41. To the extent PHARMACY is expressly authorized under this Agreement to provide mail order pharmacy services, PHARMACY shall provide such services in compliance with the requirements of the Knox-Keene Act and applicable California and federal laws regarding pharmacists and pharmacy services. Such pharmacy's processes shall conform effectively and efficiently with PBM and/or a Plan Sponsor's processes, as applicable, for prior authorization for coverage of medically necessary drugs as required by the Knox-Keene Act. Such pharmacy shall timely deliver such services via mail order to the Covered Person and shall promptly inform PBM in writing if and when it fails to meet timely delivery standards. 28 Cal. Code Reg. § 1300.67.24(b)(4).

42. Pharmacy shall comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health. If the Agreement provides benefits to enrollees or subscribers covered under the Medi-Cal Program, Pharmacy will ensure that recipient-specific immunization information is periodically reported to the California Immunization Registry (CAIR) for both children and adults. Reports shall be made following the recipient's initial health assessment and all other health care visits which result in an immunization being provided. Cal. Bus. & Prof. Code § 4052.8.

43. PHARMACY has the right to submit complaints to the California Department of Managed Health Care regarding practices pursuant to this Agreement. Cal. Health & Safety Code § 1371.39.

12.7 Colorado

COLORADO ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Colorado Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, carriers, health maintenance organizations, and managed care plans under Colorado law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. Neither PHARMACY, Plan Sponsor, nor PBM shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the other. Colo. Rev. Stat. § 10-16-121(1)(a); 3 CCR 702-4:4-2-15(A).
2. Neither Plan Sponsor nor PBM shall terminate the Agreement with PHARMACY because PHARMACY expresses disagreement with a decision by Plan Sponsor or PBM to deny or limit benefits to a Covered Person or because PHARMACY assists a Covered Person to seek reconsideration of the decision or because PHARMACY discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by a Benefit Plan or not, policy provisions of a Benefit Plan, or PHARMACY's recommendation regarding selection of a Benefit Plan based on PHARMACY's knowledge of the health needs of such patients. Colo. Rev. Stat. § 10-16-121(1)(b); 3 CCR 702-4:4-2-15(A).
3. PHARMACY shall not be subject to financial disincentives based on the number of referrals made to participating providers in the Benefit Plan for covered benefits so long as PHARMACY adheres to the utilization review policies and procedures of Plan Sponsor and PBM. Colo. Rev. Stat. § 10-16-121(d).
4. PHARMACY shall hold Covered Persons harmless for money owed to PHARMACY by Plan Sponsor or PBM. In no circumstance shall Covered Persons be liable to PHARMACY for money owed to PHARMACY by Plan Sponsor or PBM. In no event, including but not limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons (other than Plan Sponsor or PBM) acting on their behalf for services provided pursuant to the Agreement. This provision does not prohibit PHARMACY from collecting

coinsurance, deductibles, copayments, or fees for noncovered services delivered on a fee-for-service basis to Covered Persons. PHARMACY agrees that this provision shall survive termination of the Agreement, for Covered Drugs rendered prior to termination of the Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Persons. This provision is not intended to apply to services provided after the Agreement has terminated. PHARMACY agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of the Agreement. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than 30 days after the Colorado Commissioner of Insurance has received written notification of proposed changes. Colo. Rev. Stat. § 10-16-705(3); 3 CCR 702-4:4-7-1 § 12.

5. Adjustments to claims by PHARMACY, PBM, or Plan Sponsor shall be made as set out in the Agreement provided, however, that to the extent required by law, PHARMACY shall be afforded the same time period as PBM and Plan Sponsor for making adjustments to claims and provided further that the time period for adjustments to claims shall not exceed 12 months after the date of the original explanation of benefits except as otherwise required or permitted by law. Colo. Rev. Stat. § 10-16-704(4.5)(b).

6. If the Agreement provides for a duration of less than 2 years, PHARMACY and PBM shall provide 90 days advance written notice to each other before terminating the Agreement without cause. If the Agreement provides for a duration of greater than 2 years, PHARMACY and PBM shall provide 60 days advance written notice to each other before terminating the Agreement without cause. Within 15 working days of receipt from or issuance to PHARMACY of a notice of termination, PBM shall make a good faith effort to give written notice of the termination to all Covered Persons that are seen regularly by PHARMACY. Within 5 working days after PHARMACY either gives or receives notice of termination, PHARMACY shall provide PBM with a list of PHARMACY's patients that are Covered Persons under Plan Sponsors' Benefit Plans. Colo. Rev. Stat. §§ 10-16-705(7), 25-37-111.

7. PHARMACY agrees to provide Covered Drugs to Covered Persons following termination of the Agreement in the following circumstances:

    a. PHARMACY agrees to continue to provide services in accordance with the terms of the Agreement to Covered Persons for 60 days after termination without cause if notice of PHARMACY's termination was not provided to Covered Persons as outlined in paragraph 6 above.

    b. PHARMACY agrees to continue to provide services for Covered Persons being treated at an in-patient facility until discharged if Plan Sponsor terminates coverage for any

reason other than nonpayment of the premium, fraud, or abuse.

Colo. Rev. Stat. § 10-16-705(4).

8. PHARMACY shall not assign or delegate rights and responsibilities under the Agreement without prior written consent. Colo. Rev. Stat. § 10-16-705(8).
9. PHARMACY shall not discriminate, with respect to the provision of medically necessary Covered Drugs, against Covered Persons that are participants in a publicly financed program. Colo. Rev. Stat. § 10-16-705(9).
10. PHARMACY agrees that the sole responsibility for obtaining any necessary preauthorization rests with PHARMACY or the participating provider that recommends or orders particular services, treatments, or procedures and not with Covered Persons. Colo. Rev. Stat. § 10-16-705(14).
11. To the extent any definitions or provisions of the Agreement conflict with definitions or provisions contained in Benefit Plans or contained in Colorado Revised Statute, Title 10, Article 16, Part 7, the definitions, or provisions of the Agreement shall not control. Colo. Rev. Stat. § 10-16-705(15).
12. PHARMACY agrees that Plan Sponsor shall have the right to approve or disapprove PHARMACY's participation status in Plan Sponsor's network. Colo. Rev. Stat. § 10-16-706(4).
13. PHARMACY agrees that in the event of PBM's insolvency, Plan Sponsor shall have the right to require the assignment to Plan Sponsor of the provisions of the Agreement addressing PHARMACY's obligation to furnish Covered Drugs. Colo. Rev. Stat. § 10-16-706(9).
14. In the event PBM makes a material change to the Agreement, as defined by Colorado Revised Statute, section 25-37-102, PBM shall provide PHARMACY written notice of the proposed change conspicuously entitled "Notice of Material Change to Contract" at least 90 days before the effective date of the change. If PHARMACY objects to the change, PHARMACY must notify PBM in writing of the objection within 15 days of the date of the notice. If PBM and PHARMACY are unable to resolve the objection, either party may terminate the Agreement upon written notice of termination provided to the other not later than 60 days before the effective date of the material change. If PHARMACY does not object to the material change as provided herein, the change shall be effective as specified in the notice. Colo. Rev. Stat. § 25-37-104.
15. In the event PHARMACY timely objects in writing to a notice of material change to the Agreement that seeks to add a new category of coverage, as defined by Colorado Revised Statute, section 25-37-102, the addition of the category of coverage shall not be effective as to PHARMACY, and PBM shall not terminate the Agreement based on PHARMACY's objection to the addition of the category of coverage. Colo. Rev. Stat. § 25-37-104(4).

16. PBM may make an administrative change to the Agreement, as defined by Colorado Revised Statute section 25-37-102, and such change shall be effective upon at least 15 days' notice to PHARMACY. Colo. Rev. Stat. § 25-37-102(9)(c).
17. The Agreement may be modified by operation of law as required by any applicable state or federal law or regulation and PBM may disclose this change by any reasonable means. Colo. Rev. Stat. § 25-37-105.
18. PHARMACY acknowledges and agrees that PBM may assign, allow access to, sell, rent, or give its rights to PHARMACY's services to (1) Plan Sponsors providing coverage for Covered Drugs to their employees or members when such Plan Sponsors have contracted with PBM for the administration or processing of claims for payment or service provided pursuant to the Agreement and (2) affiliates, subsidiaries, or entities under common ownership or control of PBM or third parties providing or receiving administrative services from PBM or its affiliates, subsidiaries, or entities under common ownership or control with PBM. PHARMACY acknowledges and agrees that the Agreement applies to network rental arrangements and that it is for the purpose of assigning, allowing access to, selling, renting, or giving PBM's rights to PHARMACY's services. Colo. Rev. Stat. § 25-37-108.
19. Nothing in the Agreement shall be construed or shall operate to require that PHARMACY waive or forego any right or benefit to which PHARMACY may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person's status as a health care provider providing services in Colorado. Colo. Rev. Stat. § 25-37-109.
20. Upon 60 days' written notice to PBM that states the reasons therefore, PHARMACY may decline to provide services under the Agreement to Covered Persons that are "new patients." For purposes of this paragraph, "new patients" mean those patients who have not received services from PHARMACY in the immediately preceding 3 years. A patient shall not become a new patient solely by changing coverage from one Plan Sponsor or Benefit Plan to another Plan Sponsor or Benefit Plan. Colo. Rev. Stat. § 25-37-110.
21. The Agreement shall terminate automatically in the event the federal Drug Enforcement Agency or other federal law enforcement agency ceases the operations of the PHARMACY or its pharmacist due to alleged or actual criminal activity. Colo. Rev. Stat. § 25-37-111(3).
22. Nothing in the Agreement shall be construed to preclude use or disclosure of the Agreement to a third party for the purpose of enforcing the provisions of Title 25, Article 37 of Colorado Revised Statutes or other state or federal law provided the third party shall be bound by the confidentiality requirements set forth in the Agreement and required by law. Colo. Rev. Stat. § 25-37-112.

23. Consistent with all state and federal statutes and regulations, PHARMACY agrees to share medical record information with other participating providers who have treated the same enrollee to facilitate the continuity of health care services. 6 CCR 1011-2(V)(E).

24. To the extent provisions in the Agreement concerning provider disputes directly conflict with the Provider-Carrier Dispute Resolution process set forth in Colorado Insurance Regulation 4-2-23, the provisions in Regulation 4-2-23 shall control. 3 CCR 702-4:4-2-23.

25. The following shall apply with respect to PBM's MAC Lists:

    a. Information regarding PBM MAC Lists are available to PHARMACY locations in Colorado subject to such MAC Lists. PHARMACY locations in Colorado can contact MACAppeals@primetherapeutics.com for information on PBM's MAC Lists.

    b. PHARMACY locations in Colorado subject to PBM's MAC Lists may appeal reimbursement for a drug subject to maximum allowable cost pricing. PHARMACY locations in Colorado can initiate an appeal within 21 calendar days of the PHARMACY submitting the claim for which the appeal is being requested by submitting an email to MACAppeals@primetherapeutics.com detailing the challenge to the PBM maximum allowable cost, along with supporting information and/or documentation. PHARMACY may call (800) 441-6001 to speak to an individual who is responsible for processing appeals. PBM will investigate and respond to any such appeal within 21 days.

    c. If the appeal is denied, PBM will provide the challenging PHARMACY with the reason for the denial and the national drug code of a drug that may be purchased by the PHARMACY at a price that is equal to or less than the maximum allowable cost.

    d. If the appeal is upheld, PBM will make the change in the maximum allowable cost within one day after the date of determination, and PHARMACY can then reverse and rebill the claim in question.

    e. This Section 25: (i) applies only with respect to MAC Lists owned and/or controlled by PBM; and (ii) does not apply to MAC lists utilized by the state medical assistance program.

    Colo. Rev. Stat. § 25-27-103.5(1)(a) and (3).

26. After the date PBM receives a clean claim submitted by PHARMACY, PBM shall not retroactively reduce payment on the claim after the point of sale except as the result of an audit (although PBM may retroactively increase a payment to PHARMACY pursuant to a written agreement between PBM and PHARMACY, as well as make adjustments to claims in the case of a clerical error). Colo. Rev. Stat. 10-16-122.3(2)(a)-(b). A "clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (it does not include a claim based on fraud, waste, or abuse). Colo. Rev. Stat. 10-16-122.3(6)(b).

12.8 Connecticut

CONNECTICUT ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Connecticut Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health care center, health maintenance organization, managed care organization ("MCO"), insurer, or carrier licensed under Connecticut law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. In no event, including, but not limited to, nonpayment by PBM or Plan Sponsor, insolvency, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Covered Persons or a person acting on their behalf, other than PBM or Plan Sponsor for Covered Drugs provided pursuant to the Agreement. This provision shall not prohibit collection of cost-sharing amounts, or costs for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Covered Persons in accordance with the terms of the Covered Person's Benefit Plan. C.G.S.A. §§ 38a-193(c)(1)(A), 38a-479aa(l), 38a-479bb(d)(5).
2. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY shall continue providing Covered Drugs for Covered Persons for the duration of the period for which premium payment has been made to Plan Sponsor or until Covered Person's discharge from inpatient facilities, whichever time is greater. C.G.S.A. § 38a-193(c)(1)(B), (d).
3. Nothing in the Agreement shall be construed to modify the rights and benefits contained in Covered Person's Benefit Plan. C.G.S.A. § 38a-193(c)(1)(C).
4. PHARMACY shall not bill Covered Person for Covered Drugs, except for cost-sharing amounts, where Plan Sponsor or PBM denies payment because PHARMACY has failed to comply with the terms or conditions of the Agreement or the Benefit Plan. C.G.S.A. § 38a-193(c)(1)(D).
5. PHARMACY further agrees that paragraphs 1 through 4 above shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to

be for the benefit of Plan Sponsor's Covered Persons, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. C.G.S.A. § 38a-193(c)(1)(E).

6. If PHARMACY contracts with other providers or facilities who agree to provide Covered Drugs to Covered Persons of Plan Sponsor with the expectation of receiving payment directly or indirectly from Plan Sponsor or PBM, such providers or facilities shall agree to abide by paragraphs 1 through 5 above, and PHARMACY shall ensure that such agreement is memorialized in writing. C.G.S.A. § 38a-193(c)(1)(F).

7. PHARMACY, or an agent, trustee or assignee of PHARMACY shall not maintain any action at law against a Covered Person to collect sums owed by PBM or Plan Sponsor or request payment from a Covered Person for such sums. For purposes of this section "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL." PHARMACY acknowledges that pursuant section 20-7f, Connecticut General Statutes, it is an unfair trade practice in violation of chapter 735a for PHARMACY to request payment from a Covered Person, other than a copayment or deductible, for Covered Drugs, or to report to a credit reporting agency an enrollee's failure to pay a bill for medical services when Plan Sponsor has primary responsibility for payment of such services. C.G.S.A. § 38a-193(c)(3).

8. PHARMACY and PBM shall each provide the other at least 60 days' advance notice to terminate or withdraw from the Agreement. This paragraph shall not apply:

   a. When lack of such notice is necessary for the health or safety of a Covered Person;

   b. When PHARMACY has entered into a contract with PBM that is found to be based on fraud or material misrepresentation; or

   c. When PHARMACY engages in any fraudulent activity related to the terms of the Agreement.

   C.G.S.A. § 38a-193(e) and C.G.S.A. § 38a-478(h).

9. To the extent applicable and required by law, in the event PHARMACY provides Covered Drugs to Covered Persons of a managed care organization contracted with a preferred provider network, PHARMACY agrees that the Agreement shall be transferred and assigned to the managed care organization for the provision of future Covered Drugs by PHARMACY to Covered Persons, at the discretion of the managed care organization, in the event the preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the Connecticut Commissioner of Insurance, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the Commissioner, for a period in excess of 90 days. C.G.S.A. § 38a-479bb(d)(10).

10. PHARMACY agrees that in no event, including, but not limited to, nonpayment by a Plan Sponsor or PBM, the insolvency of a Plan Sponsor or PBM, or a breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than the health carrier or intermediary) acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. This Agreement does not prohibit the PHARMACY from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. Nor does this Agreement prohibit a PHARMACY and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as the PHARMACY has clearly informed the Covered Person that Plan Sponsor does not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit the PHARMACY from pursuing any available legal remedy. C.G.S.A. § 38a-477g(b)(1)(A).
11. In the event of a Plan Sponsor or PBM insolvency or other cessation of operations, the PHARMACY's obligation to deliver Covered Drugs to Covered Persons without requesting payment from a Covered Person other than a copayment for such services will continue until the earlier of (i) the termination of the Covered Person's coverage under the Benefit Plan, including any extension of coverage provided under the contract terms or applicable state or federal law for Covered Persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f of the Connecticut general statutes, or are totally disabled, or (ii) the date the Agreement between PBM and the PHARMACY would have terminated if PBM or Plan Sponsor had remained in operation, including any extension of coverage required under applicable state or federal law for Covered Persons who are in an active course of treatment or are totally disabled. C.G.S.A. § 38a-477g(b)(1)(B).
12. PHARMACY shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, Covered Persons, and PHARMACY shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a Covered Person's right to view, obtain copies of, or amend such Covered Person's medical and health records. C.G.S.A. § 38a-477g(b)(1)(C).
13. PBM shall timely notify PHARMACY of any change to the Agreement, including any provisions or other documents incorporated by reference into the Agreement, that will result in a material change to such Agreement. C.G.S.A. § 38a-477g(c)(2).

12.9 Delaware

DELAWARE ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Delaware Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health service corporations, managed care organizations, health maintenance organizations, and insurers under Delaware law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. Nothing in the Agreement shall be construed as prohibiting PHARMACY from giving its patients information regarding diagnoses, prognoses, and treatment options. 18 Del. Code § 6414.
2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a managed care organization under Delaware law, PHARMACY agrees that:
    a. In no event, including but not limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or a person (other than Plan Sponsor or PBM) acting on behalf of Covered Persons for services provided pursuant to this Agreement. This Agreement does not prohibit PHARMACY from collecting coinsurance, deductibles, or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. Code of Del. Regs. 18 1400 1403 § 7.1.1.
    b. In the event of Plan Sponsor's or PBM's insolvency or other cessation of operations, Covered Drugs to Covered Persons will continue through the period for which a premium has been paid to Plan Sponsor on behalf of Covered Persons or until Covered Person's discharge from an inpatient facility, whichever time is greater. Covered Drugs to Covered Persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Covered Person's continued confinement in an inpatient facility is no longer medically necessary. Code of Del. Regs. 18 1400 1403 § 7.1.2.

c. Paragraphs (2)(a) and (b) above shall be construed in favor of the Covered Person, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Plan Sponsor or PBM, and shall supersede any oral or written contrary agreement between PHARMACY and a Covered Person or the representative of the Covered Person if the contrary agreement is inconsistent with paragraphs (6)(a) and (b) above. Code of Del. Regs. 18 1400 1403 § 7.2.

d. To the extent that any of the definitions or provision set forth in the Agreement directly conflict with the definitions or provisions of Regulation 18 1400 1403, Code of Delaware Regulations, the Agreement shall not control. Code of Del. Regs. 18 1400 1403 § 7.3.

e. In the event that the Agreement with PHARMACY is terminated, PHARMACY agrees to continue to provide Covered Drugs to Covered Persons at the rates set forth in the Agreement for up to 120 days after notification of termination in those cases where it is medically necessary for the Covered Person to continue treatment with PHARMACY. In cases of the pregnancy of a Covered Person, medical necessity shall be deemed to have been demonstrated and PHARMACY agrees to continue to provide Covered Drugs through completion of postpartum care. This paragraph shall not apply in cases where the Agreement with PHARMACY was terminated due to unsafe health care practices that compromise the health or safety of Covered Persons. Code of Del. Regs. 18 1400 1403 § 9.3.

12.10 District of Columbia

DISTRICT OF COLUMBIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This District of Columbia Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations and carriers under District of Columbia law (collectively and/or individually, “Plan Sponsor”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY shall be permitted and obligated to discuss medical treatment options with Covered Persons. D.C. Code Ann § 31-3406(h)(2); Code of D.C. Mun. Reg. 26-A3503.11.

2. Nothing in the Agreement shall be construed to prohibit, impede, or interfere in discussions between PHARMACY and Covered Persons concerning medical treatment options, including financial coverage of those treatment options. D.C. Code Ann § 31-3406(h)(1); Code of D.C. Mun. Reg. 26-A3503.10.
3. PBM shall not terminate or refuse to contract with PHARMACY based in whole or in part on the fact that PHARMACY discussed treatment options with a Covered Person. D.C. Code Ann § 31-3406(h)(3); Code of D.C. Mun. Reg. 26-A3503.12
4. To the extent PHARMACY provides Covered Drugs to a Covered Person of a health maintenance organization, PHARMACY agrees:
    a. In the event PBM or Plan Sponsor fails to pay PHARMACY as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by PBM or Plan Sponsor. D.C. Code Ann. § 31-3412(d)(1); Code of D.C. Mun. Reg. 26-A3506.12.
    b. PHARMACY shall not collect or attempt to collect from Covered Persons sums owed by PBM or Plan Sponsor. D.C. Code Ann. § 31-3412(d)(2); Code of D.C. Mun. Reg. 26-A3506.13.
    c. Neither PHARMACY nor any agent, trustee, or assignee of PHARMACY may maintain any action at law against a Covered Person to collect sums owed by PBM or Plan Sponsor. D.C. Code Ann. § 31-3412(d)(3); Code of D.C. Mun. Reg. 26-A3506.14.
    d. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY shall continue to provide Covered Drugs to (Covered Persons for the period for which premium payment has been made or until Covered Persons' discharge from inpatient facilities, whichever is longer. D.C. Code Ann. § 31-3412(e)(2)(B); Code of D.C. Mun. Reg. 26-A3506.16(b).
    e. If PHARMACY terminates the Agreement, PHARMACY shall give PBM at least 60 days advance notice of termination. D.C. Code Ann. § 31-3412(f).

12.11 Florida

FLORIDA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Florida Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of benefits sponsor of a pharmacy benefits plan or program, including insurers, carriers, health maintenance organizations, prepaid limited health service

organizations, prepaid health clinics, and employer/multiple employer healthcare arrangements under Florida law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement or Provider Manual, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Except as provided in paragraph 9 below, without limiting the generality of the foregoing, and notwithstanding anything in the Agreement or the Provider Manual to the contrary, PHARMACY and PBM agree as follows:

1. PHARMACY shall be required to exhaust internal dispute-resolution processes set forth in the Agreement as a prerequisite to submission of a claim by PHARMACY to the statewide provider dispute resolution program pursuant to Florida Statute § 408.7057.
2. The Agreement shall be canceled upon issuance of an order by the Florida Department of Insurance pursuant to Florida Statute §§ 624.4411(3), 641.234(3), and 636.036(3).
3. PHARMACY shall not bill or otherwise seek reimbursement from or recourse against any Covered Persons, with the exception of any supplemental charges or coinsurance amounts stated in Covered Persons' Benefit Plan with Plan Sponsor. Fla. Stat. § 627.6472(4)(e).
4. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Florida law, PHARMACY agrees:
    a. Covered Persons shall not be liable to PHARMACY for any services for which Plan Sponsor is liable, as specified in Florida Statute § 641.3154. Fla. Stat. § 641.315(1).
    b. PHARMACY shall provide no less than 60 days advance written notice to PBM and the Florida Department of Insurance before terminating the Agreement for any reason. Nonpayment for goods or services rendered by PHARMACY shall not be a valid reason for avoiding the 60 days advance notice of cancellation. Fla. Stat. § 641.315(2)(a)(1), (2).
    c. PBM shall provide 60 days advance written notice to PHARMACY and the Florida Department of Insurance before terminating the Agreement, without cause, except where a patient's health is subject to imminent danger or PHARMACY's ability to practice is effectively impaired by an action by a governmental agency. Fla. Stat. § 641.315(2)(b).
5. To the extent PHARMACY provides Covered Drugs to Covered Persons of a prepaid limited health service organization under Florida law, PHARMACY agrees:
    a. In the event PBM or Plan Sponsor fails to pay for Covered Drugs already rendered to Covered Persons by PHARMACY, Plan Sponsor is liable for such fees rather than Covered Persons. Fla. Stat. § 636.035(1).

b. Covered Persons shall not be liable to PHARMACY for any services covered by Covered Persons' Benefit Plan with Plan Sponsor, with the exception of any deductible or copayment which is not covered by Covered Person's Benefit Plan or for services not authorized by Plan Sponsor. Fla. Stat. § 636.035(4), (5).

c. PHARMACY shall provide no less than 90 days advance written notice to PBM before canceling the Agreement for any reason. Nonpayment for goods or services rendered by PHARMACY shall not be a valid reason for avoiding the 90 day advance notice of cancellation. Fla. Stat. § 636.035(6)(a), (b).

d. PBM shall provide 90 days advance written notice to PHARMACY before canceling, without cause, the Agreement, except where a Covered Person is subject to imminent danger or PHARMACY's ability to practice is effectively impaired by an action by a governmental agency. Fla. Stat. § 636.035(8).

e. If any provision of the Agreement is held to be unenforceable or otherwise contrary to any applicable laws, regulations, or rules, such provision shall have no effect and shall be severable without affecting the validity or enforceability of the remaining provisions of the Agreement. Fla. Stat. § 636.035(9).

6. To the extent PHARMACY provides Covered Drugs to Covered Persons of a prepaid health clinic under Florida law, in the event Plan Sponsor fails to pay for Covered Drugs already rendered to a Covered Person by PHARMACY, Plan Sponsor is liable for such fees rather than Covered Person. Fla. Stat. § 641.43.

7. Notwithstanding anything to the contrary in the Agreement, to the extent PHARMACY provides Covered Drugs to Covered Persons of a discount medical plan organization under Florida law, the rates charged by the PHARMACY for services rendered to Covered Persons shall not be in excess of the rates set forth in the Agreement and any related attachments. Fla. Stat. § 636.214(2)(c).

8. PHARMACY shall post a consumer assistance notice, prominently displaying the notice in the reception area of PHARMACY so that the notice will be clearly noticeable by all patients. The consumer assistance notice must state that the addresses and toll-free telephone number of Plan Sponsor's grievance department shall be provided upon request. Fla. Stat. § 641.511(8).

9. For any Agreement executed, amended, adjusted, or renewed on or after July 1, 2023 that applies to pharmacist services furnished on or after January 1, 2024, between PBM and PHARMACY, the following shall apply in conformity with Florida Senate Bill 1550 (2023) and Fla. Stat. § 626.8825 and, except to the extent not allowed by law, shall supersede any contractual terms in the Agreement, this Addendum, or the Provider Manual to the contrary:

a. At the time of adjudication for electronic claims or the time of reimbursement for nonelectronic claims, PBM shall provide PHARMACY with a remittance, including such detailed information as is necessary for PHARMACY or pharmacist to identify the reimbursement schedule for the specific network applicable to the claim and which is the basis used by PBM to calculate the amount of reimbursement paid. This information must include, but is not limited to, the applicable network reimbursement ID or plan ID as defined in the most current version of the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide.

b. PBM shall ensure that any basis of reimbursement information is communicated to PHARMACY in accordance with the NCPDP Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide, when performing reconciliation for any effective rate guarantee, and that such basis of reimbursement information communicated is accurate, corresponds with the applicable network rate, and may be relied upon by PHARMACY.

c. PBM shall not charge, withhold, or recoup direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a fee may be recouped from PHARMACY. This requirement does not apply to:

    i. Any incentive payments provided by PBM to PHARMACY for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a PHARMACY audit pursuant to Fla. Stat. § 624.491.

    ii. Any recoupment that is returned to the state for programs in chapter 409 or the state group insurance program.

d. PBM shall not unilaterally change the terms of the Agreement.

e. Unless otherwise prohibited by law, PBM shall not prohibit PHARMACY or pharmacist from:

    i. Offering mail or delivery services on an opt-in basis at the sole discretion of the Covered Person.

    ii. Mailing or delivering a prescription drug to a Covered Person upon his or her request.

iii. Charging a shipping or handling fee to a Covered Person requesting a prescription drug be mailed or delivered if PHARMACY or pharmacist discloses to the Covered Person before the mailing or delivery the amount of the fee that will be charged and that the fee may not be reimbursable by the Covered Person's pharmacy benefits plan or program.

f. PBM shall provide PHARMACY, upon its request, a list of pharmacy benefits plans or programs in which PHARMACY is a part of the network. Updates to the list shall be communicated to PHARMACY within seven days. PBM shall not restrict PHARMACY or pharmacist from disclosing this information to the public.

g. PBM shall ensure that the Electronic Remittance Advice contains claim level payment adjustments in accordance with the American National Standards Institute Accredited Standards Committee, X12 format, and includes or is accompanied by the appropriate level of detail for PHARMACY to reconcile any debits or credits, including, but not limited to, PHARMACY NCPDP or NPI identifier, date of service, prescription number, refill number, adjustment code, if applicable, and transaction amount.

h. PBM shall provide a reasonable administrative appeal procedure to allow PHARMACY or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in Fla. Stat. § 627.64741 for a specific drug as being below the acquisition cost available to the challenging PHARMACY or pharmacist.

   i. The administrative appeal procedure shall include a telephone number and email address, or a website as specified in the provider Manual, for the purpose of submitting the administrative appeal. The appeal may be submitted by PHARMACY or an agent of PHARMACY directly to PBM or through a pharmacy service administration organization. PHARMACY or pharmacist shall be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal.

   ii. PBM shall respond to the administrative appeal within 30 business days after receipt of the appeal.

   iii. If the appeal is upheld, PBM shall:

      1. Update the maximum allowable cost pricing information to at least the acquisition cost available to PHARMACY;

      2. Permit PHARMACY or pharmacist to reverse and rebill the claim in question;

3. Provide to PHARMACY or pharmacist the national drug code on which the increase or change is based; and
4. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information.

iv. If the appeal is denied, PBM shall provide to PHARMACY or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in Florida which have the drug currently in stock at a price below the maximum allowable cost pricing information.

v. Every 90 days, PBM shall report to the State the total number of appeals received and denied in the preceding 90-day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted.

12.12 Georgia

GEORGIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Georgia Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Georgia law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides mail-order Covered Drugs to Covered Persons, PHARMACY shall in its initial written correspondence with each Covered Person include a notice stating that the Covered Person may obtain Covered Drugs, including prescription drugs, from other providers of pharmaceutical services and that the exclusive utilization of PHARMACY as a mail-order pharmaceutical distributor is not required. O.C.G.A. § 33-30-4.3(d).

2. To the extent that PHARMACY provides Covered Drugs to Covered Persons of a Plan Sponsor offering a preferred provider arrangement under Georgia law, PHARMACY agrees that a Covered Person shall be held harmless for provider utilization review decisions over which he has no control. Ga. Admin. Code Rule 120-2-44-.04(3).

3. To the extent that PHARMACY provides Covered Drugs to Covered Persons of a provider sponsored health care corporation under Georgia law, PHARMACY agrees:

    a. In the event that Plan Sponsor or PBM fails to pay for Covered Drugs as set forth in the Benefit Plan or the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM;

    b. In the event of the insolvency of Plan Sponsor or PBM, PHARMACY shall continue to provide Covered Drugs as set forth in the Agreement to Covered Persons who are confined on the date of insolvency in an inpatient facility until the earlier of the Covered Person's discharge or expiration of benefits.

    Ga. Admin. Code Rule 120-2-75-.06(5)-(6).

4. Any prospective authorization or other authorization required for Covered Drugs shall be conducted as set forth in the Agreement, including the pharmacy manual. Ga. Admin. Code Rule 120-2-80-.06(4).

5. The following shall apply with respect to PBM's MAC Lists:

    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum reimbursement amount pricing are First Databank and Medi-Span. O.C.G.A. § 33-64-9(a)(1).

    b. Pricing on PBM's MAC Lists will be updated at least once every 5 business days (and every 14 business days for those contracts pursuant to Article 7 of Chapter 4 of Title 49 (the Georgia Medical Assistance Act of 1977)). O.C.G.A. § 33-64-9(a)(1).

    c. PHARMACY locations in Georgia subject to PBM's MAC Lists may appeal reimbursement for a drug subject to maximum allowable cost pricing by initiating an appeal within 14 calendar days of the PHARMACY submitting the claim for which the appeal is being requested. PBM will respond to the appeal within 14 calendar days of receipt. O.C.G.A. § 33-64-9(d).

    d. This Section 5 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.13 Hawaii

HAWAII ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Hawaii Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of an insurer, nonprofit health service plan, health insurance service organization, managed care plan, health maintenance organization, and organizations entering into preferred provider arrangements under Hawaii law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. In the event that Plan Sponsor or PBM fails to pay for Covered Drugs, a Covered Person shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM. PHARMACY shall not collect or attempt to collect from a Covered Person sums owed by Plan Sponsor or PBM. PHARMACY, or its agent, trustee, or assignee shall not maintain any action at law against a Covered Person to collect sums owed by Plan Sponsor or PBM. Hawaii Rev. Stat. Ann. § 432D-8(d).
2. In the event of insolvency by Plan Sponsor or PBM, PHARMACY agrees to continue to provide services to Covered Persons for the duration of the period after the insolvency for which premium payment has been made and until a Covered Person's discharge from inpatient facilities. Hawaii Rev. Stat. Ann. § 432D-8(e)(2).
3. PHARMACY shall provide PBM with at least 60 days' advance written notice of termination of the Agreement. Hawaii Rev. Stat. Ann. § 432D-8(f).
4. PHARMACY shall comply with PBM's and Plan Sponsors' requests for any information necessary for Plan Sponsor to comply with the requirement of Hawaii Statute, Title 24, Chapter 432E, regarding the measurement of quality outcomes, access, satisfaction, and utilization of services. Hawaii Rev. Stat. Ann. § 432E-10(a).
5. The following shall apply with respect to PBM's MAC Lists:
    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum reimbursement amount pricing are First Databank and Medi-Span. Hawaii Rev. Stat. Ann. § 328-106(b).

12.14 Idaho

IDAHO ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Idaho Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health insurer, hospital services corporation, professional service corporation, managed care organization, health maintenance organization, and organizations entering into preferred provider arrangements under Idaho law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. Neither PBM nor Plan Sponsor shall make a specific payment under this Agreement, in any type or form, to PHARMACY as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate Covered Drugs provided with respect to a specific Covered Person or group of Covered Persons with similar medical conditions. Idaho Code §§ 41-1846(1)(f), 41-3928.
2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a hospital or professional service corporation or managed care organization under Idaho law, PHARMACY agrees if PBM or Plan Sponsor proposes to terminate or not renew the Agreement based on PHARMACY's breach of the Agreement, PBM or Plan Sponsor shall provide PHARMACY written notice identifying the breach and providing a reasonable period of time for PHARMACY to cure the breach prior to termination or nonrenewal. If the breach has not been cured within the time period stated, PBM or Plan Sponsor may terminate or not renew the Agreement. Provided, however, that if the breach for which PBM or Plan Sponsor proposes to terminate or not renew the Agreement is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, PBM or Plan Sponsor may terminate or not renew the Agreement immediately. Idaho Code §§ 41-3408(5), 41-3927(2).
3. To the extent PHARMACY provides Covered Drugs to Covered Persons of a hospital or professional service corporation under Idaho law, PHARMACY agrees:
    a. PHARMACY shall provide Covered Persons with Covered Drugs and PHARMACY's obligation to so furnish such Covered Drugs as provided for in the Benefit Plan shall be

a direct obligation of PHARMACY to Covered Persons, PBM**,** and Plan Sponsor. Idaho Code § 41-3415A(1).

b. PHARMACY shall be compensated as set forth in the Agreement and the attachments thereto. PHARMACY shall not request or receive from PBM, Plan Sponsor, or Covered Persons any compensation for Covered Drugs which is not in accord with the Agreement. Idaho Code § 41-3415A(2)(a).

c. PHARMACY's compensation may be prorated and settled under the circumstances and in the manner referred to in Section 41-3431, Idaho Code. Idaho Code § 41-3415A(2)(b).

d. If PHARMACY terminates the Agreement, the termination shall not be effective as to any Covered Person enrolled in a Benefit Plan in force on the date of such termination and PHARMACY shall continue to provide Covered Drugs pursuant to the Agreement until the termination of Covered Person's Benefit Plan or the next following anniversary of Covered Person's Benefit Plan, whichever date is earlier. Idaho Code § 41-3415A(2)(c).

4. The Agreement shall not be construed to require PHARMACY to deny a Covered Person access to services not covered by a Benefit Plan if the Covered Person is informed that he or she will be responsible to pay for the noncovered services and he or she nonetheless desires to obtain such services. Idaho Code § 41-3927(4)(a).

5. The Agreement shall not limit PHARMACY's ability to treat a Covered Person even at that person's request and expense if PHARMACY had been, but is no longer, a participating PHARMACY under the Benefit Plan and PHARMACY has notified the Covered Person that PHARMACY is no longer a participating PHARMACY under the Benefit Plan. Idaho Code § 41-3927(4)(b).

6. Notwithstanding anything in the Agreement, PHARMACY shall not be required to accept the unnegotiated adjustment by PBM or Plan Sponsor of PHARMACY's contractual reimbursement rate to equal the lowest reimbursement rate PHARMACY has agreed to charge any other Plan Sponsor. Idaho Code §§ 41-3927(4)(c), 41-3443(1).

7. Notwithstanding anything in the Agreement, PHARMACY shall not be required to adjust, or enter into negotiations to adjust, its charges to PBM or Plan Sponsor if PHARMACY agrees to charge another Plan Sponsor lower rates. Idaho Code §§ 41-3927(4)(d), 41-3443(2).

8. PHARMACY shall not be required to disclose its contractual reimbursement rates from other Plan Sponsors. Idaho Code §§ 41-3927(4)(e), 41-3443(3).

9. To the extent the Agreement requires PHARMACY to indemnify and hold harmless a managed care organization Plan Sponsor under certain circumstances, to the extent required by law, such indemnification applies so long as the managed care organization

Plan Sponsor also agrees to indemnify and hold harmless the provider under comparable circumstances. Idaho Code § 41-3927(6).

12.15 Illinois

ILLINOIS ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Illinois Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Illinois law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY agrees to participate in the quality assurance programs instituted by PBM and Plan Sponsors. 215 ILCS 125/2-8(b) and 215 ILCS 130/2008(b); 50 Ill. Admin. Code § 5421.50(4).
2. PHARMACY agrees that in no event including, but not limited to, nonpayment by PBM and/or Plan Sponsor of amounts due PHARMACY under the Agreement, insolvency of PBM and/or Plan Sponsor or any breach of the Agreement, shall PHARMACY or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from or have any recourse against the Covered Person, persons acting on the Covered Person's behalf (other than PBM or Plan Sponsor), the employer or group contract holder for services provided pursuant to the Agreement except for the payment of applicable co-payments for services covered by Plan Sponsor or fees for services not covered by Plan Sponsor. The requirements of this clause shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Plan Sponsors' Covered Persons shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between PHARMACY and a Covered Person or persons acting on the Covered Person's behalf (other than PBM or Plan Sponsor). 215 ILCS 130/2008(a).
3. Nothing in the Agreement shall be construed to prohibit or discourage PHARMACY from discussing any health care services and health care providers, utilization review and quality

assurance policies, terms and conditions of a Benefit Plan and Benefit Plan policy with Covered Persons, prospective Covered Persons, providers, or the public. 215 ILCS 134/30.

4. Nothing in the Agreement shall be construed as permitting or allowing PHARMACY to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act. 215 ILCS 134/30.
5. PBM shall not retaliate against PHARMACY based on PHARMACY advocating for appropriate health care services for patients. For purposes of this paragraph, "advocating for medically appropriate health care services" means to appeal a decision to deny payment for a health care service pursuant to the reasonable grievance or appeal procedure established by PBM and/or Plan Sponsor or to protest a decision, policy, or practice that PHARMACY, consistent with that degree of learning and skill ordinarily possessed by other pharmacy providers practicing in the same or similar locality and under similar circumstances, reasonably believes impairs the provider's ability to provide appropriate health care services to his or her patients. 215 ILCS 134/35.
6. PBM shall not take future contractual action regarding PHARMACY based solely on PHARMACY's participation in health care services appeals, complaints, or external independent reviews under the Illinois Health Carrier External Review Act. 215 ILCS 134/45.
7. Nothing in the Agreement shall be construed in a manner so as to discriminate against PHARMACY. 215 ILCS 134/72.
8. Notwithstanding anything to the contrary in the Agreement, liability relating to the activities, actions, or omissions of PBM, Plan Sponsor and/or their officer, employees, or agents shall not be transferred to PHARMACY by indemnification, hold harmless provisions, or otherwise. Nothing in this paragraph shall relieve PHARMACY from liability for its own negligence in the performance of its duties arising from treatment of a patient. 215 ILCS 134/95.
9. PBM shall give PHARMACY at least 60 days' notice of nonrenewal or termination of PHARMACY. The notice shall include a name and address to which PHARMACY may direct comments and concerns regarding the nonrenewal or termination. However, immediate written notice may be provided without 60 days' notice when PHARMACY's license has been disciplined by a state licensing board. 215 ILCS 134/20; 50 Ill. Admin. Code §§ 2051.290(f), 5420.50(b). PBM may terminate the Agreement immediately for cause. 50 Ill. Admin. Code § 2051.290(f)(2).
10. PHARMACY shall give PBM at least 60 days' notice for termination with cause, as defined in the Agreement, and at least 90 days' notice for termination without cause. 50 Ill. Admin. Code §§ 5420.50(a), 5421.50(a)(5).

11. In connection with Preferred Provider Programs (as defined under Illinois law), either party shall give the other party at least thirty (30) days' notice for termination without cause. 50 Ill. Admin. Code §§ 2051.290(f)(1).
12. PHARMACY must maintain and provide evidence of adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to PBM, effective as of the date of the Agreement. PHARMACY must give PBM at least 15 days advance notice of cancellation of such coverage and must notify PBM within no less than 10 days after PHARMACY's receipt of notice of any reduction or cancellation of the required coverage. 50 Ill. Admin. Code §§ 2051.290(i), 5421.50(a)(7).
13. PHARMACY shall be responsible for providing Covered Drugs as set forth in the Agreement, including the application of discount services, co-payments, benefit maximums, limitations and exclusions, and discounted amounts or rates as further set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(a).
14. PHARMACY agrees to comply with all administrative policies and procedures of PBM and Plan Sponsor, including, but not limited to, credentialing or recredentialing requirements, utilization review requirements, and referral procedures. 50 Ill. Admin Code § 2051.290(b).
15. PHARMACY shall maintain and make medical records available to PBM and/or Plan Sponsor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Covered Persons, and to make such medical records available to appropriate state and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating grievances or complaints and to show compliance with the applicable state and federal laws related to privacy and confidentiality of medical records. 50 Ill. Admin Code § 2051.290(c).
16. PHARMACY shall be licensed by the State of Illinois to provide Covered Drugs and shall notify PBM immediately whenever there is a change in licensure or certification status. 50 Ill. Admin. Code § 2051.290(d).
17. Upon the termination of the Agreement, PHARMACY shall be responsible for continuing provision of Covered Drugs to the extent required by law or regulation or as otherwise set forth in the Agreement. 50 Ill. Admin. Code § 2051.290(g).
18. Neither PBM nor PHARMACY shall sell, lease, assign or otherwise delegate the rights and responsibilities under the Agreement without the prior written and informed consent of the other party. PHARMACY's written consent must also be obtained for any assignment or assumption of the Agreement in the event that PBM is bought by another administrator or insurer. PHARMACY hereby gives its consent to such assignment or assumption of the Agreement. 50 Ill. Admin. Code § 2051.290(h).
19. PHARMACY shall provide Covered Drugs without discrimination against any Covered Person on the basis of participation in the Benefit Plan, source of payment, age, sex,

ethnicity, religion, sexual preference, health status or disability. 50 Ill. Admin. Code § 2051.290(j).

20. PHARMACY shall collect all applicable co-payments, coinsurance and/or deductibles from Covered Persons, and shall provide notice to Covered Persons of their personal financial obligations for services that are not covered. PHARMACY's rates for providing Covered Drugs to Covered Persons shall be in accordance with the Agreement. PHARMACY shall not charge Covered Persons more than the discounted rates provided by the Agreement for Covered Drugs. 50 Ill. Admin. Code § 2051.290(k).
21. PHARMACY shall comply with Plan Sponsors' requirements regarding operating hours and availability. 50 Ill. Admin. Code § 2051.290(l).
22. PBM's payment obligations to PHARMACY, including the method and amount of reimbursement and the frequency of payment, shall be as set forth in the Agreement, and any attachments thereto. 215 ILCS 5/512-7(a); 50 Ill. Admin. Code § 2051.290(m).
23. PBM's services, the types of information that will be submitted to PHARMACY, and the types of information that will be accessible to the PHARMACY shall be as set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(n).
24. PBM shall provide a method for PHARMACY to obtain each Plan Sponsor's initial information and adequate notice of change in benefits and co-payments. PBM shall provide PHARMACY with all of PBM's operational policies, which may be included in the attachments to the Agreement. 50 Ill. Admin. Code § 2051.290(o).
25. Internal appeal or arbitration procedures for settling contractual disputes or disagreements between PBM and PHARMACY shall be as set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(p).

12.16 Indiana

INDIANA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Indiana Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, health maintenance organizations ("HMOs"), limited service HMOs, Medicaid managed care organizations, preferred provider organizations, or other third party payers under Indiana law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. PBM shall identify to PHARMACY (and its Pharmacy Services Administrative Organization [PSAO] if applicable) the sources used by PBM to calculate the drug product reimbursement paid for Covered Drugs available under the pharmacy health plan administered by PBM. Ind. Code 27-1-24.5-22(a)(1).
2. PHARMACY and its PSAO have the right to obtain from PBM, within ten (10) calendar days after a request, a current list of the sources used to determine maximum allowable cost pricing. PBM will update the maximum allowable cost list at least every seven (7) calendar days and provide to PHARMACY and its PSAO maximum allowable cost list updates in a format that is readily available and accessible. 760 Ind. Admin. Code 5-4-1(a); Ind. Code 27-1-24.5-22(a)(3).
3. PBM shall determine that a prescription drug: (a) Is not obsolete; (b) Is generally available for purchase by pharmacies in Indiana from a national or regional wholesaler licensed in Indiana; and (c) Is not temporarily unavailable, listed on a drug shortage list, or unable to be lawfully substituted before the prescription drug is placed or continued on a maximum allowable cost list. Ind. Code 27-1-24.5-22(a)(4).
4. PBM's process for PHARMACY, its PSAO, or its Group Purchasing Organization to appeal disputes concerning maximum allowable cost pricing shall: (a) Include the right to appeal a claim up to sixty (60) days following the initial filing of the claim; (b) Investigate and resolve the appeal within thirty (30) calendar days after the appeal is received; (c) In the case of an appeal denial, provide the reason for the denial and the national drug code number of the prescription drug that is available from a national or regional wholesaler operating in Indiana; and (d) In the case of an appeal approval: (i) change the maximum allowable cost of the drug for PHARMACY as of the initial date of service that the appealed drug was dispensed; (ii) adjust the maximum allowable cost of the drug for PHARMACY and for all other contracted pharmacies in the same network of PBM that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed; (iii) notify each pharmacy in PBM's network that the maximum allowable cost for the drug has been adjusted as a result of an approved appeal; (iv) adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable; (v) allow PHARMACY and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and (vi) make retroactive price adjustments in the next payment cycle unless otherwise agreed to by PHARMACY. Ind. Code 27-1-24.5-22(b)(1)-(4).

5. PBM's claims auditing procedures (or claims auditing procedures of PBM's contracted auditor): (a) Will not use extrapolation or any similar methodology; (b) Will not allow for recovery by PBM of a submitted claim due to clerical or other error where the patient has received the drug for which the claim was submitted; (c) Will allow for recovery by PHARMACY for underpayments by PBM; and (d) Will only allow for PBM to recover overpayments on claims that are actually audited and discovered to include a recoverable error. Ind. Code 27-1-24.5-22(b)(5).

6. PBM (or PBM's contracted auditor) will comply with the following in conducting an audit of PHARMACY: (a) The contract under which the audit is performed will provide a description of audit procedures that will be followed; (b) For an onsite audit conducted at PHARMACY's location, the auditor that conducts the audit will provide written notice to PHARMACY or pharmacist at least fourteen (14) calendar days before conducting the initial onsite audit for each audit cycle; (c) The auditor will not interfere with the delivery of pharmacist services to a patient, and must use every effort to minimize inconvenience and disruption to PHARMACY operations during the audit (although audits may be performed during normal business hours of PHARMACY); (d) If the audit requires use of clinical or professional judgment, the audit must be conducted by or in consultation with an individual licensed as a pharmacist under IC 25-26; (e) The auditor must allow the use of written or otherwise transmitted hospital, physician, or other health practitioner records to validate a PHARMACY record; (f) The auditor must perform the audit according to the same standards and parameters that the auditor uses to audit all other similarly situated pharmacies; (g) The period covered by the audit must not exceed twenty-four (24) months after the date on which a claim that is the subject of the audit was submitted to or adjudicated by PBM (unless a longer period is required under federal or state law), and PHARMACY will be permitted to resubmit electronically any claims disputed by the audit for a period of at least thirty (30) calendar days; (h) The auditor will not schedule an audit to begin during the first seven (7) calendar days of a month without the voluntary consent of PHARMACY; (i) Payment to the auditor for conducting the audit must not be based on a percentage of the amount recovered as a result of the audit; (j) Within twenty-four (24) hours of receiving the notice of an audit, PHARMACY may reschedule the audit to a date not more than fourteen (14) calendar days after the date proposed by the auditor (although if the auditor is unable to reschedule within the fourteen (14) calendar day period, the auditor must select and reschedule the audit for a date after the fourteen (14) calendar day period); and (k) The auditor must allow PHARMACY or pharmacist to produce documentation to address a discrepancy found during the audit. 760 Ind. Admin. Code 5-3-3.

7. To the extent that PHARMACY participates in the federal 340B Drug Pricing Program as a 340B Covered Entity, the following shall not apply: (a) A reimbursement rate for a prescription drug that would diminish the 340B benefit to PHARMACY as a 340B Covered Entity; (b) A fee or adjustment that is not imposed on a pharmacy that is not a 340B

Covered Entity; (c) A fee or adjustment amount that exceeds the fee or adjustment amount imposed on a pharmacy that is not a 340B Covered Entity; (d) Any provision that prevents or interferes with an individual's choice to receive a prescription drug from PHARMACY as a 340B Covered Entity, including the administration of the drug; (e) Any provision that excludes a 340B Covered Entity from PBM's networks based on the PHARMACY's participation in the federal 340B Drug Pricing Program; and (f) Any provision that discriminates against PHARMACY as a 340B Covered Entity.

8. PHARMACY acknowledges and agrees that PBM may lease, rent, or otherwise grant access to PHARMACY's services under the Agreement to third parties that are: (a) Employers or entities providing coverage for Covered Drugs to their employees or members when such employers and/or entities have contracted with PBM or its affiliate for the administration or processing of claims for payment or service provided under the Agreement; and (b) Affiliates or subsidiaries of PBM or entities providing or receiving administrative services from PBM or its affiliates or subsidiaries. Any such third party that is granted access to PHARMACY's services under the Agreement shall be obligated to comply with the applicable terms of the Agreement. PHARMACY further acknowledges and agrees that contemporaneously with the execution of the Agreement, PBM has identified to PHARMACY those third parties known at the time of contracting to which PBM will grant access to PHARMACY's services. Ind. Code §§ 27-1-37.3-7, 27-1-37.3-8.
9. In the event Plan Sponsor or PBM fails to pay for Covered Drugs for any reason, including insolvency or breach of the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM. This provision does not prohibit the collection of copayments or uncovered charges consented to by Covered Persons. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-1(a)(4), 27-13-34-15(1).
10. PHARMACY or its trustee, agent, representative, or assignee shall not bring or maintain a legal action against a Covered Person to collect sums owed to PHARMACY by Plan Sponsor or PBM. If PHARMACY brings or maintains a legal action against a Covered Person for an amount owed to PHARMACY by Plan Sponsor or PBM, PHARMACY shall be liable to the Covered Person for costs and attorney's fees incurred by the Covered Person in defending the action. This provision does not prohibit the collection of copayments or uncovered charges consented to by the Covered Person. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-3(a), 27-13-34-15(2).

12.17 Iowa

IOWA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Iowa Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Iowa law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. Notwithstanding anything to the contrary in the Agreement, the parties must provide at least 60 days prior written notice before terminating the Agreement; provided, however, in the event PBM has evidence that PHARMACY has engaged in fraudulent conduct or poses a significant risk to patient care or safety, PBM may immediately suspend PHARMACY from further performance under the Agreement upon written notice of the suspension and reasoning therefor is provided to pharmacy, the covered entity, and the commissioner. Iowa Admin. Code § 191-59.6(510B)(1) and .6(510B)(3)(a).
2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization or a limited service organization under Iowa law, PHARMACY agrees as follows:
    a. PHARMACY, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Plan Sponsor, Plan Sponsor's insolvency, or breach of this Agreement, shall PHARMACY, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person or persons other than Plan Sponsor acting on their behalf for Covered Drugs pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Plan Sponsor's behalf made in accordance with the terms of the agreement between Plan Sponsor and the Covered Person. Iowa Admin. Code §§ 191-40.18(514B); 191-41.16(514B).
    b. PHARMACY, or its assignee or subcontractor, further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person and

that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and the Covered Person or persons acting on their behalf. Iowa Admin. Code § 191-40.18(514B); 191-41.16(514B).

3. Prior to placement of a particular prescription drug on a maximum allowable cost list, PBM shall ensure that all of the following requirements are met:
    a. The particular prescription drug must be listed as therapeutically and pharmaceutically equivalent in the most recent edition of the publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations," published by the United States Food and Drug Administration, otherwise known as the Orange Book.
    b. The particular prescription drug must not be obsolete or temporarily unavailable.
    c. The particular prescription drug must be available for purchase, without limitations, by all pharmacies in the state from a national or regional wholesale distributor that is licensed in the state.
4. For each maximum allowable cost list that PBM uses in Iowa, PBM shall:
    a. Provide PHARMACY reasonable access to the maximum allowable cost list to which PHARMACY is subject.
    b. Update the maximum allowable cost list within seven calendar days from the date of an increase of 10% or more in the pharmacy acquisition cost of a prescription drug on the list by one or more wholesale distributors doing business in Iowa.
    c. Update the maximum allowable cost list within seven calendar days from the date of a change in the methodology, or a change in the value of a variable applied in the methodology, on which the maximum allowable cost list is based.
    d. Provide a reasonable process for PHARMACY to receive prompt notice of all changes to the maximum allowable cost list to which PHARMACY is subject.
5. PHARMACY locations in Iowa subject to the PBM MAC Lists may comment on, contest, or appeal a MAC price within 10 calendar days of the applicable fill date by submitting an email to RxNetworksDept@magellanhealth.com, detailing the basis for the comment, contest, or appeal of the MAC price, along with supporting information and/or documentation. If PBM determines that the MAC pricing has been applied incorrectly, PBM will make the change in the maximum allowable cost and PHARMACY can then reverse and rebill the claim in question. Iowa Code § 510B.8A.
6. PBM shall not assess, charge, or collect from PHARMACY any claims processing fees, performance-based fees, network participation fees, or accreditation fees. Iowa Code § 510B.7.

12.18 Kansas

KANSAS ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Kansas Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of Covered Entities, including insurers, health maintenance organizations, nonprofit medical and hospital service corporations, or preferred provider organizations under Kansas law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of HMOs and Medicare Provider Organizations:

    a. If there is valid Medicaid coverage providing benefits for Covered Drugs, the Medicaid coverage shall be the source of last resort of any payment to PHARMACY. Kan. Stat. Ann. § 40-3208(b).

    b. Nothing in the Agreement shall be construed to require Covered Persons to guarantee payment to PHARMACY, other than copayments and deductibles, in the event of nonpayment by Plan Sponsor or PBM for Covered Drugs performed under the Agreement. If Plan Sponsor or PBM fails to pay for Covered Drugs as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any amounts owed by Plan Sponsor or PBM. Any action by PHARMACY to collect or attempt to collect from a Covered Person any sum owed by Plan Sponsor or PBM to PHARMACY is expressly prohibited. Kan. Stat. Ann. § 40-3209(b).

    c. In the event of the insolvency of Plan Sponsor or PBM, PHARMACY shall continue providing Covered Drugs to Covered Persons for the period of time for which premiums have been paid to Plan Sponsor by a Covered Person and, with respect to Covered Persons who are confined to an inpatient facility, until their discharge or expiration of benefits. Kan. Stat. Ann. § 40-3227(k)(2).

    d. If PHARMACY's participation under the Agreement is terminated for any reason, PHARMACY shall continue to provide Covered Drugs to Covered Persons for a period up to 90 days in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the

Covered Person has special circumstances such as, a disability, a life-threatening illness, or is in the third trimester of pregnancy. Covered Persons shall not be liable to PHARMACY for Covered Drugs during this continuation period other than for any deductibles or copayment amounts specified in the certificate of coverage or other contract between Covered Persons and Plan Sponsor. PHARMACY shall be entitled to payment for Covered Drugs during this continuation period at the rate specified in the Agreement. Kan. Stat. Ann. § 40-3230.

2. Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, and to the extent PHARMACY provides Covered Drugs to Covered Persons of Covered Entities, PBM agrees that, upon request of PHARMACY, PBM shall provide a dispute resolution process to PHARMACY that involves an independent fact finder for dispute involving non-MAC issues. Specifically, PHARMACY may refer the dispute to binding arbitration in accordance with the commercial arbitration rules of the American Arbitration Association ("AAA"). If PBM and PHARMACY cannot agree upon the arbitrator, the arbitrator shall be chosen by the applicable AAA office. Judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. PBM and PHARMACY will jointly share the costs of the arbitrator. PBM and PHARMACY agree that the losing party will reimburse the prevailing party for the prevailing party's reasonable attorney's fees and related arbitration costs. Kan. Stat. Ann. § 40-3823(b)(6). Disputes involving MAC issues will be resolved according to the terms of the Agreement and Provider Manual, and consistent with the requirements of Kan. Stat. Ann. § 40-3830(f)-(j).

12.19 Kentucky

KENTUCKY ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Kentucky Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Kentucky law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY may not, under any circumstance, including nonpayment of moneys due PHARMACY by Plan Sponsor and/or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, bill charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Covered Persons, or any persons acting on their behalf, for services provided in accordance with the Agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for services that are not covered. This provision shall survive the termination of the Agreement. Ky. Rev. Stat. Ann. §§ 304.17A-254(2); 304.17A-527(1)(a), (c); 304.17A-310(5); 304.17C-060(1)(a), (b); 806 KAR 17:300 (Section 3); 806 KAR 17:440 (Section 3).
2. In the event the Agreement is terminated for any reason, other than a quality-of-care issue or fraud, PHARMACY shall continue to provide services and PBM shall continue to reimburse PHARMACY in accordance with the Agreement until the Covered Person is discharged from an inpatient facility, or the active course of treatment is completed, whichever is greater. In the case of a pregnant woman, PHARMACY shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement terminates. This provision shall survive termination of the agreement. Ky. Rev. Stat. Ann. § 304.17A-527(1)(b)-(c); 806 KAR 17:300 (Section 3).
3. In the event of the insolvency of Plan Sponsor or PBM, PHARMACY shall continue providing Covered Drugs to Covered Persons for the duration of the contract period for which premiums have been paid or until the date of discharge from an inpatient facility, whichever is longer. Ky. Rev. Stat. Ann. § 304.17A-310(6).
4. Upon written request, PBM shall provide or make available to PHARMACY, when contracting or renewing an existing contract with PHARMACY, the payment or fee schedules or other information sufficient to enable PHARMACY to determine the manner and amount of payments for PHARMACY's services under the Agreement prior to the final execution or renewal of the contract and shall provide PHARMACY any change in such payment or fee schedules at least 90 days prior to the effective date of the change. Ky. Rev. Stat. Ann. §§ 304.17A-254(7); 304.17A-527(1)(d); 304.17A-577; 806 KAR 17:300 (Section 3).
5. If PHARMACY enters into any subcontract agreement with another provider to provide Covered Drugs to Covered Persons where the subcontracted provider will bill PBM or Covered Persons directly for the subcontracted services, the subcontract agreement must meet all requirements of Title XXV, Chapter 304, Subtitle 17A of the Kentucky Insurance Code and be filed with the Kentucky Commissioner of Insurance. Ky. Rev. Stat. Ann. §§ 304.17A-527(1)(e); 304.17C-060(1)(c); 806 KAR 17:300 (Section 3); 806 KAR 17:440 (Section 3).

6. The reimbursement rate identified in the PHARMACY Agreement shall apply to all Covered Drug services rendered by PHARMACY to all Plan Sponsors' Covered Persons. Ky. Rev. Stat. Ann. § 304.17A-728; 806 KAR 17:300 (Section 3).
7. PBM and PHARMACY shall comply with Ky. Rev. Stat. Ann. §§ 304.17A-700 to 304.17A-730, 205.593, 304.14-135, and 304.99-123 regarding payment of claims. Ky. Rev. Stat. Ann. § 304.17A-726.
8. To the extent the Agreement requires PHARMACY to submit claims electronically, payment shall be made electronically, if requested by PHARMACY, for clean claims submitted electronically in the form required by PBM and/or Plan Sponsor if PHARMACY agrees to accept claims details for these payments electronically and provides accurate electronic funds transfer information to PBM and the claims comply with 45 CFR Part 142. Ky. Rev. Stat. Ann. § 304.17A-705.
9. Any audit of PHARMACY's records under this Agreement, except for audits conducted on behalf of a state agency pursuant to KRS Chapter 205 or audits resulting from allegations of fraud, willful misrepresentation, or abuse, shall comply with Chapter 304, Subtitle 17A of Ky. Rev. Stat. Ann. §§ 304.17A-741 and 304.17A-743. Ky. Rev. Sat. Ann. §§ 304.17A-740; 304.17A-745; 304.17A-747.
10. The Addendum and Agreement shall be governed by Kentucky law. 806 KAR 17:440 (Section 3).
11. The sources used by PBM to calculate the drug product reimbursement paid for covered drugs available under pharmacy health benefit plans administered by PBM are identified in the Agreement, including the pharmacy manual. Ky. Rev. Stat. Ann. § 304.17A-162(1)(a).
12. The following shall apply with respect to PBM's MAC Lists:
    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum allowable cost pricing are identified on the PBM MAC Lists.
    b. PHARMACY locations in Kentucky subject to PBM MAC Lists may appeal a maximum allowable cost for a specific drug or drugs on PBM's MAC Lists as follows:
        i. PHARMACY must initiate the appeal within 60 days following the initial claim through the MRx web address, detailing the challenge to the PBM maximum allowable cost, and submitting supporting information and/or documentation.
        ii. PBM will investigate and resolve the appeal within 10 days.
            1. If the appeal is denied, PBM will provide the reason for the denial and identify the NDC of a drug product that may be purchased by pharmacies at a price at or below the maximum allowable cost.

2. If the appeal is upheld, PBM will make the change in the maximum allowable cost and PHARMACY can then reverse and rebill the claim in question.

Ky. Rev. Stat. Ann § 304.017A-162.

c. This Section 12 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.20 Louisiana

LOUISIANA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Louisiana Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health insurer, health maintenance organization ("HMO"), managed care organization, and preferred provider organizations under Louisiana law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY may communicate with patients regarding their health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. PHARMACY shall not, however, solicit alternative coverage arrangements for the primary purpose of securing financial gain. La. Stat. Ann – Rev. Stat. § 22:1007(B).
2. Neither PBM nor Plan Sponsor shall prohibit or restrict PHARMACY from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of Plan Sponsor or PBM which may negatively impact upon the quality of, or access to, patient care. La. Stat. Ann – Rev. Stat. § 22:1007(E).
3. Neither PBM nor Plan Sponsor shall prohibit or restrict PHARMACY from advocating to PBM or Plan Sponsor on behalf of Covered Persons for approval of coverage of a particular course of treatment or for the provision of health care services. La. Stat. Ann – Rev. Stat. § 22:1007(F).
4. PHARMACY shall not be required to provide indemnification or otherwise assume liability relating to activities, actions, or omissions of Plan Sponsor. La. Stat. Ann – Rev. Stat. § 22:1007(G).

5. No provision of the Agreement shall operate to provide an incentive or specific payment made directly, in any form, to PHARMACY as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific Covered Person or groups of Covered Persons with similar medical conditions. La. Stat. Ann – Rev. Stat. § 22:263(E); La. Admin. Code tit. 37, § XIII.5307(A)(3).
6. In the event an HMO Plan Sponsor fails to pay for Covered Drugs as set forth in the evidence of coverage, Covered Persons shall not be liable to PHARMACY for any sums owed by HMO Plan Sponsor to PHARMACY. Neither PHARMACY, its agents, trustee, nor assignee may maintain an action at law against a Covered Person of an HMO Plan Sponsor to collect sums owed by the HMO Plan Sponsor. La. Stat. Ann – Rev. Stat. § 22:263(A)(1) and (C).
7. The procedure for processing and resolving enrollee grievances, including the location and telephone number where grievances may be submitted, is available by contacting the Benefit Plan. La. Stat. Ann – Rev. Stat. § 22:263(A)(3).
8. The methodology by which payment will be made is set forth in the Agreement. La. Stat. Ann – Rev. Stat. § 22:263(A)(2).
9. PHARMACY agrees to participate in pharmacy audits in the manner detailed in the Agreement. To the extent of a direct conflict between the terms of the Agreement and Louisiana Stat. 22:1856.1, the provisions of Louisiana Stat. 22:1856.1 shall control. La. Stat. Ann – Rev. Stat. § 22:1856.1.

12.21 Maine

MAINE ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Maine Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization, insurer or carrier licensed under Maine law (collectively and/or individually, “Plan Sponsor”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. In the event that PBM or Plan Sponsor fails to pay for Covered Drugs as set forth in the Agreement, the Covered Person may not be held liable to PHARMACY, and its agent, trustee

or assignee may not maintain any action at law against a Covered Person to collect sums owed by PBM or Plan Sponsor. If a petition to liquidate PBM or Plan Sponsor is filed with a court of competent jurisdiction, then after the date of filing the petition for liquidation:

a. PHARMACY is prohibited from collecting or attempting to collect from a Covered Person amounts normally payable by PBM or Plan Sponsor;

b. PHARMACY or its agent, trustee or assignee may not maintain any action at law against a Covered Person to collect amounts for Covered Drugs normally payable by PBM or Plan Sponsor.

Nothing in this paragraph prohibits PHARMACY from collecting or attempting to collect from a Covered Person any amounts for services not normally payable by PBM or Plan Sponsor, including applicable copayments or deductibles. 24-A M.R.S. § 4204(6); 24-A M.R.S. § 4303(8-A)(B).

2. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY shall continue providing Covered Drugs for Covered Persons for the duration of the period for which premium payment has been made to Plan Sponsor and until Covered Person's discharge from inpatient facilities. 24-A M.R.S. § 4204(7).

3. PHARMACY shall provide PBM at least 60 days advance notice to terminate or withdraw from the Agreement. 24-A M.R.S. § 4204(8).

4. In the event of the insolvency of PBM, Plan Sponsor may require the assignment of this Agreement to itself, and PHARMACY shall continue to provide services to Covered Persons. CMR 02-031-191 § 11.

5. PHARMACY shall allow appropriate access to medical records of Covered Persons for purposes of quality management, and quality reviews and complaint investigations conducted by PBM, Plan Sponsor, the State, or the State's designee. CMR 10-144-109 § 1.03-2 E.3.

6. PHARMACY shall have policies and procedures for 1) protecting the confidentiality of Covered Person health information; 2) limiting access to health care information on a need-to-know basis, consistent with existing law; 3) holding all health care information confidential and not divulging it without Covered Person's authorization, except as consistent with existing law; and 4) allowing Covered Persons access to their medical records, consistent with existing law. CMR 10-144-109 § 1.03-2 E.4.

7. PHARMACY shall retain records of its affairs and transactions with PBM and Plan Sponsor for a period of at least 6 years. CMR 02-031-191 §10.B.

8. Once PBM has received payment from Plan Sponsors for Covered Drugs provided by PHARMACY under this Agreement, PBM shall remit amounts due to PHARMACY within the timeframes provided in Maine Revised Statutes § 4317. 24-A M.R.S. § 4317(6).

12.22 Maryland

MARYLAND ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Maryland Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health insurer, nonprofit health service plan, health maintenance organization, or carrier under Maryland law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY shall not, under any circumstances, including nonpayment of moneys due PHARMACY by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Covered Persons or any persons other than Plan Sponsor acting on their behalf, for Covered Drugs provided in accordance with the Agreement. This provision shall not operate to preclude collection from Covered Persons of copayments or supplemental charges in accordance with the terms of the Benefit Plan, or charges for services not covered. PHARMACY agrees that this provision shall survive termination of this Agreement regardless of the cause giving rise to termination. Md. Code Health-General § 19-710(i).
2. Nothing in the Agreement shall be construed to require PHARMACY to indemnify or hold Plan Sponsor harmless from a coverage decision or negligent act of the Plan Sponsor. Md. Code Health-General § 19-710(t); Md. Code Ins. § 15-117.
3. PBM and PHARMACY shall provide written notice to the other of intent to terminate the Agreement at least 90 days prior to the termination. This provision shall not apply to PBM, however, in the event PBM terminates PHARMACY for fraud, patient abuse, incompetence, or loss of PHARMACY's license. PHARMACY shall continue to provide Covered Drugs to Covered Persons from the date of PHARMACY's notice of intent to terminate until the effective date of termination. Md. Code Ins. § 15-112.2(e).
4. Notwithstanding anything to the contrary in the Agreement, PHARMACY shall not, as a condition of the Agreement, be required to participate in all PBM Networks. Md. Code Ins. § 15-112.2(b) and (d).

5. To the extent required by law, nothing in the Agreement shall operate: (a) to preclude PHARMACY from providing services at a lower rate of reimbursement to members of carriers who are not contracted with PBM; (b) to require PHARMACY to accept from PBM the same reimbursement arrangement that PHARMACY has with a carrier not contracted with PBM if the reimbursement arrangement with that carrier is for a lower rate of reimbursement ; or (c) to require PHARMACY to certify that the reimbursement rates in this Agreement are not higher than the reimbursement rates being received by PHARMACY from carriers not contracted with PBM. Md. Code Ins. § 15-112(l).
6. PBM and Plan Sponsor shall not, as a condition to this Agreement, prohibit PHARMACY from discussing with or communicating to a Covered Person, public official, or other person information that is necessary or appropriate for the delivery of health care services, including: (a) communications that relate to treatment alternatives; (b) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under PHARMACY's care; (c) communications that relate to a Covered Person's right to appeal a coverage determination of a Plan Sponsor with which PHARMACY, or the Covered Person does not agree; and (d) opinions and the basis of an opinion about public policy issues. Md. Code Ins. § 15-116.
7. For purposes of this Agreement, "Experimental Medical Care" shall have the meaning set forth in the Benefit Plan documents. Md. Code Ins. § 15-123(d).
8. PBM shall not assign, transfer, or subcontract this Agreement, wholly or partly, to an insurer that offers personal injury protection under Md. Code Ins. § 19-505 without first informing PHARMACY and obtaining PHARMACY's written consent. PBM shall not terminate, limit, or otherwise impair PHARMACY's rights under the Agreement based on PHARMACY's refusal to agree to an assignment, transfer, or subcontract of all or part of the Agreement to an insurer that offers personal injury protection coverage under Md. Code Ins. § 19-505. Md. Code Ins. § 15-125(b).
9. PHARMACY's participation under this Agreement shall not be conditioned of PHARMACY's participation in a Network for workers' compensation services. PBM shall not terminate, limit, or otherwise impair PHARMACY's rights under this Agreement based on PHARMACY's election not to participate in a Network for workers' compensation services. Md. Code Ins. § 15-125(c).
10. Upon execution of the Agreement, and at least 30 days prior to a change, PBM shall disclose to PHARMACY: (a) applicable terms, conditions, and reimbursement rates; (b) the process and procedures for verifying Covered Drugs and beneficiary eligibility; (c) the process and procedures for dispute resolution and audit appeals process; and (d) the process and procedures for verifying the prescription drugs included on the Benefit Plan's formularies. Md. Code Ins. § 15-1628.

11. This Agreement shall not be effective until 30 days following its submission in duplicate to the Maryland Insurance Commissioner. COMAR 31.12.02.13(C).

12. No amendment to the following provisions or information provided in connection with such provisions shall be effective until 30 days following its submission to the Maryland Insurance Commissioner: (a) Section 1 of this Addendum (hold-harmless clause); (b) Section 2 of this Addendum (indemnification); (c) Section 4 of this Addendum (participation in other Networks); (d) Section 8 of this Addendum (assignment to insurers offering personal injury protection; (e) any provision dealing with the administration of a coordination of benefits clause; (f) termination of this Agreement; (g) any provision dealing with the applicability of Maryland law; and (h) any provision revised to comply with Maryland law. COMAR 31.12.02.13(C)(4).

13. The following shall apply with respect to PBM's MAC Lists:

    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum allowable cost pricing are First Databank and Medi-Span.

    b. PHARMACY locations in Maryland subject to a PBM MAC List may appeal, investigate, or dispute a maximum allowable cost for a specific drug or drugs on the applicable MAC List within 21 days after the applicable claim date by following the process specified at https://magellanrx.com/provider/macappeals, detailing the challenge to the PBM maximum allowable cost, and submitting supporting information and/or documentation. PHARMACY locations in Maryland may obtain the phone number of the individual who is responsible for processing appeals by submitting a request for such via MACAppeals@primetherapeutics.com. PBM will respond to any such appeal within 21 days after the appeal is filed by either upholding or denying the appeal and:

        i. If the appeal is upheld, PBM will make the change in the maximum allowable cost within 1 business day of upholding the appeal and PHARMACY can then reverse and rebill the claim in question and any subsequent similar claims; or

        ii. If the appeal is denied, provide the challenging PHARMACY or Pharmacist the reason for the denial and the NDC of a drug product generally available for purchase from national or regional wholesalers, by pharmacies in Maryland at or below PBM's MAC.

    c. This Section 13 applies only with respect to MAC Lists owned and/or controlled by PBM.

    Md. Code Ins. § 15-1628.1.

12.23 Massachusetts

MASSACHUSETTS ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Massachusetts Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a Health Maintenance Organization ("HMO"), Insurer, or Carrier licensed under Massachusetts law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. PBM shall not refuse to contract with or compensate for covered pharmacy services of an otherwise Covered PHARMACY solely because PHARMACY has in good faith:
    a. Communicated with or advocated on behalf of one of more of his/her/its prospective, current, or former patients regarding the provisions, terms, or requirements of PBM or Plan Sponsor's Benefit Plans as they relate to the needs of PHARMACY's patients; or
    b. Communicated with one or more of his/her/its prospective, current, or former patients with respect to the method by which PHARMACY is compensated by PBM or Plan Sponsor for services provided to patient. 211 CMR 52.12(1); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).
2. PHARMACY is not required to indemnify Plan Sponsor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Plan Sponsor based on Plan Sponsor's management decisions, utilization review provisions or other policies, guidelines, or actions. 211 CMR 52.12(2); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).
3. Neither party shall terminate this Agreement without cause. 211 CMR 52.12(5); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).
4. PBM shall provide a written statement to PHARMACY of the reason or reasons for termination of this Agreement. 211 CMR 52.12(6); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).
5. PBM shall notify PHARMACY in writing of modifications in payments, modifications in covered services or modifications in PBM'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 PHARMACY, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between PBM and PHARMACY. 211 CMR 52.12(7); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).

6. PHARMACY shall not bill Covered Persons for charges for covered pharmacy services other than for deductibles, copayments, or coinsurance. 211 CMR 52.12(8); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).

7. PHARMACY shall not bill Covered Persons for nonpayment by PBM or Plan Sponsor of amounts owed under this Agreement due to the insolvency of PBM or Plan Sponsor. This requirement shall survive the termination of this Agreement for services rendered prior to the termination of this Agreement, regardless of the cause of the termination. 211 CMR 52.12(9); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).

8. PHARMACY shall comply with PBM's and Plan Sponsor's requirements for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. 211 CMR 52.12(10); Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).

9. Within 45 days after the receipt by PBM of a claim for reimbursement to PHARMACY for pharmacy services, Plan Sponsor through PBM shall: (1) make payment for such services provided, (2) notify PHARMACY in writing of the reason or reasons for nonpayment, or (3) notify PHARMACY in writing of what additional information or documentation is necessary to complete claims for such reimbursement. If Plan Sponsor fails to comply with this provision for any claims related to the provision of health care services, Plan Sponsor shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after PBM's receipt of request for reimbursement at the rate of 1.5% per month, not to exceed 18% per year. This provision relating to interest payments shall not apply to a claim that PBM or Plan Sponsor is investigating because of suspected fraud. Mass. Gen. Laws Ann. 176G § 6; 176I § 2; Managed Care Checklist: Requirements for Provider Contracts, Page 11 (Rev. 121212).

10. PHARMACY agrees that in no event, including but not limited to nonpayment by PBM or Plan Sponsor of amounts due PHARMACY under this Agreement, insolvency of PBM or Plan Sponsor or any breach of this Agreement by PBM or Plan Sponsor, shall PHARMACY or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf, other than PBM or Plan Sponsor, the employer or the group contract holder for services provided pursuant to this Agreement except for the payment of applicable co-payment, co-insurance, or deductibles for services covered by the Plan

Sponsor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. Plan Sponsor's Covered Persons, any persons acting on the Covered Person's behalf, other than PBM or Plan Sponsor, and the employer or group contract holder shall be third party beneficiaries of this clause. This provision supersedes any oral or written agreement hereafter entered into between PHARMACY and the Covered Person, persons acting on the Covered Person's behalf, other than PBM or Plan Sponsor, and employer or group contract holder. Mass. Gen. Ann. Laws Ann. 176G, § 21.

11. PHARMACY agrees to participate in audits pursuant to the audit procedures described in the Agreement. To the extent of a direct conflict between the terms of the Agreement and the provisions of Massachusetts General Laws Chapter 175, Section 226, the provisions of Chapter 175, Section 226 shall control. Mass. Gen. Laws Ann. 175, § 226(b)(1).

12.24 Michigan

MICHIGAN ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Michigan Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of carriers, health maintenance organizations and health care service corporations, under Michigan law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

1. Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:
   - PHARMACY will in no event (including, but not limited to, non-payment by PBM or any Plan Sponsor, PBM or any Plan Sponsor's insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items. Mich. Compiled Laws § 500.3529(3); Mich. Admin. Code § 325.6345(2).
   - PHARMACY represents and warrants that it is, and will maintain, in good standing, all federal, state, and local licenses and certifications as required by law. Mich. Compiled Laws § 500.3529(4)(a); Mich. Admin. Code § 325.6345(3)(a).

- PBM, and Plan Sponsors shall have the access PHARMACY records and reports concerning services to Covered Persons, as set forth in the Agreement. Mich. Compiled Laws § 500.3529(4)(b); Mich. Admin. Code § 325.6345(3)(b).
- PHARMACY must comply with the quality assurance initiatives required by PBM or Plan Sponsor, including any special quality management requirements and programs established by PBM or Plan Sponsors. Mich. Compiled Laws § 500.3529(4)(c); Mich. Admin. Code § 325.6345(3)(c).
- In the event of a Plan Sponsor's insolvency, PHARMACY agrees to continue providing Covered Drugs to Covered Persons. PHARMACY acknowledges that Plan Sponsor is required by law to provide a mechanism for appropriate sharing of the continuation of provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of PHARMACY. Mich. Compiled Laws § 500.3561.
- If PHARMACY provides Covered Drugs to Covered Persons of a Plan Sponsor which is a Michigan Medicaid Health Plan ("MHP"), for dates of service beginning October 1, 2020, PHARMACY will be reimbursed at least a $3.00 Professional Dispensing Fee for each MHP-covered prescription if PHARMACY has a Community Health Automated Medicaid Processing System (CHAMPS) provider specialty of 'Independent'.

2. Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows with regard to audits involving PHARMACY:

   - PBM will provide written notice to PHARMACY at least 2 weeks before initiating and scheduling the initial on-site audit for each audit cycle. If PHARMACY on average dispenses more than 600 prescriptions per week, PBM will not initiate or schedule an audit during the first 5 business days of a month without the express consent of PHARMACY. PBM will be flexible in initiating and scheduling an audit at a time that is reasonably convenient to PHARMACY. Within 3 business days after PHARMACY receives notice of an on-site audit, PHARMACY may reschedule the audit to a date not more than 10 business days after the date proposed by PBM.
   - PBM will utilize every effort to minimize inconvenience and disruption to PHARMACY operations during the audit process. PBM will not interfere with the delivery of pharmacy services to a patient.
   - PBM will conduct an audit that involves clinical or professional judgment by or in consultation with a pharmacist.
   - Subject to the requirements of Article 15 of the Michigan Public Health Code, 1978 PA 368, MCL 333.16101 to 333.18838, for the purpose of validating a pharmacy record with respect to orders, refills, or changes in prescriptions, PHARMACY is allowed the use of either of the following:

    - Hospital or physician records that are written or that are transmitted or stored electronically, including file annotations, document images, and other supporting documentation that is date- and time-stamped.
    - A prescription that complies with the requirements of the Michigan Board of Pharmacy created under section 17721 of the Public Health Code, 1978 PA 368, MCL 333.17721, and federal law.
- PBM will base any finding of an overpayment or underpayment on the actual overpayment or underpayment of claims.
- PBM will base any recoupment or payment adjustments of claims on a calculation that is reasonable and proportional in relation to the type of error detected.
- If there is a finding of an underpayment, PBM will reimburse PHARMACY as soon as possible after detection.
- PBM will conduct its audit of PHARMACY under the same standards and parameters that PBM uses when auditing other similarly situated pharmacies.
- PBM will audit only claims submitted or adjudicated within the 1-year period preceding the initiation of the audit unless a longer period is permitted under federal or state law.
- PBM will not receive payment and not compensate the auditor based on the amount recovered.
- PBM will not include the dispensing fee amount in a finding of an overpayment unless any of the following apply:
    - The prescription was not dispensed. As used in this addendum, “dispense” means that term as defined in section 17703 of the Public Health Code, 1978 PA 368, MCL 333.17703.
    - The prescription was not delivered to the patient. As used in this addendum, “deliver” means that term as defined in section 17703 of the Public Health Code, 1978 PA 368, MCL 333.17703.
    - The prescriber denied prior authorization.
    - The prescription was a medication error by PHARMACY.
    - The overpayment is solely based on an extra dispensing fee.
- PHARMACY may appeal preliminary audit reports within 30 days as further described below.
- PHARMACY has 30 days after PHARMACY receives the final audit report to file an appeal under this section.
- PBM will not limit the days’ supply for unit-of-use items, such as topicals, drops, vials, and inhalants, beyond manufacturer recommendations.

- PBM will, if the only commercially available package size exceeds the maximum days' supply, not use the dispensing of the package size as the basis for recoupment.
- PBM will, if the only commercially available package size exceeds the maximum days' supply and the claim was affirmatively adjudicated, not recoup the claim as an early refill.
- In conducting an audit of wholesale invoices, PBM will do all of the following:
  - Not audit the claims of another carrier or PBM.
  - Within 5 business days after a request by the audited PHARMACY, provide supporting documentation provided to PBM by the audited PHARMACY's suppliers.
  - Not utilize any of the following as a basis for recoupment:
    - The national drug code for the dispensed drug is in a quantity that is a sub-unit or multiple of the purchased drug as reflected on a supporting wholesale invoice.
    - The correct quantity dispensed is reflected on the audited PHARMACY claim.
    - The drug dispensed by PHARMACY on an audited PHARMACY claim is identical to the labeler and product code section under the national drug code. A difference in the package code under the national drug code is not subject to recoupment.
  - Accept as evidence each of the following:
    - Supplier invoices issued to the audited PHARMACY before the date of dispensing the drug underlying the audited claim.
    - Invoices issued to the audited PHARMACY from any supplier permitted by law to transfer ownership of the drug acquired by the audited PHARMACY, subject to validation by the supplier.
    - Copies of supplier invoices in the possession of the audited PHARMACY.
- Upon completion of an audit of PHARMACY, PBM will do all of the following:
  - Deliver a preliminary written audit report to PHARMACY not later than 60 days after the completion of the audit. The preliminary written audit report must include contact information for the person performing the audit and a description of the appeals process.
  - Allow PHARMACY at least 30 days after its receipt of the preliminary written audit report to produce documentation to address any discrepancy found during the audit.
  - If an appeal is not filed, deliver a final written audit report to PHARMACY within 90 days. If an appeal is filed, deliver a final written audit report to PHARMACY within 90 days after the conclusion of the appeal.

- Except as otherwise provided, recoup disputed money or overpayments or restore underpayments only after the final written audit report is delivered to PHARMACY.

- Except as required by federal law, PBM will not conduct an extrapolation audit in calculating recoupments, restoration, or penalties for an audit. "Extrapolation audit" means an audit of a sample of prescription drug benefit claims submitted by PHARMACY to the carrier that is then used to estimate audit results for a larger batch or group of claims not reviewed during the audit.
- Any clerical or record-keeping error, including a typographical error, a scrivener's error, or a computer error, regarding a required document or record that is found during an audit does not, on its face, constitute fraud. An error does not subject the individual involved to criminal penalties without proof of intent to commit fraud. To the extent that an audit results in the identification of a clerical or record-keeping error, including a typographical error, a scrivener's error, or a computer error, in a required document or record, PHARMACY is not subject to recoupment of money to PBM unless the clerical error or record-keeping error surpasses the statistical threshold established by the Centers for Medicare and Medicaid Services or the carrier can provide proof of intent to commit fraud or the error results in actual financial harm to the carrier, PBM, or a Covered Person or enrollee.
- The audit requirements provided above do not apply to any of the following:
  - An audit conducted to investigate fraud, willful misrepresentation, or abuse, including, but not limited to, investigative audits or audits conducted under any other statute that authorizes investigation relating to insurance fraud.
  - An audit based on a criminal investigation.

Mich. Compiled Laws § 550.838.

12.25 Minnesota

MINNESOTA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Minnesota Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health plan company, health maintenance organization ("HMO"), or insurer licensed under Minnesota law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. PHARMACY acknowledges and agrees that it has been given a complete copy of the Agreement, including all attachments and exhibits, operating manuals, guidelines, and fee schedule. M.S.A. 62Q.735, subdiv. 1.

2. In accordance with and to the extent required by M.S.A. 62Q.739(a), in the event the Agreement contains only a unilateral indemnification provision for PBM, the following is added to the indemnification provision:

   PBM shall indemnify and hold harmless PHARMACY and its employees, agents, and representatives against loss, expense, liability, or damage, including, without limitation, any and all claims, causes of action, judgments, awards, settlements, costs, fees, or debts of whatever nature, including without limitation reasonable attorneys' fees and costs, arising out of or in connection with PBM's breach of this Agreement.

3. The Agreement may not be terminated or fail to be renewed by PBM without cause unless PHARMACY is given a written notice of the termination or nonrenewal 120 days before the effective date. M.S.A. 62Q.739(b). If PHARMACY intends to terminate the Agreement without cause, PHARMACY must give PBM at least 120 days' advance written notice of its intent to terminate. M.S.A. 62D.123, subdiv. 3.

4. PHARMACY AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST A COVERED PERSON OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THE AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE PLAN SPONSOR, (2) INSOLVENCY OF THE PLAN SPONSOR, OR (3) BREACH OF THE AGREEMENT. THIS PROVISION DOES NOT PROHIBIT PHARMACY FROM COLLECTING CO-PAYMENTS OR FEES FOR UNCOVERED SERVICES.

   THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF COVERED PERSONS. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THE AGREEMENT TERMINATES.

   THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PHARMACY AND THE COVERED PERSON OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THE AGREEMENT.

   M.S.A. 62D.123, subdiv. 1; M.S.A. 62D.12, subdiv. 5.

5. PHARMACY must cooperate with and participate in the quality assurance programs, dispute resolution procedures, and utilization review programs of PBM and Plan Sponsor. M.S.A. 62D.123, subdiv. 2.

6. PHARMACY agrees to review Claims subject to any limitations or requirements as set forth in the Agreement. M.S.A. 62C.16, subdiv. 2.

7. If PHARMACY is subject to a tax under section M.S.A. 295.52 or if PHARMACY has paid additional expense transferred under M.S.A. 295.582 by a wholesale drug distributor, PHARMACY may transfer such additional expense generated by M.S.A. 295.52 obligations on to Plan Sponsor through PBM for the purchase of health care services on behalf of an Covered Person, and Plan Sponsor (not PBM) shall be responsible for payments due to the extent agreed upon by Plan Sponsor and PBM and as required by law. M.S.A. 295.582.

8. Nothing in the Agreement shall require PHARMACY to participate in a network under a category of coverage that differs from the categories of coverage to which the Agreement applies, without the affirmative consent of PHARMACY. Further, nothing in the Agreement shall be construed to require, as a condition of participation, that PHARMACY participate in a new or different health plan, product, or other arrangement within a category of coverage specified in the Agreement that results in a different underlying financial reimbursement methodology without the affirmative consent of PHARMACY. For purposes of this paragraph, to the extent required by law, the procedure required for obtaining consent shall be as set forth in M.S.A. 62Q.74.

9. The following shall apply with respect to PBM's MAC Lists:

    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized to determine maximum allowable cost pricing for PHARMACY locations in Minnesota include MediSpan and First Databank.

    b. PHARMACY locations in Minnesota subject to a PBM MAC List may appeal, investigate, or dispute a maximum allowable cost for a specific drug or drugs on the applicable MAC List within 15 business days after the initial claim date by submitting an appeal to MACAppeals@primetherapeutics.com, detailing the challenge to the PBM maximum allowable cost, along with supporting information and/or documentation. PBM will investigate and respond to any such appeal within 7 business days after the appeal is filed by either upholding or denying the appeal and:

        i. If the appeal is upheld, PBM will make the change in the maximum allowable cost within 1 business day of upholding the appeal (in which case, PBM will make the change effective for similarly situated pharmacies that are subject to the same MAC List), and PHARMACY can then reverse and rebill the claim in question, or

        ii. If the appeal is denied, provide the challenging PHARMACY the reason for the denial and the NDC of a drug product generally available for purchase from national or regional wholesalers, by pharmacies in Minnesota at or below PBM's MAC.

M.S.A. 151.71, subdiv. 2.

c. This Section 9 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.26 Mississippi

MISSISSIPPI ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Mississippi Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of hospital and medical service associations, health maintenance organizations, managed care entities, and insurers under Mississippi law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent that the timely claim payment provisions of the Agreement differ from, but are at least as stringent as, the provisions Mississippi Code § 73-21-155(3), the provisions of the Agreement shall control. Miss. Code Ann. § 73-21-155(4)(d).
2. PHARMACY agrees to participate in pharmacy audits in the manner detailed in the Agreement. To the extent of a direct conflict between the terms of the Agreement and the Mississippi Pharmacy Audit Integrity Act codified at Miss. Code Ann. § 73-21-175 et seq., the provisions of the Mississippi Pharmacy Audit Integrity Act shall control. Miss. Code Ann. § 73-21-183(1)(a).
3. To the extent the Agreement allows for a no cause termination, each party shall provide the other party at least 60 days' written notice before termination without cause. Miss Code § 83-41-325(17); CMSR § 19-003-16.06.L.
4. PHARMACY agrees that in no event, including but not limited to nonpayment by the Plan Sponsor or PBM, insolvency of the Plan Sponsor or PBM, or breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than the Plan Sponsor or PBM) acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. This Agreement does not prohibit PHARMACY from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence

of coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. Nor does this Agreement prohibit a PHARMACY (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 an Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as the PHARMACY has clearly informed the Covered Person that the Plan Sponsor may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit PHARMACY from pursuing any available legal remedy. Miss. Code Ann. § 83-41-325(13); CMSR § 19-003-16.06.B.

5. In the event of a Plan Sponsor or PBM insolvency or cessation of operations, PHARMACY shall continue to provide Covered Drugs pursuant to the terms of the Agreement to Covered Persons following for the duration of the period for which premium payment has been made to Plan Sponsor and, for those Covered Persons confined on the date of insolvency, until the Covered Person's discharge from inpatient facilities, whichever is later. Miss. Code Ann. § 83-41-325(16); CMSR § 19-003-16.06.C.
6. Sections 4 and 5 above shall be construed in favor of Covered Persons, shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement to the contrary between PHARMACY and a Covered Person or the Covered Person's representative. CMSR § 19-003-16.06.D.
7. PHARMACY shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons and shall comply with applicable Laws related to the confidentiality of medical or health records. CMSR § 19-003-16.06.K.
8. The definitions and provisions contained in a Managed Care Plan as defined in Miss. Code Ann. § 83-41-403(b) or CMSR § 19-003-016, et. seq. control over and supersede any inconsistent definition, term, or condition of this Agreement. CMSR § 19-003-16.06.T.
9. Plan Sponsors have the right to approve or disapprove participation of any PHARMACY for the purpose of providing Covered Drugs to Covered Persons. CMSR § 19-003-16.07.C.
10. In the event of PBM's insolvency, PBM may assign PHARMACY's obligations under Section 5 above to Plan Sponsor. CMSR § 19-003-16.07.H.
11. This Agreement cannot be assigned by PHARMACY without the consent of PBM and Plan Sponsor. CMSR § 19-003-16.06.M.
12. Payment and reimbursement methodologies are set forth in the Agreement (including attachments). CMSR § 19-003-16.06.S.

12.27 Missouri

MISSOURI ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Missouri Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization, health plan, insurer or carrier licensed under Missouri law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. PHARMACY is not prohibited or restricted from disclosing to any Covered Person any information that PHARMACY deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of other therapy, consultation or test, the decision of any Plan Sponsor to authorize or deny services, or the process that the Plan Sponsor or any person contracting with the Plan Sponsor uses or proposes to use, to authorize or deny health care services or benefits. RSMo. 354.441, 354.559

2. PHARMACY agrees that in no event, including but not limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of this Agreement, shall the PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person, other than the Plan Sponsor or PBM, acting on behalf of the Covered Person, for Covered Drugs provided pursuant to this Agreement. This Agreement shall not prohibit the PHARMACY from collecting coinsurance, deductibles, or co-payments, as specifically provided in the evidence of coverage, or fees for services that are not Covered Drugs delivered on a fee-for-service basis to Covered Person. This Agreement shall not prohibit a provider, except for a health care professional who is employed full time on the staff of Plan Sponsor and has agreed to provide services exclusively to Plan Sponsor's Covered Persons and no others, and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as the provider has clearly informed the Covered Person that the Plan Sponsor may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit the PHARMACY from pursuing any available legal remedy, including, but not limited to, collecting from any insurance carrier providing coverage to a Covered Person. RSMo. 354.606.2; Mo. 20 CSR 400-7.080(1), (3).

3. Either party can exercise right of nonrenewal at the expiration of contract period or upon 60 day' notice. Nonrenewal does not constitute termination. RSMo. 354.609.3.

4. In the event of Plan Sponsor's or PBM's insolvency or other cessation of operations, Covered Drugs to Covered Persons shall continue to be provided by PHARMACY through the period for which a premium has been paid to the Plan Sponsor on behalf of the Covered Person or until the Covered Person's discharge from an inpatient facility, whichever time is greater. RSMo. 354.606.3.

5. Paragraphs 2 and 4 above shall: (1) be construed in favor of the Covered Persons; (2) survive the termination of this Agreement regardless of the reasons for termination, including the insolvency of Plan Sponsor, PBM or Plan Sponsor's intermediary; (3) supersede any oral or written contrary agreement between PHARMACY and Covered Person or the representative of Covered Person if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Drug provisions required by paragraphs 2 and 4 above; and (4) be binding upon all individuals with whom a PHARMACY may subcontract to provide services to Covered Persons. RSMo. 354.606.4; Mo. 20 CSR 400-7.080(3).

6. The Plan Sponsor, PBM, and the PHARMACY are independent contractors. Mo. 20 CSR 400-7.080(2).

7. In no event shall PHARMACY collect or attempt to collect from a Covered Person any money owed to the PHARMACY by Plan Sponsor or PBM nor shall PHARMACY collect or attempt to collect from a Covered Person any money in excess of the coinsurance, co-payment, or deductibles. RSMo. 354.606.5.

8. PHARMACY must make health records available to appropriate state and federal authorities involved in assessing the quality of care (but shall not disclose individual identities), or investigating the grievances or complaints of Covered Persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records. RSMo. 354.606.12. PHARMACY shall furnish records PBM, or Plan Sponsor may require in order to document and/or demonstrate that PHARMACY is capable of meeting the terms of the Agreement. RSMo. 354.603.1(3).

9. The rights and responsibilities of PHARMACY under this Agreement shall not be assigned or delegated by PHARMACY without the prior written consent of PBM or Plan Sponsor, as applicable. RSMo. 354.606.13. Plan Sponsor shall have the right, in the event of PBM's insolvency, to require the assignment to Plan Sponsor of the provisions of this Agreement addressing the PHARMACY's obligation to furnish Covered Drugs. RSMo. 354.621.6.

10. PHARMACY must furnish Covered Drugs to all Covered Persons without regard to the Covered Person's enrollment in a plan as a private purchaser of the plan or as a participant in a publicly financed program of health care services. RSMo. 354.606.14.

11. PHARMACY must collect applicable coinsurance, co-payments or deductibles from Covered Persons and must notify Covered Persons of their personal financial obligations for services that are not covered. RSMo. 354.606.15.

12. At least 60 days written notice must be provided to the other party before terminating this Agreement without cause. This written notice shall include an explanation of why the Agreement is being terminated. Within 15 working days of the date that the PHARMACY either gives or receives notice of termination, the PHARMACY shall supply PBM and Plan Sponsor with a list of those patients of the PHARMACY that are covered by a Benefit Plan of the Plan Sponsor. RSMo. 354.609.1.

13. To the extent required by law, PBM shall not terminate the Agreement unless it gives PHARMACY a written explanation of the reason(s) for the proposed termination and an opportunity for review or hearing, except in the case of imminent harm to patients, determination of fraud, or final disciplinary action by a licensing board or other governmental agency. The notice to PHARMACY shall include (i) reasons for the proposed action, (ii) statement of the right to request a hearing or review before a panel appointed by PBM, (iii) a time limit of not less than 30 days within which to request a hearing or review, and (iv) a time limit for a hearing date which shall be held within 30 days of receipt of the request for a hearing. The hearing panel shall comply with the requirements set forth in RSMo. 354.609.2(3)-(6).

14. Upon termination of this Agreement, PHARMACY must continue care to Covered Persons for a period of up to 90 days where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. In such circumstances, Covered Person shall not be liable to PHARMACY for any amounts owed for medical care other than deductibles or co-payment amounts specified in the certificate of coverage or other contract between the Covered Person and Plan Sponsor as set forth in paragraph 2 above. In the event the terminated PHARMACY is authorized to continue treating Covered Person pursuant to this paragraph, PHARMACY shall have the right to be paid at the previously contracted rate for services provided to the Covered Person as required by RSMo. 354.612.1.

15. Unless such other time is specified in the Agreement, PHARMACY may file claims for reimbursement for Covered Drugs provided in Missouri for a period of up to six (6) months from the date of service. RSMo. 376.384.1(2). In the event of a conflict between the requirements of RSMo. 376.383 and RSMO. 376.384 and the provisions of the Agreement, the requirements of RSMo. 376.383 and RSMO. 376.384 shall control. RSMo. 376.383; RSMO. 376.384.

16. To the extent PHARMACY provides Covered Drug services to Covered Persons of a discount medical plan under Missouri law, PHARMACY agrees that the scope of services shall be as set forth in the Agreement, that PHARMACY will adhere to the fee schedule in the Agreement, and that PHARMACY will not charge Covered Persons more than the discounted rates provided for by the Agreement. RSMo 376.1514.

17. PHARMACY agrees to participate in pharmacy audits as set forth in the Agreement. In the event of a direct conflict between the terms of the Agreement and Section 338.600 of the Revised Statutes of Missouri concerning pharmacy audits, Section 338.600 shall control. RSMo. 338.600.
18. PHARMACY will be notified on an ongoing basis of specific Covered Drugs via the POS system. RSMO 354.606.1.
19. PBM shall notify PHARMACY in accordance with the applicable terms and conditions set forth in the Agreement of PHARMACY's responsibilities with respect to PBM's and Plan Sponsors' applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs. RSMo. 354.606.8.
20. The parties acknowledge and agree that the Agreement does not require the use of hospitalists as a condition for PHARMACY participation under this Agreement. RSMo. 354.606.9.
21. Nothing in the Agreement shall be construed to induce PHARMACY to provide less than medically necessary services to a Covered Person. RSMo. 354.606.10.
22. Nothing herein prohibits PHARMACY from advocating on behalf of Covered Persons within the utilization review or grievance processes established by PBM or the Plan Sponsor. RSMo. 354.606.11.
23. PBM will not penalize PHARMACY because provider reports in good faith to state or federal authorities any act or practice by PBM or Plan Sponsor that may jeopardize patient health or welfare. RSMo. 354.606.16.
24. PHARMACY can determine in a timely manner whether a person is covered as set forth in the Agreement (e.g., POS system). RSMo. 354.606.17.
25. Resolution of administrative, payment, or other disputes between PBM and PHARMACY shall be handled in accordance with the dispute resolution provisions set forth in the Agreement (to the extent not inconsistent with the provisions of RSMo. 354.600-354.636). RSMo. 354.606.19.
26. To the extent that any definitions or provisions of the Agreement conflict with definitions or provisions contained in Benefit Plans or in sections 354.600 to 354.636 of the Revised Statutes of Missouri, the conflicting definitions and/or provisions of the Agreement shall not control. RSMo. 354.606(20).
27. PBM will not terminate the Agreement solely or in part because PHARMACY in good faith: (i) advocates on behalf of a Covered Person; (ii) files a complaint against PBM or Plan Sponsor; (iii) appeals a decision of PBM or Plan Sponsor; (iv) provides information or files a

report with the department of insurance, financial institutions, and professional registration; or (v) requests a hearing or review pursuant to RSMo. 354.609. RSMo. 354.609.5.

28. Notwithstanding anything to the contrary, to the extent required by law, PHARMACY shall have at least 30 days to review a managed care contract. RSMo. 354.609.6.
29. Notwithstanding legitimate and medically based referral patterns, neither party shall act in a manner that unreasonably restricts a Covered Person's access to the entire network, unless the HMO Plan Sponsor has a written agreement with the holder of the benefits contract (not this Agreement) to a reduced network, and has requested an exception for a reduced network per 20 CSR 400-7.095 and filed an access plan for the reduced network prior to selling a new product per RSMo. 354.603.2. RSMo. 354.603.1(4).
30. Nothing in this Agreement shall be construed to conflict with a Covered Person's right to sue someone under RSMo. 538.205(4).
31. Nothing in this Agreement shall be construed to conflict with Missouri's Coordination of Benefits regulation or Missouri case law that prohibits subrogation from liable third parties in connection with fully insured contracts. 20 CSR 400-2.030.
32. PBM and PHARMACY shall comply with RSMo. Sections 354600 to 354.636. RSMo. 354.621.1.
33. PBM will transmit utilization documentation and claims paid data to the HMO Plan Sponsor to the extent required by RSMo. 354.621.3.
34. PBM will maintain the documents hereunder to the extent required by RSMo. 354.621.4 for at least 5 years. RSMo. 354.612.4. HMO and DIFP Plan Sponsors will have access to all documents that relate to compliance with RSMo. Sections 354-600 to 354.636 in accordance with RSMo. 354.621.5.
35. The following shall apply with respect to PBM's MAC Lists:
    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum reimbursement amount pricing are First Databank and Medi-Span.
    b. PHARMACY locations in Missouri subject to PBM's MAC Lists may appeal reimbursement for a drug subject to maximum allowable cost pricing within 14 calendar days of the PHARMACY submitting the claim for which the appeal is being requested. PBM will respond to such appeal with 14 calendar days of receipt.
    c. This Section 35 applies only with respect to MAC Lists owned and/or controlled by PBM.

    RSMo. 376.388 2(1), 5.

12.28 Montana

MONTANA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Montana Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, managed care community networks, multiple employer welfare arrangements, insurers, or carriers under Montana law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a heath carrier offering a managed care plan under Montana law, PHARMACY agrees:

2. That PHARMACY may not for any reason, including but not limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a Covered Person or a person other than Plan Sponsor or PBM acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. This Agreement does not prohibit PHARMACY from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. This Agreement does not prohibit PHARMACY, except a health care professional who is employed full-time on the staff of a Plan Sponsor and who has agreed to provide services exclusively to that Plan Sponsor's Covered Persons and no others, and a Covered Person from agreeing to continue services solely at the expense of the Covered Person if PHARMACY has clearly informed the Covered Person that Plan Sponsor may not cover or continue to cover a specific service or services. Except as provided in this Agreement, this Agreement does not prohibit PHARMACY from pursuing any legal remedy available for obtaining payment for services from Plan Sponsor. Mont. Code Ann. § 33-36-202(1).

3. If PBM or Plan Sponsor becomes insolvent or otherwise ceases operations, Covered Drugs to Covered Persons will continue through the end of the period for which a premium has been paid to Plan Sponsor on behalf of the Covered Person, but not to exceed 30 days, or until the Covered Person's discharge from an acute care inpatient facility, whichever occurs last. Covered Drugs to a Covered Person confined in an acute care inpatient facility on the

date of insolvency or other cessation of operations must be continued by PHARMACY until the confinement in an inpatient facility is no longer medically necessary. Mont. Code Ann. § 33-36-202(2).

4. The provisions of paragraphs (1)(a) and (b) above must be construed in favor of the Covered Person, survive the termination of this Agreement regardless of the reason for termination, including the insolvency of PBM or Plan Sponsor, and supersede an oral or written contrary agreement between PHARMACY and an Covered Person or the representative of an Covered Person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by paragraphs (1)(a) and (b) above. Mont. Code Ann. § 33-36-202(3).
5. To the extent permitted by law, PBM and PHARMACY shall provide at least 60 days written notice to each other before terminating the Agreement without cause. Mont. Code Ann. § 33-36-204(5).
6. PHARMACY has responsibilities and obligations under administrative policies and programs of PBM and Plan Sponsor as set forth in the Agreement, including payment terms, utilization reviews, the quality assurance program, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and compliance with applicable federal and state laws. Mont. Code Ann. § 33-36-204(1), (12).
7. PHARMACY shall make its health records available to appropriate state and federal authorities, in accordance with applicable state and federal laws related to confidentiality of medical or health records, when such authorities are involved in assessing the quality of care or investigating a grievance or complaint of a Covered Person. Mont. Code Ann. § 33-36-202(4).
8. PHARMACY shall furnish Covered Drugs to Covered Persons without regard to the Covered Person's enrollment in the Benefit Plan as a private purchaser or as a participant in a publicly financed program of health services. This paragraph does not apply to circumstances in which PHARMACY should not render services because of PHARMACY's lack of training, experience, or skill or because of a restriction on PHARMACY's license. Mont. Code Ann. § 33-36-204(6).
9. PHARMACY shall be required to collect applicable coinsurance, copayments, or deductibles from Covered Persons as set forth in the Agreement. Mont. Code Ann. § 33-36-204(7).
10. To the extent any of the definitions or provisions contained in the Agreement conflict with definitions or provisions of Benefit Plans or with Title 33, Chapter 36, Part 2, Mont. Code Ann., the definitions, and provisions of the Agreement shall not control. Mont. Code Ann. § 33-36-204(11).

12.29 Nebraska

NEBRASKA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICPATING PHARMACY AGREEMENT

This Nebraska Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of hospital service corporations, health maintenance organizations, preferred provider organizations, prepaid limited health service organizations, managed care organizations, insurers, or carriers under Nebraska law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Nebraska law, PHARMACY agrees:
    a. If PBM or Plan Sponsor fails to pay for Covered Drugs as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed to PHARMACY by PBM or Plan Sponsor. PHARMACY and its agent, trustee, or assignee may not maintain an action at law or attempt to collect from a Covered Person sums owed to PHARMACY by PBM or Plan Sponsor. Neb. Rev. Stat. § 44-32,141.
    b. If PHARMACY terminates this Agreement, PHARMACY must provide PBM with at least 60 days' notice of termination. Neb. Rev. Stat. § 44-32,142.
    c. In the event of insolvency of Plan Sponsor or PBM, PHARMACY shall continue to provide Covered Drugs to Covered Persons for the remainder of the period for which premiums have been paid on their behalf or until the Covered Person's discharge from an inpatient facility, whichever is longer. Neb. Rev. Stat. § 44-32,143.
2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a prepaid limited health service organization under Nebraska law, PHARMACY agrees:
    a. If PBM or Plan Sponsor fails to pay for Covered Drugs as set forth in the Agreement for any reason whatsoever, including, but not limited to, insolvency or breach of contract, Covered Persons shall not be liable to PHARMACY for any sums owed to PHARMACY under this Agreement. Neb. Rev. Stat. § 44-4717(1).

b. PHARMACY and its agent, trustee, or assignee may not maintain an action at law or attempt to collect from Covered Persons sums owed to PHARMACY by PBM or Plan Sponsor. Neb. Rev. Stat. § 44-4717(2).

c. Paragraphs 2(a) and (b) shall not prohibit PHARMACY from collecting copayments from Covered Persons. Neb. Rev. Stat. § 44-4717(3).

d. The provisions in paragraphs 2(a), (b), and (c) shall survive the termination of the Agreement, regardless of the reason giving rise to the termination. Neb. Rev. Stat. § 44-4717(4).

e. Termination of the Agreement shall not release PHARMACY from the obligations and duties imposed by the Agreement to complete treatments in progress on Covered Persons for specific conditions for a period not to exceed 30 days at the same schedule of copayment or other applicable charges in effect upon the effective date of termination of the Agreement. Neb. Rev. Stat. § 44-4717(5).

f. Any amendment to the provisions of the Agreement shall be submitted to and be approved by the Director of the Nebraska Department of Insurance prior to becoming effective. Neb. Rev. Stat. § 44-4717(6).

3. To the extent PHARMACY provides Covered Drugs to Covered Persons of a managed care plan under Nebraska law, PHARMACY agrees:

a. PHARMACY agrees that in no event, including, but not limited to, nonpayment by PBM or Plan Sponsor, insolvency of the Plan Sponsor or PBM, or breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Covered Persons or a person, other than the Plan Sponsor or PBM, acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. This Agreement does not prohibit PHARMACY from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to Covered Persons. Nor does this Agreement prohibit PHARMACY, except for a health care professional who is employed full time on the staff of Plan Sponsor and has agreed to provide Covered Drugs exclusively to Plan Sponsor's Covered Persons and no others, and a Covered Person from agreeing to continue Covered Drugs solely at the expense of the Covered Person, as long as PHARMACY has clearly informed the Covered Person that Plan Sponsor may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this Agreement does not prohibit PHARMACY from pursuing any available legal remedy. Neb. Rev. Stat. § 44-7106(2)(b).

b. If Plan Sponsor offers a closed plan or combination plan having a closed component and a participating provider, in the event of the insolvency, or other cessation of

operations, of the Plan Sponsor or PBM, Covered Drugs to Covered Persons will continue through the period for which a premium has been paid on behalf of the Covered Person or until the Covered Person's discharge from an inpatient facility, whichever time is greater. Covered Drugs to Covered Persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. Neb. Rev. Stat. § 44-7106(2)(c).

c. The provisions set forth in paragraphs 3(a) and (b) above shall be construed in favor of the Covered Person, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of the Plan Sponsor or PBM, and shall supersede any oral or written contrary agreement between PHARMACY and a Covered Person or the representative of a Covered Person if the contrary agreement is inconsistent with paragraphs 3(a) and (b) above. Neb. Rev. Stat. § 44-7106(2)(d).

d. PHARMACY shall make its health records available to state and federal authorities involved in assessing the quality of care or investigating grievances or complaints of Covered Persons, and shall comply with applicable state and federal laws related to the confidentiality of medical or health records. Neb. Rev. Stat. § 44-7106(2)(j).

e. PHARMACY shall not delegate or assign the rights and responsibilities under the Agreement without PBM's prior written consent. Neb. Rev. Stat. § 44-7106(2)(l).

f. In the event there is a contradiction between the provisions and definitions in the Agreement and Plan Sponsor's managed care plan, the provisions and definitions in the managed care plan will govern. Neb. Rev. Stat. § 44-7106(2)(r).

g. Plan Sponsor has the right to disapprove PHARMACY's participation in its Benefit Plans. Neb. Rev. Stat. § 44-7107(2)(c).

h. In the event of PBM's insolvency, Plan Sponsor has the right to require the assignment to it of the provisions of the Agreement addressing PHARMACY's obligation to furnish Covered Drugs. Nev. Rev. Stat. § 44-1707(2)(h).

4. To the extent PHARMACY provides Covered Drugs to Covered Persons of a discount medical plan organization under Nebraska law, PHARMACY agrees:

a. The Agreement contains a list of the medical or ancillary services and products that PHARMACY has agreed to provide at a discount;

b. The Agreement states the amount of the discounts or, alternatively, a fee schedule that reflects PHARMACY's discounted rates; and

c. PHARMACY will not charge Covered Persons more than the discounted rates set forth in the Agreement.

Neb. Rev. Stat. § 44-8309.

Effective January 1, 2023, without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. The Agreement shall not prohibit or restrict PHARMACY or any pharmacist from, or penalize PHARMACY or pharmacist for, disclosing to any covered person any health care information that PHARMACY or pharmacist deems appropriate regarding:
    a. The nature of treatment, risks, or an alternative to such treatment;
    b. The availability of an alternate therapy, consultation, or test;
    c. The decision of a utilization reviewer or similar person to authorize or deny a service;
    d. The process that is used to authorize or deny a health care service or benefit; or
    e. Information on any financial incentive or structure used by the health carrier.
2. PBM shall not prohibit PHARMACY or a pharmacist from discussing information regarding the total cost for a pharmacist service for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.
3. PBM shall not prohibit, restrict, or limit disclosure of information to the Director of the Insurance Department, law enforcement, or a state or federal governmental official, provided that: (a) The recipient of the information represents that such recipient has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and (b) Prior to disclosure of information designated as confidential, the pharmacist or PHARMACY marks as confidential any document in which the information appears, or requests confidential treatment for any oral communication of the information.
4. PBM shall not terminate the contract with or penalize a pharmacist or PHARMACY due to the pharmacist or PHARMACY: (a) Disclosing information about a PBM practice, except information determined to be a trade secret, as determined by state law or the director; or (b) Sharing any portion of the Agreement with the Director pursuant to a complaint or a query regarding whether the Agreement is in compliance with the Pharmacy Benefit Manager Licensure and Regulation Act.
5. A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price. Any such amount paid by a covered person shall be attributable toward any deductible or, to the extent consistent with section 2707 of the federal Public Health Service Act, 42 U.S.C. 300gg-6, as such section existed on January 1, 2022, the annual out-of-pocket maximum under the covered person's health benefit plan. Neb. Rev. Stat. § 44-4606.

Effective January 1, 2023, without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. Unless otherwise prohibited by federal law, an auditing entity conducting a PHARMACY audit shall: (a) Give PHARMACY notice fifteen business days prior to conducting an initial onsite audit; (b) For any audit that involves clinical or professional judgment, conduct such audit by or in consultation with a pharmacist; and (c) Audit PHARMACY under the same standards and parameters as other similarly situated pharmacies.
2. Unless otherwise prohibited by federal law, for any PHARMACY audit conducted by an auditing entity: (a) The period covered by the audit shall not exceed twenty-four months from the date that the claim was submitted to the auditing entity, unless a longer period is required under state or federal law; (b) If an auditing entity uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample; (c) The auditing entity shall provide PHARMACY a masked list containing any prescription number or date range that the auditing entity is seeking to audit; (d) No onsite audit shall take place during the first five business days of the month without the consent of PHARMACY; (e) No auditor shall enter the area of PHARMACY where patient-specific information is available without being escorted by an employee of PHARMACY and, to the extent possible, each auditor shall remain out of the sight and hearing range of any PHARMACY customer; (f) No recoupment shall be deducted from or applied against a future remittance until after the appeal process is complete and both parties receive the results of the final audit; (g) PBM shall not require information to be written on a prescription unless such information is required to be written on the prescription by state or federal law; (h) Recoupment may be assessed for information not written on a prescription if: (a) Such information is required by PBM or the information is required by the federal Food and Drug Administration or the drug manufacturer's product safety program; and (b) The information required is not readily available for the auditing entity at the time of the audit; and (i) No auditing entity or agent shall receive payment based on a percentage of any recoupment.
3. For recoupment under the Pharmacy Benefit Manager Licensure and Regulation Act, the auditing entity shall:
    a. Include consumer-oriented parameters based on manufacturer listings in the audit parameters;
    b. Consider the PHARMACY's usual and customary price for a compounded medication as the reimbursable cost, unless the pricing method is outlined in the Agreement;
    c. Base a finding of overpayment or underpayment on the actual overpayment or underpayment and not a projection that relies on the number of patients served who have a similar diagnosis, the number of similar orders, or the number of refills for similar drugs;

d. Not use extrapolation to calculate the recoupment or penalties unless required by state or federal law;

e. Not include a dispensing fee in the calculation of an overpayment, unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by PHARMACY, or the identified overpayment is solely based on an extra dispensing fee;

f. Not consider as fraud any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record. Such error may be subject to recoupment;

g. Not assess any recoupment in the case of an error that has no actual financial harm to the covered person or health benefit plan. An error that is the result of PHARMACY failing to comply with a formal corrective action plan may be subject to recoupment; and

h. Not allow interest to accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

4. To validate a PHARMACY record and the delivery of a PHARMACY service, the PHARMACY may use an authentic and verifiable statement or record, including a medication administration record of a nursing home, assisted-living facility, hospital, physician, or other authorized practitioner or an additional audit documentation parameter located in the Provider Manual. Any legal prescription may be used to validate a claim in connection with a prescription, refill, or change in a prescription, including a medication administration record, fax, e-prescription, or documented telephone call from the prescriber to the prescriber's agent.

5. The auditing entity conducting the audit shall establish a written appeal process which shall include procedures for appealing both a preliminary audit report and a final audit report.

6. A preliminary audit report shall be delivered to PHARMACY within one hundred twenty days after the conclusion of the audit. PHARMACY shall be allowed at least thirty days following receipt of a preliminary audit report to provide documentation to address any discrepancy found in the audit. A final audit report shall be delivered to PHARMACY within one hundred twenty days after receipt of the preliminary audit report or the appeal process has been exhausted, whichever is later. An auditing entity shall remit any money due to PHARMACY or pharmacist as the result of an underpayment of a claim within forty-five days after the appeal process has been exhausted and the final audit report has been issued.

7. Where contractually required, an auditing entity shall provide a copy to the plan sponsor of any of the plan sponsor's claims that were included in the audit, and any recouped money shall be returned to the health benefit plan or plan sponsor.

8. These requirements do not apply to any investigative audit that involves suspected fraud, willful misrepresentation, or abuse, or any audit completed by a state-funded health care program.

   Neb. Rev. Stat. § 44-4607.

Effective January 1, 2023, without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. PBM shall: (a) Update any maximum allowable cost price list at least every seven business days, noting any price change from the previous list, and provide a means by which PHARMACY may promptly review a current price in an electronic, print, or telephonic format within one business day of any such change at no cost to PHARMACY; (b) Maintain a procedure to eliminate a product from the maximum allowable cost price list in a timely manner to remain consistent with any change in the marketplace; and (c) Make the maximum allowable cost price list available to PHARMACY in a format that is readily accessible and usable to PHARMACY.
2. PBM shall not place a prescription drug on a maximum allowable cost price list unless the drug is available for purchase by pharmacies in Nebraska from a national or regional drug wholesaler and is not obsolete.
3. A process shall exist to appeal, investigate, and resolve disputes regarding any maximum allowable cost price, and such process shall include: (a) A fifteen-business-day limit on the right to appeal following submission of an initial claim by PHARMACY; (b) A requirement that any appeal be investigated and resolved within seven business days after the appeal is received by PBM; and (c) A requirement that PBM provide a reason for any denial of an appeal and identify the national drug code for the drug that may be purchased by PHARMACY at a price at or below the price on the maximum allowable cost price list as determined by PBM.
4. If an appeal is determined to be valid by PBM, PBM shall: (a) Make an adjustment in the drug price no later than one day after the appeal is resolved; and (b) Permit PHARMACY to reverse and rebill the claim in question, using the date of the original claim.

   Neb. Rev. Stat. § 44-4608.

Effective January 1, 2023, without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. To the extent that PHARMACY is a 340B contract pharmacy, PBM shall not reimburse PHARMACY for a PHARMACY-dispensed drug that is subject to an agreement under 42 U.S.C. 256b at a rate lower than that paid for the same drug to similarly situated pharmacies that are not 340B contract pharmacies, and shall not assess any fee,

chargeback, or other adjustment upon PHARMACY on the basis that PHARMACY participates in the program set forth in 42 U.S.C. 256b.

2. PBM shall not discriminate against PHARMACY in a manner that prevents or interferes with a covered individual's choice to receive such drug from a 340B covered entity or from PHARMACY as a 340B contract pharmacy.

   Neb. Rev. Stat. § 44-4609.

12.30 Nevada

NEVADA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Nevada Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, carriers, health maintenance organizations, prepaid limited health service organizations, or managed care organizations under Nevada law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. If the Agreement is terminated by PBM or Plan Sponsor for reasons other than medical incompetence or professional misconduct of PHARMACY, PHARMACY agrees to continue to provide services to Covered Persons who are undergoing a medically necessary course of treatment until the later of the 120th day after the Agreement is terminated or, with respect to Covered Persons who are pregnant, until the 45th day after delivery or the date the pregnancy otherwise ends. During this continuation period, PHARMACY agrees to accept the reimbursement rates and terms of participation in effect under the Agreement before it terminated. PHARMACY further agrees not to seek payment from Covered Persons for any service provided by PHARMACY during this continuation period that PHARMACY could not have received from the Covered Persons if the Agreement were still in effect. N.R.S. §§ 689A.04036; 689B.0303; 695C.1691; 695G.164.

2. PBM shall approve or deny a claim for services within 30 days after it receives the claim. If the claim is approved, Plan Sponsor or PBM shall pay the claim within 30 days after it is approved. If PBM requires additional information to determine whether to approve or deny the claim, it shall notify PHARMACY of its request for additional information with 20 days after it receives the claim. PBM shall notify PHARMACY of all specific reasons for any

delay in approving or denying the claim. PBM shall approve or deny the claim within 30 days after receiving the additional information requested. If the claim is approved, Plan Sponsor or PBM shall pay the claim within 30 days after it receives the additional information. PBM shall not ask PHARMACY to resubmit information that PHARMACY has already provided, unless PBM provides a legitimate reason for the request and the purpose of the request is not to delay payment of the claim, harass PHARMACY or discourage the filing of clams. Plan Sponsor or PBM shall not pay only part of a claim that has been approved and is fully payable. If any approved claim is not paid as set forth in this provision, Plan Sponsor shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest shall be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid. N.R.S. §§ 695C.185; 695C.187 (See also N.R.S. §§ 689A.410; 689B.255; 689C.485; 695A.188; 695B.2505).

3. If Plan Sponsor or PBM fails to pay a claim within the time period set forth in the Agreement for an Covered Person of a Plan Sponsor contracted to provide managed care to recipients of Medicaid under the Nevada state plan or contracted to provide insurance pursuant to the Children's Health Insurance Program, Plan Sponsor shall pay PHARMACY interest at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest shall be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid. N.R.S. § 695C.128.

4. PHARMACY releases Covered Persons from liability for the cost of Covered Drugs rendered pursuant to the Agreement. If Plan Sponsor or PBM fails to pay for Covered Drugs for any reason, including, but not limited to insolvency or breach of the Agreement, Covered Persons shall not be liable to PHARMACY for any money owed to PHARMACY pursuant to the Agreement. Neither PHARMACY nor its agent, trustee, nor assignee may maintain an action at law or attempt to collect from a Covered Person any money that Plan Sponsor or PBM owes to PHARMACY. This provision does not prohibit the collection of any uncovered charges which a Covered Person agreed to pay or the collection of any copayment from a Covered Person. This provision survives termination of the Agreement, regardless of the reason for termination. N.R.S. § 695F.220(1)-(4); Nev. Admin. Code §§ 695C.190(2); 695C.530(2); 695F.300(2).

5. Termination of the Agreement shall not release PHARMACY from its obligation to complete any procedure on a Covered Person who is receiving treatment for a specific condition for a period not to exceed 60 days, at the same schedule of copayment or any other applicable charge in effect when the Agreement is terminated. N.R.S. § 695F.220(5).

6. Any amendment to the Agreement must be submitted to the Nevada Commissioner of Insurance for approval before the amendment is effective. N.R.S. § 695F.220(5).
7. Any party wishing to terminate this Agreement must give the other party at least ninety (90) days' advance written notice. Nev. Admin. Code § 689B.160.
8. The Agreement shall be effective for at least 1 year, subject to any right of termination stated in the Agreement and this Regulatory Addendum. Nev. Admin. Code §§ 695C.190(3); 695C.530(5); 695F.300(3).
9. PHARMACY shall participate in any quality assurance program adopted by Plan Sponsor or PBM. Nev. Admin. Code §§ 695C.190(4); 695C.530(3); 695F.300(4).
10. PHARMACY shall provide all medically necessary Covered Drugs to each Covered Person for the period for which a premium has been paid to Plan Sponsor. Nev. Admin. Code §§ 695C.190(5); 695C.530(4); 695F.300(5).
11. PHARMACY must provide proof of insurance against loss resulting from injuries to third parties from PHARMACY's practice of Pharmacy or a reasonable substitute for it as determined by PBM or Plan Sponsor. PHARMACY shall indemnity PBM and Plan Sponsor for any liability resulting from the health care services rendered by PHARMACY. Nev. Admin. Code §§ 695C.190(6); 695C.530(6); 695F.300(6).
12. PHARMACY agrees that PBM may assign the Agreement to Plan Sponsor. Nev. Admin. Code § 695C.505(12).
13. PHARMACY shall transfer or arrange for the maintenance of the records of Covered Persons who are its patients if the PHARMACY terminates its contract with PBM. Nev. Admin. Code §§ 695C.530(7); 695F.300(7).

12.31 New Hampshire

NEW HAMPSHIRE ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICPATING PHARMACY AGREEMENT

This New Hampshire Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of an accident or health insurer, health service corporation, health maintenance organization, and organizations entering into preferred provider agreements under New Hampshire law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. In no event, including but not limited to nonpayment by Plan Sponsor or PBM insolvency of Plan Sponsor or PBM or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Covered Person or a person acting on behalf of a Covered Person (other than Plan Sponsor or PBM) for Covered Drugs provided pursuant to the Agreement. This provision does not prohibit PHARMACY from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for non-covered services delivered on a fee-for-service basis to Covered Persons. Nor does this provision prohibit PHARMACY and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as PHARMACY has clearly informed the Covered Person that Plan Sponsor may not cover or continue to cover a specific service or services. Except as otherwise provided in the Agreement, this provision does not prohibit PHARMACY from pursuing any available legal remedy. PHARMACY agrees that this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Persons. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. Any modifications, additions or deletions to this provision shall become effective on a date no earlier than 15 business days after the New Hampshire Insurance Commissioner has received written notice of such proposed changes. N.H. Rev. Stat. § 420-J:8(I).
2. The Agreement shall not be construed to limit information PHARMACY may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of Plan Sponsor's products as they relate to the needs of PHARMACY's patients except for trade secrets of significant competitive value. N.H. Rev. Stat. §§ 420-C:5-a, 420-J:8(V).
3. PHARMACY shall have 60 days from the postmarked date to review any proposed contract with PBM and any modifications to the Agreement, excluding those modifications that are expressly permitted under the Agreement. N.H. Rev. Stat. § 420-J:8(VII).
4. PBM shall give PHARMACY notice of material changes to the applicable reimbursement at least 60 days in advance of the effective date. N.H. Rev. Stat. § 420-J:8(VIII).
5. Neither PBM nor Plan Sponsor shall remove PHARMACY from the Network or refuse to renew PHARMACY's enrollment in the Network due to PHARMACY's participation in a Covered Person's internal grievance procedure or external review. N.H. Rev. Stat. § 420-J:8(X).
6. In the event the Agreement is terminated for a reason other than unprofessional behavior by PHARMACY, PHARMACY agrees to continue to provide Covered Drugs to Covered Persons for 60 days from the date of termination. PHARMACY agrees to provide Covered

Drugs during this period in accordance with the terms and conditions imposed by the Agreement and agrees to accept as full payment the reimbursement amount that would have applied had the Agreement not terminated. N.H. Rev. Stat. § 420-J:8(XI).

7. In no event shall PHARMACY charge a Covered Person more than the lower of the PHARMACY's usual and customary charge or the Covered Person's contracted copayment. N.H. Rev. Stat. §§ 318:47-h(I); 420-J:7-b(X)(a).

12.32 New Jersey

NEW JERSEY ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This New Jersey Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, carriers, and health maintenance organizations ("HMOs") under New Jersey law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY shall participate in pharmacy audits as set forth in the Agreement. Notwithstanding anything to the contrary, audits shall occur at a time mutually agreeable to PHARMACY and PBM. Audits of PHARMACY shall not include a review of any document relating to any person or prescription plan other than those reimbursable by Plan Sponsors. N.J. Stat. Ann. §§ 17:48-6j(a)(5); 17:48A-7i(a)(5); 17:48E-35.7(a)(5); 17B:26-2.li(a)(5); 17B:27-46.li(a)(5); 26:2J-4.7(a)(5).

2. Nothing in the Agreement shall be construed to prohibit, directly or indirectly, PHARMACY from charging Covered Persons for services rendered by PHARMACY that are in addition to charges for the drug, for dispensing the drug, for prescription counseling, and those services required by law, provided that the services rendered shall be subject to the approval of the Board of Pharmacy and provided that PHARMACY disclose to Covered Persons the charges for the additional services and their out-of-pocket costs for those services before dispensing the drug. N.J. Stat. Ann. §§ 17:48-6j(a)(6); 17:48A-7i(a)(6); 17:48E-35.7(a)(6); 17B:26-2.li(a)(6); 17B:27-46-li(a)(6); 26:2J-4.7(a)(6).

3. Neither PBM nor Plan Sponsor shall terminate the Agreement or penalize PHARMACY solely because PHARMACY filed a complaint or an appeal as permitted by New Jersey law. N.J.A.C. §§ 11:24-15.2(b)(2); 11:24A-4.15(b)(2); 11:24B-5.2(a)(15).

4. Neither PBM nor Plan Sponsor shall penalize PHARMACY or terminate the Agreement because PHARMACY acts as an advocate for a Covered Person in seeking appropriate, medically necessary health care services. N.J. Stat. Ann. § 26:2S-9(a); N.J.A.C. §§ 11:24-15.2(b)(3); 11:24A-4.15(b)(3); 11:24B-5.2(a)(15).

5. PHARMACY agrees that in the event that PBM or Plan Sponsor fails to pay for Covered Drugs for any reason whatsoever, including, but not limited to, insolvency of PBM or Plan Sponsor, or breach of contract, Covered Persons shall not be liable to PHARMACY for any sums owed PHARMACY under the Agreement. PHARMACY shall hold Covered Persons harmless for the cost of Covered Drugs, whether or not PHARMACY believes its compensation for the Covered Drugs is made in accordance with the reimbursement provision of the Agreement or is otherwise inadequate. PHARMACY shall not balance bill Covered Persons who have obtained Covered Drugs through the Network in accordance with the Benefit Plan. PHARMACY shall not bill, charge, or collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than PBM or Plan Sponsor) acting on behalf of a Covered Person for Covered Drugs provided pursuant to the Agreement. Neither PHARMACY nor its trustee or assignee may maintain an action at law or attempt to collect from Covered Persons sums owed to PHARMACY by PBM or Plan Sponsor. This provision shall not be construed to prohibit collection of required copayments, deductibles, or coinsurance, if any, or uncovered charges consented to and lawfully owed to PHARMACY by Covered Persons provided PHARMACY informed the Covered Person that Plan Sponsor may not cover or continue to cover the services. N.J. Stat. Ann. §§ 17:48F-13; 17:48H-18; N.J.A.C. §§ 11:4-37.4(c)(8); 11:24-15.2(b)(7); 11:24B-5.2(a)(10).

6. PHARMACY has the right to communicate openly with Covered Persons about all appropriate diagnostic testing and treatment options. N.J. Stat. Ann. § 26:2S-9(c); N.J.A.C. §§ 11:24-15.2(b)(13); 11:24A-4.15(b)(11); 11:24B-5.2(a)(14).

7. Plan Sponsor is a third-party beneficiary of the Agreement and shall have privity of contract with PHARMACY such that Plan Sponsor shall have standing to enforce the Agreement with PHARMACY. N.J.A.C. §§ 11:24-15.2(f); 11:24B-5.7(a).

8. PHARMACY shall not discriminate in its treatment of Covered Persons of an HMO Plan Sponsor or any other Plan Sponsor. N.J.A.C. §§ 11:24-15.2(b)(8); 11:24A-4.15(b)(7): 11:24B-5.2(a)(16).

9. PHARMACY shall comply with PBM and Plan Sponsors' quality assurance and utilization review programs in accordance with the Agreement. PHARMACY's activities and records relevant to the provision of Covered Drugs may be monitored from time to time by PBM, Plan Sponsor, or a contractor acting on either's behalf in order to perform quality assurance and continuous quality improvement functions. N.J.A.C. §§ 11:24-15.2(b)(9); 11:24A-4.15(b)(8); 11:24B-5.2(a)(3-4).

10. PHARMACY shall maintain licensure, certification and adequate malpractice covered in an amount determined sufficient for its anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate year. N.J.A.C. §§ 11:24-15.2(b)(10); 11:24B-5.2(b)(12).

11. Covered Persons' information shall be kept confidential by PHARMACY, subject to the requirements of state and federal law. However, PBM, Plan Sponsor, and PHARMACY shall have mutual rights to Covered Persons' medical records, as well as timely and appropriate communication of patient information, so that each may perform their respective duties efficiently and effectively. N.J.A.C. §§ 11:24-15.2(b)(11); 11:24A-4.15(b)(9).

12. This Agreement shall be construed in accordance with New Jersey Law. N.J.A.C. § 11:24B-5.2(a)(7).

13. PBM and PHARMACY agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. PHARMACY may initiate a formal internal review of any complaint or grievance brought by PHARMACY, including compensation and claims issues, by submitting the complaint or grievance to PBM in writing. PBM will review the complaint or grievance and communicate a written response to PHARMACY in accordance with the requirements of New Jersey Law (which shall not exceed 30 days following receipt of the compliant or grievance). Complaints or grievances brought by PHARMACY relating to payment of Claims will be reviewed at no cost to the PHARMACY by employees of PBM who are not responsible for Claims payment on a day-to-day basis, and a written response shall be communicated to PHARMACY within 10 business days after receipt of such complaint or grievance, or as otherwise required under New Jersey Law. The written response shall include: (a) the names, titles and qualifying credentials of the persons participating in the internal review; (a) a statement of PHARMACY's grievance; and (c) the decision of the reviewers' along with a detailed explanation of the contractual basis for the decision; (d) a description of the evidence or documentation which supports the decision; and (e) if the decision is adverse to PHARMACY, a description of the method to obtain an external review of the decision. PHARMACY shall have the right to submit complaints and grievances to DOBI or DHS, depending upon the issue involved, if not satisfied with the resolution of the complaint or grievance through the internal provider compliant mechanism described herein.

    If any dispute, or complaint or grievance arising under this Agreement is not satisfactorily resolved by the parties themselves, PBM and PHARMACY agree to submit such dispute, complaint, or grievance to binding arbitration. The party wishing to initiate arbitration must notify the other party by written demand. Any such arbitration shall be held in New Jersey. Such arbitration shall be conducted in accordance with the commercial rules of the American Arbitration Association. The costs of the arbitration under this paragraph shall be borne equally by the parities, and the results of the arbitration shall be issued no later than

30 business days from the receipt by the arbitrator of all documentation necessary to complete its review.

N.J.A.C. §§ 11:22-1.8; 11:24-15.2(b)(12); 11:24A-4.15(b)(10); 11:24B-5.2(a)(18).

14. In the event that any provision of this Agreement is determined to be in conflict with state or federal Law, such provision will be deemed modified to the extent necessary to make it conform to the requirements of such Law. N.J.A.C. §11:24B-5.2(a)(1).

15. Notwithstanding anything to the contrary, PBM shall not have a unilateral right, acting in its own accord, or at the request of Plan Sponsor, to amend the Agreement or to require PHARMACY to abide by amended terms of the Agreement during either a notice of termination period or a continuity of care period in the event PHARMACY elects to terminate the Agreement rather than accept the amendment. This paragraph shall not apply in the event the amendment is required by state of federal law. Notwithstanding the foregoing, to the extent that the Agreement permits unilateral changes, "adverse changes" may only be made with sufficient advance notice to permit termination in advance of the effective date of the change. For purposes of this provision, "adverse change" means any action taken that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to PHARMACY or the administrative expenses incurred by PHARMACY in complying with the change. With respect to the terms of the Agreement that were the subject to negotiation, no changes will be made unilaterally to the administration of the Agreement materially impacting those terms. N.J.A.C. 11:24C-4.3(c)(4). Any adverse change during the term of the Agreement may be made in accordance with the terms of the Agreement (but not upon automatic renewal) upon 90 days' notice prior to the effective date of the change. If PHARMACY declines to accept the amendment, PHARMACY may terminate the Agreement as set forth in N.J.A.C. § 11:24C-4.3(c)(3). N.J.A.C. §§ 11:24B-5.2(c)(2); 11:24C-4.2; 11:24C-4.3.

16. Nothing in the Agreement shall be construed to provide that PHARMACY will be denied payment with respect to a medically necessary health care service or supply if the service was not pre-certified or pre-authorized to the extent such denial is not permitted by law. Payment to PHARMACY may be reduced by up to 50% of the amount that otherwise would have been paid had pre-certification or pre-authorization been obtained. N.J.A.C. § 11:24B-5.2(c)(6).

17. This Agreement shall become effective as of the Effective Date appearing on the signature page hereof, subject to prior approval by the New Jersey Departments of Health and Senior Services and Banking and Insurance and shall continue in effect from year to year unless terminated as provided in the Agreement.

    a. Notwithstanding the foregoing, either party may terminate the Agreement without cause by giving to the other party at least ninety (90) days prior written notice of the date of termination. N.J.A.C. §§ 11:24-15.2(b)(1)(i); 11:24B-5.3(b).

b. PBM may immediately terminate this Agreement without notice at any time if PHARMACY (i) commits fraud, (ii) fails to meet its obligations or otherwise breaches this Agreement, or (iii) in the sole discretion of the medical director of PBM or Plan Sponsor, represents an imminent danger to a Covered Person or the public health, safety, and welfare. N.J.A.C. §§ 11:24-3.5(a)(1)(ii); 11:24-15.2(b)(1)(i); 11:24A-4.8(b); 11:24B-5.3(c).

c. Either party may, subject to applicable state Law, terminate this Agreement at any time if the other party is adjudged bankrupt; voluntarily files a petition in or for bankruptcy, reorganization, or an arrangement with creditors; or makes a general assignment for the benefit of creditors by giving to the other party at least ninety (90) days prior written notice of the date of termination.

d. If PBM terminates this Agreement prior to the renewal date, other than pursuant to b) hereof, PBM shall provide PHARMACY with 90 days prior written notice setting forth the reasons for termination ("Termination Notice"), setting forth PHARMACY's right to a hearing any exception thereto, and the procedures for exercising that right. Within 10 days of receipt of the Termination Notice, PHARMACY shall be entitled to request a hearing in writing with respect to the termination ("Hearing Request"). Within 30 days of receipt of a Hearing Request, PBM shall hold a hearing before a panel appointed by PBM in accordance with N.J.A.C. §§ 11:24-3.6(b); 11:24A-4.9. The panel shall consist of no less than 3 people, at least one person on the panel shall be a clinical peer in the same or substantially similar discipline and specialty as PHARMACY, and PBM shall not preclude PHARMACY from being present at the hearing or represented by counsel. The panel shall render a decision in writing within 30 days of the close of the hearing, unless within such 30-day period the panel provides notice to both PHARMACY and PBM of the need for an extension for rendering the decision.

   The panel's decision shall set forth the relevant provision of the Agreement and the facts upon which PBM or Plan Sponsor and PHARMACY relied at the hearing. The panel shall recommend that PHARMACY be terminated, reinstated, or provisionally reinstated. The panel shall specify the reasons for its recommendations, including the reasons for any conditions for provisional reinstatement. The panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences for failure to meet the conditions. In the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of the duration of the Agreement. In the event that panel recommends that PHARMACY be terminated, PBM or Plan Sponsor shall provide notice of the termination to Covered Persons in accordance with N.J.A.C. §§ 11:24-3.5.

N.J.A.C. §§ 11:24-3.5(a)(1)(i); 11:24-3.6; 11:24-15.2(b)(1)(i-ii); 11:24A-4.8(a); 11:24A-4.9; 11:24A-4.15(b)(1)(i); 11:24B-5.3(d-c).

e. In the event the Agreement terminates, PHARMACY agrees to continue to provide Covered Drugs under the terms of the Agreement, and at the contracted rates under the Agreement, to Covered Persons for up to 4 months following the date of termination when it is medically necessary for the Covered Person to continue such services, except as follows:

   i. In the case of pregnancy of a Covered Person, Medical Necessity shall be deemed to have been demonstrated and coverage of services under the Agreement by the terminated PHARMACY shall continue to postpartum evaluation of the Covered Person, up to 6 weeks after delivery;

   ii. In the case of post-operative care, coverage of services under the Agreement by the terminated PHARMACY shall continue for a period up to 6 months;

   iii. In the case of oncological treatment, coverage of services under the Agreement by the terminated PHARMACY shall continue for a period up to 1 year;

   iv. In the case of psychiatric treatment, coverage of services under the Agreement by the terminated PHARMACY shall continue for a period of up to 1 year; and

   v. In the event that the PHARMACY terminates the Agreement, coverage of services under the Agreement by the terminated PHARMACY shall continue for Covered Persons who received services from the PHARMACY immediately prior to the date of termination for 30 days following the date of termination, but for the remainder of the 4 month period under e) only in cases where it is medically necessary to continue treatment with the terminated PHARMACY or in accordance with Items 1) through 4) above as they may apply. The determination as to the medical necessity of a Covered Person's treatment with PHARMACY shall be subject to the appeal procedures provided by New Jersey law.

   Notwithstanding the forgoing under e), terminated PHARMACY shall not be required to continue to provide Covered Drugs under the Agreement in the event the Agreement terminates because i) PBM determines that PHARMACY is an imminent danger to one or more Covered Persons or the public health, safety and welfare, ii) PBM determines that PHARMACY committed fraud, iii) PBM determines that PHARMACY breached the Agreement, or iv) PHARMACY is the subject of disciplinary action by any regulatory agency or board of the State of New Jersey.

   N.J.A.C. §§ 11:24-15.2(b)(4); 11:24-3.5(c)(1-4); 11:24A-4.8(d)(1-4) and (7); 11:24A-4.15(b)(4); 11:24B-5.3(f-g).

f. PHARMACY's participation in the hearing process will not be deemed an abrogation of the PHARMACY's legal rights. N.J.A.C. §§ 11:24-15.2(b)(1)(iv); 11:24A-4.15(b)(1)(iv).

18. PBM will not make the terms of the Agreement available to any third party to lease the network unless: (i) the agreement specifically states that PBM may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity; (ii) every third party accessing the Agreement is contractually obligated to comply with all of its terms; (iii) all such third parties in existence as of the date the Agreement is entered into are identified; (iv) PBM includes on its website a listing, updated no less frequently than every 90 days, identifying all such third parties; (v) each third party is required to identify the source of the discount on all remittance advices and/or explanation of payment under which a discount is taken; (vi) the third party is notified of the termination of a provider contract upon issuance of the termination by PBM or upon receipt of notice by PHARMACY; (vii) the third party ceases its right to PHARMACY's discounted rate upon termination of the Agreement between PHARMACY and PBM; and (viii) PBM delivers to PHARMACY a copy of any agreement relied on in the adjudication of a claim within 30 days after the date of a request from PHARMACY. For purposes of this provision, "third party" does not include any employer or other group for whom PBM provides administrative services, including at least the payment of claims. N.J.A.C. § 11:24C-4.3(c)(5).
19. The following shall apply with respect to PBM's MAC Lists:
    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum reimbursement amount pricing are First Databank and Medi-Span.
    b. PHARMACY locations in New Hampshire subject to PBM's MAC Lists may appeal reimbursement for a drug subject to MAC pricing within 14 calendar days of the PHARMACY submitting the claim for which the appeal is being requested. PHARMACY may call (800) 441-6001 to speak to an individual who is responsible for processing appeals. PBM will investigate and respond to any such appeal within 14 calendar days of receipt.
    c. If the appeal is denied, PBM will provide the challenging PHARMACY with the reason for the denial and the national drug code of a drug that may be purchased by the PHARMACY in New Hampshire at a price that is equal to or less than the MAC.
    d. If the appeal is upheld, PBM will make the change in the MAC and PHARMACY can then reverse and rebill the claim in question.
    e. This Section 19 applies only with respect to MAC Lists owned and/or controlled by PBM.

    N.J. Stat. Ann. §§ 17B:27F-2(a)(1); F-4.

12.33 New Mexico

NEW MEXICO ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This New Mexico Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health plans, health maintenance organizations, multiple employer welfare arrangements, managed health care plans, preferred provider arrangements, nonprofit health care plans, insurers, or carriers under New Mexico law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

1. Notwithstanding anything to the contrary, no provisions in the Agreement shall operate to relieve either party of liability for its actions or inactions. N.M. Stat. Ann. § 59A-16-21.1(D).
2. PHARMACY shall be responsible for providing Covered Drugs to Covered Persons subject to the limitations and conditions set forth in the Agreement. N.M. Admin. Code § 13.10.22.12(B).
3. PHARMACY agrees that in no event, including but limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person, or person acting on behalf of the Covered Person, for Covered Drugs provided pursuant to the Agreement. This does not prohibit PHARMACY from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to Covered Persons referenced above, nor from any recourse against Plan Sponsor, PBM, or their successors. N.M. Stat. Ann. § 59A-46-13(E); N.M. Admin. Code § 13.10.22.12(C). The hold harmless provisions of this paragraph shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of Plan Sponsor or PBM. N.M. Admin. Code § 13.10.22.12(L).
4. PHARMACY and PBM have rights and responsibilities with respect to administrative policies and programs as set forth in the Agreement, including but not limited to, payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs. N.M. Admin. Code § 13.10.22.12(D).

5. PHARMACY shall maintain health records necessary to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity or appropriateness of health care services provided to Covered Persons. PHARMACY shall make such health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Covered Persons, and shall comply with all applicable state and federal laws related to the confidentiality of such records. N.M. Admin. Code § 13.10.22.12(E).
6. PHARMACY may not assign or delegate its contractual rights or responsibilities under the Agreement without PBM's prior written consent. N.M. Admin. Code § 13.10.22.12(F).
7. PHARMACY shall maintain adequate professional liability and malpractice insurance and shall notify PBM not more than 10 days after PHARMACY's receipt of notice of any reduction or cancellation of such coverage. N.M. Admin. Code § 13.10.22.12(G).
8. PHARMACY shall observe, protect, and promote the rights of Covered Persons as patients. N.M. Admin. Code § 13.10.22.12(H).
9. PHARMACY shall provide Covered Drugs to Covered Persons without discrimination on the basis of a patient's participation in the Benefit Plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when PHARMACY appropriately does not render services due to limitations arising from its lack of training, experience, or skill, or due to licensing restrictions. To the extent required by law, PHARMACY is entitled to receive from Plan Sponsor, at no cost to PHARMACY, interpreters for limited English proficient individuals and interpretive services for patients who qualify under the American with Disabilities Act (ADA). N.M. Admin. Code § 13.10.22.12(I).
10. PHARMACY shall be responsible for providing Covered Drugs to Covered Persons during the days and hours as set forth in the Agreement and credentialing forms provided hereunder. N.M. Admin. Code § 13.10.22.12(J).
11. Procedures for dispute resolution mechanisms available to the parties are set forth in the Agreement. N.M. Admin. Code § 13.10.22.12(K).
12. Terms used in the Agreement that are defined by New Mexico statutes and Insurance Division regulations shall be construed in the Agreement in a manner consistent with the definitions contained in such laws and regulations. N.M. Admin. Code § 13.10.22.12(M).
13. Nothing in the Agreement shall be construed to:
    a. Offer an inducement, financial or otherwise, to provide less than medically necessary services to a Covered Person;

b. Penalize PHARMACY for assisting a Covered Person to seek reconsideration of Plan Sponsor's or PBM's decision to deny or limit benefits to the Covered Person;

c. Prohibit PHARMACY from discussing treatment options with Covered Persons irrespective of Plan Sponsor's or PBM's position on treatment options, or from advocating on behalf of a Covered Person within the utilization review or grievance processes established by Plan Sponsor or PBM; or

d. Prohibit PHARMACY from using disparaging language or making disparaging comments when referring to Plan Sponsor or PBM.

e. Require PHARMACY to violate any recognized fiduciary duty of its profession or place its license in jeopardy.

N.M. Stat. Ann. § 59A-57-6(A); N.M. Admin. Code § 13.10.22.12(N).

14. The parties acknowledge that a Plan Sponsor failing to pay PHARMACY or Covered Person for out of pocket covered expenses within 45 days after a clean claim has been received by PBM on Plan Sponsor's behalf shall be liable for the amount due and unpaid with interest on that amount at the rate at one and one half times the rate established by a bulletin entered by the Superintendent of the New Mexico Division of Insurance in January of each calendar year. For purposes of this paragraph, "clean claim" means a manually or electronically submitted claim that contains all the required data elements for accurate adjudication without the need for additional information from outside of PBM's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by Plan Sponsor or PBM, or particular circumstances requiring special treatment that prevents timely payment from being made by Plan Sponsor. N.M. Admin. Code § 13.10.22.12(O).

15. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under New Mexico law, PHARMACY agrees:

    a. PHARMACY shall provide PBM at least 60 days prior written notice of its intent to terminate the Agreement. N.M. Stat. Ann. § 59A-46-13(G).

    b. In the event of PBM's or Plan Sponsor's insolvency, PHARMACY shall provide all medically necessary Covered Drugs to each Covered Person for the period for which a premium has been paid to Plan Sponsor, and until Covered Person's discharge from an inpatient facility. N.M. Stat. Ann. § 59A-46-13(F)(2).

16. For PHARMACY claims adjudicated on or after July 1,2019, PBM shall not charge PHARMACY a fee related to the adjudication of a claim, including: (a) the receipt and processing of a PHARMACY claim; (b) the development or management of a claim processing or adjudication network; or (c) participation in a claim processing or claim adjudication network. Any such fees inadvertently charged shall be refunded to

PHARMACY. PBM shall not charge PHARMACY other fees not enumerated within this paragraph unless the fee for service is itemized in the Agreement, Addendum, or Provider Manual. N.M. Stat. Ann. § 59A-61-7.

17. To the extent applicable, PBM shall abide by the requirements of the Pharmacy Benefits Manager Regulation Act. N.M. Stat. Ann. § 59A-61-1 et seq.

12.34 New York

NEW YORK ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Addendum has been separately entered into between Magellan Rx Management, LLC ("PBM"), Magellan Rx Management IPA, Inc. ("IPA"), and the undersigned pharmacy ("PHARMACY").

Whereas PBM and PHARMACY have entered into that certain Participating Pharmacy Agreement, under which PHARMACY has agreed to provide pharmacy services (the "Agreement").

Whereas New York law requires that entities arranging for the provision of pharmacy services for Health Maintenance Organizations or other Managed Care Organizations authorized under Article 44 of the New York Public Health Law (collectively, "HMO") be a company organized under the laws of New York to operate as an independent practice association or otherwise exempt from such requirement.

Whereas, IPA is a New York limited liability company, organized under the laws of New York to operate as an independent practice association, and is a wholly owned subsidiary of PBM.

Whereas PBM, PHARMACY, and IPA desire to amend the Agreement to add IPA as a party to the Agreement and to clarify IPA's role in providing and maintaining the network of pharmacies, in which PHARMACY participates, that provide Covered Drugs to Covered Persons of HMOs and to otherwise amend the Agreement as set forth in this Addendum.

Now, therefore, for purposes of PHARMACY's participation in the pharmacy networks that provide Covered Drugs to Covered Persons of HMOs, PBM, PHARMACY, and IPA agree as follows:

1. In the event any provision in this Addendum conflicts with the terms of the Agreement, the terms of this Addendum shall govern.
2. Notwithstanding anything in the Agreement to the contrary, PHARMACY understands and agrees that the pharmacy networks providing Covered Drugs to Covered Persons of HMOs in which PHARMACY participates are provided and maintained by IPA.

3. PHARMACY agrees that it will participate in all IPA pharmacy networks in which (i) PHARMACY participates in as of the date of the acceptance of this Agreement by IPA; (ii) PHARMACY executes a Network Participation Addendum accepted by IPA for such pharmacy network(s); and/or (iii) PHARMACY agrees to participate as evidenced by its provision of Covered Drugs to Covered Persons of an HMOs utilizing such pharmacy network(s).
4. In addition to the entities listed in the indemnification provision of the Agreement, PHARMACY's indemnification obligations under such provision shall extend to IPA and HMOs. Neither IPA nor PBM is responsible or liable for PHARMACY's professional judgment in its provision of prescription drugs and services.
5. PHARMACY must provide to IPA or PBM, upon request, evidence of all such licenses, certifications, and insurance policies referenced in the Agreement.
6. PHARMACY, IPA, and PBM are independent entities. PHARMACY shall perform all services under the Agreement and this Addendum as an independent contractor and shall exercise its own professional judgment in providing such services. Except for the indemnity provisions of the Agreement, no provision of the Agreement is for the benefit of any person or entity who is not a party hereto, and no such party will have any right or cause of action hereunder. Neither the Agreement nor this Addendum shall be assigned, sub-contracted, delegated, or transferred by PHARMACY without the prior written consent of IPA and PBM.
7. This Addendum shall be in effect from the date of acceptance by IPA.
8. IPA will act as representative for PHARMACY with regard to the payment of claims by an HMO or its delegatee, and in IPA's capacity as representative will assist PHARMACY in resolving any claims adjudication issues, complaints or concerns that PHARMACY may have with an HMO or its delegatee. To the extent that PHARMACY has any complaints with respect to receipt of payments from an HMO or its delegatee for services rendered pursuant to this Agreement, those complaints should be directed to IPA and not to the HMO.
9. To the extent that PHARMACY shall provide pharmacy services to Covered Persons enrolled with an HMO, PHARMACY agrees to comply with any requirements for participation as a pharmacy in New York. Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement or this Addendum to the contrary, PHARMACY agrees as follows:

   The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts," attached to the Agreement as Appendix A, are expressly incorporated into this Agreement, and are binding upon the Article 44 plans and providers that contract with such plans, and who are a party to this Agreement. In the event of any

inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments, and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.

New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

Appendix A

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the Article 44 plans and providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses.

A. Definitions for Purposes of this Appendix

"Managed Care Organization" or "MCO" 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 a comprehensive health services plan, or a health and long-term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"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, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to

terminate this Agreement, if so directed by DOH, 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 DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a medical group Provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO´s Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty days in advance of implementation, including but not limited to:

   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO 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 the Provider is a primary care practitioner, the Provider agrees to provide twenty–four (24) hour coverage and back–up coverage when the Provider is unavailable. The 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 MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO´s or IPA/ACO´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) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.
9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:
    - The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider´s or IPA/ACO´s performance does not satisfy the standards set forth in the Medicaid Managed Care contract.
    - The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider´s or IPA/ACO´s performance.
    - The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.
    - The MCO and the Provider or IPA/ACO agree that a woman´s enrollment in the MCO´s Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother´s county of fiscal responsibility.
    - The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
    - The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
    - The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with

the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix A-1 attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form–LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

- The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee´s involvement in any program under Medicare, Medicaid, or a Title XX services program (block grant programs).
- The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).
- The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.
- The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than $25,000 during the 12–month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.
- The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG´s website, within five (5) days of executing this agreement, stating that:
    - The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred, or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

- All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
- Payment requests are submitted in accordance with applicable law.

– The Provider or IPA/ACO agrees to require that an officer, director, or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG´s website, before the subcontractor requests payment under the subcontract, acknowledging that:

- The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred, or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
- All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
- Payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.
11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA´s Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27–F of the Public Health Law, and Mental Hygiene Law § 33.13.
12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363–d(2) and 18 NYCRR § 521.3.
13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363–d(2) is in

place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG´s website.

C. Payment and Risk Arrangements

1. Enrollee Non–liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, 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 MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care 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 MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long Term Care plan designated as a Program of All–Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, 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 in writing 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 services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO 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, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406–c(5–c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on

the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/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.
5. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.
6. The parties agree to follow Section 3224–a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.
7. The parties agree to follow Section 3224–b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association´s Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services´ Healthcare Common Procedure Coding System (HCPCS).
8. The parties agree to follow Section 3224–b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient´s name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

9. The parties agree to follow Section 3224–c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.

10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:

    - Provide for the MCO´s ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
    - Include a provision to address circumstance where the Provider´s financial condition indicates an inability to continue accepting such risk; and
    - Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
    - Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.
    - The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby: (i) the parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3); and (ii) the IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO´s progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and (iii) the IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and (iv) the parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO´s enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

D. Records and Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee´s medical records and other personally identifiable information (including encounter data for government–sponsored programs) available to the MCO (and IPA/ACO

if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee´s medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to 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, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, 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 a period of six years after the date of service, and in the case of a minor, for three years after majority or six years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non–renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non–renewal of an agreement

between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 days´ notice provided the MCO demonstrates to the satisfaction of DOH, 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 the MCO and a health care professional, the MCO 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. The MCO shall provide the health care professional 60 days´ notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO´s Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO´s Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO´s enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "Provider" shall include the IPA/ACO and the IPA/ACO´s contracted Providers if this Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. Arbitration

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.

G. IPA/ACO–Specific Provisions

Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO´s analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual Providers.

Appendix A-1

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

12.35 North Carolina

NORTH CAROLINA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This North Carolina Addendum applies to the extent that PHARMACY provides Covered Drugs, to Covered Persons of a health maintenance organization, health benefit plan, preferred provider benefit plan, or insurer licensed under North Carolina law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. In the event of termination of this Agreement or the insolvency of Plan Sponsor or PBM, PHARMACY agrees to continue to provide Covered Drugs: (1) to Covered Persons receiving inpatient care until the Covered Persons are ready for discharge; and (2) to Covered Persons for the duration of the period after the Plan Sponsor's insolvency for which the Covered Person's premium payment has been made. 11 N.C.A.C. 20.0202(5)(b); N.C. Gen. Stat. § 58-67-120(2).
2. In the event of termination of this Agreement or the insolvency of Plan Sponsor or PBM, PHARMACY agrees to cooperate in the transition of administrative duties and records. 11 N.C.A.C. 20.0202(5)(a).
3. PHARMACY shall maintain licensure, accreditation, and credentials sufficient to meet PBM's and Plan Sponsor's credential verification program requirements and shall notify PBM of subsequent changes in status of any information relating to PHARMACY's professional credentials. 11 N.C.A.C. 20.0202(6).
4. PHARMACY shall maintain professional liability insurance coverage in an amount acceptable to PBM and notify PBM of subsequent changes in status of professional liability insurance on a timely basis. 11 N.C.A.C. 20.0202(7).
5. PHARMACY shall not bill any Covered Person for Covered Services, except for specified Coinsurance, Copayments, and applicable Deductibles. This provision does not prohibit PHARMACY and a Covered Person from agreeing to continue non-Covered Services at the Covered Person's expense, as long as PHARMACY has notified the Covered Person in advance that Plan Sponsor may not cover or continue to cover specific services and that the Covered Person chooses to receive the service. 11 N.C.A.C. 20.0202(8).

6. PHARMACY agrees to arrange for call coverage or other backup to provide service in accordance with PBM's and Plan Sponsor's standards for PHARMACY accessibility. 11 N.C.A.C. 20.0202(9).
7. PBM or Plan Sponsor shall provide mechanisms to allow PHARMACY to verify, before rendering services, that the patient for which the prescription has been claimed is a Covered Person and is entitled to Covered Drugs based on current information possessed by PBM and Plan Sponsor. 11 N.C.A.C. 20.0202(10).
8. PHARMACY shall: (1) maintain confidentiality of Covered Persons' medical records and personal information as required by N.C. Gen. Stat. 58, Art. 39 and other health records as required by law; (2) maintain adequate medical and other health records according to industry and Benefit Plan standards; (3) make copies of such records available to PBM, Plan Sponsor, and the North Carolina Department of Insurance ("Department") in conjunction with its regulation of Plan Sponsor. 11 N.C.A.C. 20.0202(11).
9. PHARMACY shall cooperate fully and timely in the investigation and resolution of any complaint or grievance filed by a Covered Person or their authorized representative. 11 N.C.A.C. 20.0202(12).
10. PHARMACY shall not discriminate against Covered Persons on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. 11 N.C.A.C. 20.0202(13).
11. PBM or Plan Sponsor shall provide advance notice of, and PHARMACY shall comply with PBM's and Plan Sponsor's policies on benefit exclusions, administrative and utilization management programs, credentialing and quality assessment programs, and provider sanction programs provided, however, that none of these programs shall override the professional or ethical responsibility of PHARMACY or interfere with PHARMACY's ability to provide information or assistance to Covered Persons. PBM or Plan Sponsor shall provide notice of changes to such policies and provide PHARMACY with sufficient time to comply with such changes. 11 N.C.A.C. 20.0202(15)(b) and (16).
12. PBM or Plan Sponsor shall provide PHARMACY with performance feedback reports if PHARMACY's compensation is related to efficiency criteria. 11 N.C.A.C. 20.0202(15)(a).
13. PHARMACY authorizes and PBM agrees to include PHARMACY's name (or that of its parent company) in the provider directory distributed to Plan Sponsor's Covered Persons, if applicable to pharmacies. 11 N.C.A.C. 20.0202(17).
14. PHARMACY shall not assign, delegate, or transfer its duties and obligations under this Agreement without PBM's prior written consent. PBM or Plan Sponsor shall notify PHARMACY, in writing, of any duties or obligations that are to be delegated or transferred before such delegation or transfer. 11 N.C.A.C. 20.0202(19).

15. In the event that PBM or Plan Sponsor fails to pay for Covered Drugs as set forth in this Agreement, the Covered Person shall not be liable to PHARMACY for any sums owed by PBM or Plan Sponsor. No other provision of this Agreement shall, under any circumstances, change the effect of this section. PHARMACY, its agent, trustee, or assignee, may not maintain any action at law against a Covered Person to collect any sums owed by PBM or Plan Sponsor. N.C. Gen. Stat. § 58-67-115.
16. PHARMACY acknowledges and agrees that Plan Sponsor retains the right and ability to approve or disapprove PHARMACY's participation as well as the ability to monitor and oversee PHARMACY's offering of services to Covered Persons. 11 N.C.A.C. 20.0204.
17. PBM or Plan Sponsor shall provide PHARMACY with information about Plan Sponsor's benefit designs and incentives that are used to encourage Covered Persons to use preferred providers. N.C. Gen. Stat. Ann. § 58-50-56(f).
18. The reimbursement methodology under the Agreement is fee-for-service. 11 N.C.A.C. 20.0202(14).
19. To the extent definitions within the Agreement conflict with those set forth in the Benefit Plan, the Benefit Plan documents shall control. 11 N.C.A.C. 20.0202(2).
20. Notices required to be given to a party pursuant to the Agreement shall be in writing and addressed to the party at the address set forth in the Agreement and shall be deemed given and received: (i) 5 business days following the date the notices were placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. N.C. Gen. Stat. Ann. § 58-50-275(b).
21. Notwithstanding anything to the contrary in the Agreement, nothing herein shall:
    a. Prohibit or grant PBM or Plan Sponsor an option to prohibit, PHARMACY from contracting with another health insurance carrier to provide health care services at a rate that is equal to or lower than the payment specified in the contract;
    b. Require PHARMACY to accept a lower payment rate in the event that the PHARMACY agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract;
    c. Require or grant PBM or Plan Sponsor an option to require, termination or renegotiation of an existing health care contract in the event that PHARMACY agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract;
    d. Require or grant PBM or Plan Sponsor an option to require, PHARMACY to disclose, directly or indirectly, PHARMACY's contractual rates with another health insurance carrier;

e. Require or grant PBM or Plan Sponsor an option to require, the non-negotiated adjustment by the issuer of PHARMACY's contractual rate to equal the lowest rate PHARMACY has agreed to charge any other health insurance carrier; or

f. Require or grant PBM or Plan Sponsor an option to require, PHARMACY to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in the contract. N.C. Gen. Stat. Ann. § 58-50-295.

12.36 North Dakota

NORTH DAKOTA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This North Dakota Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under North Dakota law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY will in no event (including, but not limited to, non-payment by PBM or any Plan Sponsor, PBM or any Plan Sponsor's insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Person or other persons acting on their behalf. Neither PHARMACY or its agents, trustees, or assignees may maintain an action at law or attempt to collect from Covered Persons amounts owed to PHARMACY by Plan Sponsor or PBM. This provision does not prohibit the collection of Copayments or charges for non-covered services or items consented to by Covered Persons. This limitation shall survive termination of this Agreement for any reason. N.D. Cent. Code §§ 26.1-17.1-16; 26.1-18.1-12.
2. Notwithstanding anything to the contrary in the Agreement, PHARMACY shall not be required to indemnify PBM or Plan Sponsor for negligence, willful misconduct, or breach of contract committed by PBM or Plan Sponsor, and PHARMACY shall not be deemed to have waived any right to seek legal redress against PBM or Plan Sponsor. N.D. Cent. Code § 26.1-04-03(16).
3. To the extent PHARMACY services Covered Persons of an HMO under North Dakota Law, PHARMACY agrees that notwithstanding anything in the Agreement to the contrary,

PHARMACY must give PBM at least 60 days advance notice of termination of the Agreement. N.D. Cent. Code § 26.1-18.1-12(6).

4. The following shall apply with respect to PBM's MAC Lists:

   a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum allowable cost pricing are identified on the PBM MAC List.

   b. PBM MAC Lists are updated at least every seven business days.

   c. The sources utilized by PBM to determine the maximum allowable cost pricing are identified on the PBM MAC Lists, which are available to PHARMACY locations in North Dakota at the beginning of each PHARMACY contract, and upon contract renewal.

   d. The pricing set forth on the PBM MAC Lists will not be set below the sources utilized by PBM and will not include the dispensing fee in the calculation of the MAC price.

   e. This Section 4: (i) applies only with respect to MAC Lists owned and/or controlled by PBM; and (ii) does not apply with respect to North Dakota Medicaid programs.

   N.D. Cent. Code § 19-02.1-14.2.

12.37 Ohio

OHIO ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Ohio Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, health insuring corporations, health maintenance organizations, and health benefit plans under Ohio law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY agrees to provide services to Covered Persons as further set forth in the Agreement. Ohio Rev. Code § 1751.13(C)(1).

2. PHARMACY agrees that in no event, including but not limited to nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Covered Person to whom health care services have been

provided, or person acting on behalf of the Covered Person, for health care services provided pursuant to the Agreement. This does not prohibit PHARMACY from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Plan Sponsor or its successor. This provision shall survive termination of the Agreement with respect to Covered Drugs provided during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of PBM or Plan Sponsor. Ohio Rev. Code §§ 1751.13(C)(2), (12); 1751.60(C).

3. In the event of PBM or Plan Sponsor's insolvency or discontinuance of operations, PHARMACY shall continue to provide Covered Drugs to Covered Persons as needed to complete any medically necessary procedures commenced but unfinished at the time of the insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all Covered Drugs that constitute medically necessary follow-up care for that procedure. If a Covered Person is receiving necessary inpatient care at a hospital, PHARMACY shall continue to provide services until the earliest of the following: (a) the Covered Person's discharge from the hospital; (b) the determination by the Covered Person's attending physician that inpatient care is no longer medically indicated; (c) the Covered Person's reaching the limit for contractual benefits; or (d) the effective date of any new coverage. This provision shall not require PHARMACY to continue to provide Covered Drugs after the occurrence of any of the following:
    a. The end of the 30 period following the entry of a liquidation order under Chapter 3909 of the Ohio Revised Code;
    b. The end of the Covered Person's period of coverage for a contractual prepayment or premium;
    c. The Covered Person obtains equivalent coverage with another health insuring corporation or insurer, or the Covered Person's employer obtains such coverage for the Covered Person;
    d. The Covered Person or the Covered Person's employer terminates coverage under the Benefit Plan; or
    e. A liquidator affects a transfer of the Plan Sponsor's obligations under the Benefit Plan pursuant to Ohio law. Ohio Rev. Code § 1751.13(C)(3).
4. PHARMACY shall abide by PBM and Plan Sponsor's administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs as further set forth in the Agreement. Ohio Rev. Code § 1751.13(C)(4).

5. PHARMACY agrees to make available its records to PBM and Plan Sponsor to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Covered Persons as set forth in the Agreement. PHARMACY agrees to make its health records available to state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons. PHARMACY further agrees to comply with applicable state and federal laws related to the confidentiality of medical or health records. Ohio Rev. Code § 1751.13(C)(5).
6. PHARMACY shall not assign or delegate the contractual rights and responsibilities under the Agreement without the prior written consent of PBM. Ohio Rev. Code § 1751.13(C)(6).
7. PHARMACY shall maintain adequate professional liability and malpractice insurance as set forth in the Agreement. PHARMACY shall notify PBM not more than 10 days after PHARMACY's receipt of notice of any reduction or cancellation of such coverage. Ohio Rev. Code § 1751.13(C)(7).
8. PHARMACY shall observe, protect, and promote the rights of Covered Persons as patients. Ohio Rev. Code § 1751.13(C)(8).
9. PHARMACY shall provide health care services without discrimination on the basis of the Covered Person's participation in the Benefit Plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for service rendered to Covered Persons. This requirement shall not apply to circumstances when PHARMACY does not render services due to limitations arising from PHARMACY's lack of training, experience, or skill, or due to licensing restrictions. Ohio Rev. Code § 1751.13(C)(9).
10. Resolution of disputes arising out of the Agreement shall be resolved pursuant to the terms set forth therein. Ohio Rev. Code § 1751.13(C)(11).
11. Terms used in the Agreement that are defined by Title XVII [17], Chapter 1751, Ohio Revised Code, shall be construed in a manner consistent with those statutory definitions. Ohio Rev. Code § 1751.13(C)(13).
12. Plan Sponsor retains the right to approve or disapprove PHARMACY's participation under the Agreement. Ohio Rev. Code §§ 1751.13(E), (F)(3).
13. PHARMACY acknowledges that Plan Sponsor is a third-party beneficiary of the Agreement. Ohio Rev. Code § 1751.13(F)(2).
14. PHARMACY acknowledges that Plan Sponsor retains statutory responsibility to monitor and oversee the offering of Covered Drugs to its Covered Persons. Ohio Rev. Code § 1751.13(G).
15. The following shall apply with respect to PBM's MAC Lists:

a. The current sources used to determine MAC pricing are available to PHARMACIES in Ohio within 10 days of any request by an Ohio PHARMACY for such information.

b. PBM MAC Lists are available to PHARMACIES in Ohio in a readily available, accessible, secure, and searchable format at [_____].

c. PBM will update and implement pricing information from the currently utilized pricing sources at least every 7 days.

d. Prior to placing a prescription drug on the MAC Lists, PBM will ensure that all of the following conditions are met:

    i. The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalence evaluations or has an "NR" or "NA" rating or similar rating by national recognized reference.

    ii. The drug is generally available for purchase by PHARMACIES in Ohio from a national or regional wholesaler and is not obsolete.

e. PBM has and shall maintain an electronic process to appeal, investigate, and resolve disputes regarding MAC pricing available to Ohio PHARMACIES as follows:

    i. Ohio PHARMACIES shall have 21 days to appeal following the initial claim;

    ii. PBM will investigate and resolve the appeal within 21 days after receipt of the appeal;

    iii. Ohio PHARMACIES may contact PBM at [telephone number] to speak to a person responsible for processing appeals;

    iv. If an appeal is denied, PBM will provide a reason for the denial, the NDC, and identity of the national or regional wholesalers from whom the drug was available for purchase at a price at or below the benchmark price determined by PBM;

    v. If the appeal is upheld or granted, PBM will adjust the MAC to the upheld appeal price not later than 1 business day after the date of determination of the appeal. The adjustment shall be retroactive to the date the appeal was made and shall apply to all similarly situated pharmacies as determined by PBM. This requirement does not prohibit PBM from retroactively adjusting a claim for the appealing Ohio PHARMACY or for any other similarly situated pharmacies.

f. This Section 15 applies only with respect to MAC Lists owned and/or controlled by PBM.

Ohio Rev. Code § 3959.111.

12.38 Oklahoma

OKLAHOMA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Oklahoma Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, preferred provider organizations, health services corporations, multiple employer welfare arrangements, health insurance service organizations, and insurers under Oklahoma law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Oklahoma law, PHARMACY agrees:
    a. In the event that Plan Sponsor or PBM fails to pay for Covered Drugs as set forth in the Agreement, Covered Person shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM. 36 Okla. Stat. § 6913(D)(1).
    b. PHARMACY shall provide Covered Drugs for the duration of the period after Plan Sponsor's insolvency for which premium payment has been made and until the Covered Person's discharge from an inpatient facility. 36 Okla. Stat. § 6913(E)(2).
    c. If PHARMACY terminates the Agreement, PHARMACY shall provide PBM at least 90 days advance written notice. 36 Okla. Stat. § 6913(F).
2. The following shall apply with respect to PBM's MAC Lists:
    a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing MAC pricing are identified on the PBM MAC Lists.
    b. Pricing on PBM's MAC Lists will be updated at least every 7 calendar days.
    c. This Section 2 applies only with respect to MAC Lists owned and/or controlled by PBM.

    59 Okla. Stat. § 360(A).

12.39 Oregon

OREGON ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Oregon Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, carriers, health maintenance organizations, health care service contractors, and discount medical plan organizations under Oregon law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY will in no event (including, but not limited to, non-payment by PBM or any Plan Sponsor, PBM or any Plan Sponsor's insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Person or someone acting on Covered Person's behalf. Or. Rev. Stat. §§ 743B.204; 750.095(2).
2. To the extent PHARMACY services Covered persons of a discount medical plan organization under Oregon law, PHARMACY agrees:
    a. The Agreement and applicable Fee Schedule(s) identify PHARMACY services to be provided to Covered Persons and the applicable reimbursement rates under such program. Or. Rev. Stat. §§ 742.424(2)(a), (b).
    b. In no event will PHARMACY charge a Covered Person more than the lower of the PHARMACY's Usual and Customary Charge or the applicable discounted rate. Or. Rev. Stat. § 742.424(2)(c).
3. In the event PHARMACY is a Tribal Health Provider, as defined by the state of Oregon, for services to be offered through a health benefit plan certified by the Exchange as a Qualified Health Plan (QHP), PHARMACY shall so notify PBM in writing of such status, in which case the parties shall use the QHP Addendum for Indian Health Care Providers to supplement and amend the Agreement. PHARMACY acknowledges and agrees that the Exchange may

amend the QHP Addendum for Indian Health Care Providers, in which case the parties will be required to amend the Agreement to reflect such change(s) within 90 days of adoption of the change. PHARMACY acknowledges that the Exchange may be notified of Tribal Health Provider contractual relationships hereunder. Or. Admin. R. § 945-020-0040.

12.40 Pennsylvania

PENNSYLVANIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Pennsylvania Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of medical service corporations, managed care insurance plans, health maintenance organizations, and insurers under Pennsylvania law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Pennsylvania law, PHARMACY agrees:
    a. If PHARMACY terminates the Agreement, it must give PBM at least 60 days advance notice. 31 Pa. Admin. Code § 301.124.
    b. PHARMACY hereby agrees that in no event, including, but not limited to non-payment by PBM or Plan Sponsor, insolvency of PBM or Plan Sponsor, or breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons other than Plan Sponsor acting on behalf of the Covered Person for Covered Drugs as set forth in this Agreement. This provision shall not prohibit collecting supplemental charges or copayments in accordance with the terms of the applicable agreement between Plan Sponsor and the Covered Person. 31 Pa. Admin. Code § 301.122.
    c. PHARMACY further agrees that (i) the hold harmless provisions in paragraph 1(b) above shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person and that (ii) this hold harmless provision supersedes any oral or written contrary

agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. 31 Pa. Admin. Code § 301.122.

d. Any modification, addition, or deletion to the provisions in paragraphs 1(a), (b) or (c) above shall become effective on a date no earlier than 15 days after the Pennsylvania Secretary of Health has received written notice of such proposed changes. 31 Pa. Admin. Code § 301.122.

e. In the event of the insolvency of PBM or Plan Sponsor, PHARMACY shall continue to provide Covered Drugs for the duration of the period after the insolvency for which premium payment has been made or until the Covered Person's discharge from an inpatient facility or expiration of benefits (limited to Covered Drugs directly related to the condition which occasioned the admission), whichever is longer. 31 Pa. Admin. Code § 301.123(b)(2).

f. PHARMACY acknowledges and agrees that any delegation by Plan Sponsor to PBM for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to Plan Sponsor's oversight and monitoring of PBM's performance. 28 Pa. Admin. Code § 9.725(2).

g. PHARMACY acknowledges and agrees that Plan Sponsors, upon failure of PBM to properly implement and administer the systems, or to take prompt corrective action after identifying quality, enrollee satisfaction or other problems, may terminate their contracts with PBM, and that as a result of the termination, PHARMACY's participation in Plan Sponsor's Benefit Plans may also be terminated. 28 Pa. Admin. Code § 9.725(3).

2. To the extent PHARMACY provides Covered Drugs to Covered Persons of a managed care organization under Pennsylvania law, PHARMACY agrees:

   a. PHARMACY acknowledges and agrees that nothing in the Agreement limits the following:

      i. The authority of Plan Sponsor to ensure PHARMACY's participation in and compliance with Plan Sponsor's quality assurance, utilization management, enrollee complaint and grievance systems and procedures or limits.

      ii. The Department of Health's authority to monitor the effectiveness of Plan Sponsor's systems and procedures or the extent to which Plan Sponsors adequately monitor any function delegated to PBM, or to require Plan Sponsor to take prompt corrective action regarding quality of care or consumer grievances and complaints.

iii. Plan Sponsor's authority to sanction or terminate a PHARMACY found to be providing inadequate or poor-quality care or failing to comply with Plan Sponsor systems, standards or procedures as agreed to by PBM.

28 Pa. Admin. Code § 9.725(1).

b. PHARMACY acknowledges and agrees that any delegation by Plan Sponsor to PBM for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to Plan Sponsor's oversight and monitoring of PBM's performance. 28 Pa. Admin. Code § 9.725(2).

c. PHARMACY acknowledges and agrees that Plan Sponsors, upon failure of PBM to properly implement and administer the systems, or to take prompt corrective action after identifying quality, enrollee satisfaction or other problems, may terminate their contracts with PBM, and that as a result of the termination, PHARMACY's participation in Plan Sponsor's Benefit Plans may also be terminated. 28 Pa. Admin. Code § 9.725(3).

d. In no event including, but not limited to, non-payment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or a breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the Covered Person or persons other than Plan Sponsor acting on behalf of the Covered Person for Covered Drugs set forth in this Agreement. This provision does not prohibit collecting supplemental charges or co-payments in accordance with the terms of the agreement between Plan Sponsor and the Covered Person. 28 Pa. Admin. Code § 9.722(e)(1)(iii); 28 Pa. Admin. Code § 9.725(4).

e. PHARMACY further agrees that (i) the hold harmless provisions in paragraph 2(b) above shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person and that (ii) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. 28 Pa. Admin. Code § 9.722(e)(1); 28 Pa. Admin. Code § 9.725(4).

f. PHARMACY shall keep confidential records of Covered Persons in accordance with 40 Pa. Stat. § 991.2131 and all applicable State and Federal regulations. PHARMACY agrees to grant access to records to the employees and agents of the Pennsylvania Department of Health, Insurance Department, and Department of Public Welfare with direct responsibility for quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with State law. 28 Pa. Admin. Code § 9.722(e)(2).

g. PHARMACY agrees to participate in and abide by the decisions of PBM's and Plan Sponsor's quality assurance, utilization review and Covered Person complaint and grievance systems. 28 Pa. Admin. Code § 9.722(e)(3).

h. PHARMACY agrees to resolve all disputes, controversies and claims in the manner set forth in the Agreement and any related attachments. 28 Pa. Admin. Code § 9.722(e)(4); 40 Pa. Stat. § 991.2162(f).

i. PHARMACY agrees to adhere to all State and Federal laws and regulations. 28 Pa. Admin. Code § 9.722(e)(5).

j. PBM shall make payment to PHARMACY for Covered Drugs rendered to Covered Persons within the time required by State law, which currently requires payment within 45 days after the date a claim for payment is received with all documentation reasonably necessary for PBM to process the claim. 28 Pa. Admin. Code § 9.722(e)(6).

k. Notwithstanding anything to the contrary in the Agreement, PBM and PHARMACY shall provide each other at least 60 days prior written notice if either party terminates the Agreement without cause. 28 Pa. Admin. Code § 9.722(e)(7).

l. PBM shall give PHARMACY at least 30 days prior written notice of any changes to contracts, policies or procedures affecting PHARMACY or the provision or payment of health care services to Covered Persons, unless the change is required by Law. 28 Pa. Admin. Code § 9.722(e)(8).

3. To the extent PHARMACY provides Covered Drugs to Covered Persons of a preferred provider organization under Pennsylvania Law, PHARMACY agrees:

a. PHARMACY hereby agrees that in no event, including, but not limited to non-payment by PBM or Plan Sponsor, insolvency of PBM or Plan Sponsor, or breach of this Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons other than PBM or Plan Sponsor acting on behalf the Covered Person for Covered Drugs as set forth in this Agreement. This provision shall not prohibit collecting supplemental charges or copayments in accordance with the terms of the applicable agreement between Plan Sponsor and the Covered Person. 31 Pa. Admin. Code §§ 152.14, 152.104(a)(3)(i).

b. PHARMACY agrees to participate in and abide by the decisions of PBM's and Plan Sponsor's quality assurance, utilization review and Covered Person complaint and grievance systems. 31 Pa. Admin. Code § 152.104(a)(3)(ii), (iii).

c. PHARMACY agrees to abide by Plan Sponsor's rules and regulations for preferred providers, including those regarding hospital privileges, credentialing, in-office reviews, and similar rules. 31 Pa. Admin. Code § 152.104(a)(3)(iv).

d. PHARMACY shall keep confidential records of Covered Persons in accordance with 40 Pa. Stat. § 991.2131 and all applicable State and Federal regulations. PHARMACY agrees to grant access to records to the employees and agents of the Pennsylvania Department of Health, Insurance Department, and Department of Public Welfare with direct responsibility for quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with State law. 31 Pa. Admin. Code § 152.104(a)(3)(v).

e. PHARMACY agrees that Plan Sponsor may immediately terminate PHARMACY's participation and preferred status if PHARMACY is found to be harming Covered Persons. 31 Pa. Admin. Code § 152.104(a)(3)(vi).

4. The following shall apply with respect to PBM's MAC Lists:

a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum reimbursement amount pricing are First Databank and Medi-Span. 40 Pa. Statutes § 4532(a)(1).

b. PHARMACY locations in Pennsylvania subject to PBM's MAC Lists may appeal reimbursement for a drug subject to MAC pricing within 14 calendar days of the PHARMACY submitting the claim for which the appeal is being requested. PHARMACY may call (800) 441-6001 to speak to an individual who is responsible for processing appeals. PBM will investigate and resolve any such appeal within 14 calendar days of receipt. 40 Pa. Statutes § 4533 (a).

c. This Section 4 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.41 Rhode Island

RHODE ISLAND ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Rhode Island Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization, health plan, insurer or carrier licensed under Rhode Island law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. Notwithstanding anything to the contrary in the Agreement, PBM shall not terminate PHARMACY "without cause;" provided, however, that "cause" shall include lack of need due to economic considerations. R.I. Gen. Laws § 23-17.13-3(c)(10); Code of R.I. Rules § 14 000 022.5.3.
2. PBM shall afford PHARMACY due process for all adverse decisions resulting in a change of PHARMACY's status as a participating PHARMACY. PBM shall notify PHARMACY of the proposed actions and the reasons for the proposed action. PBM shall give PHARMACY the opportunity to contest the proposed action and participate in the internal appeals process set forth in the Agreement. R.I. Gen. Laws § 23-17.13-3(c)(11); Code of R.I. Rules § 14 000 022.5.12.
3. PHARMACY agrees that in the event of the insolvency of Plan Sponsor or PBM, Covered Persons shall not be liable to PHARMACY for charges for Covered Drugs received before the time of insolvency. R.I. Gen. Laws § 27-41-13(h).
4. PHARMACY and PBM shall provide at least 90 days written notice of any termination of the Agreement and notice of such termination may be provided by PBM to Plan Sponsor to the Director of Insurance as required by law. R.I. Gen. Laws § 27-41-13(i).
5. In the event of the insolvency of Plan Sponsor or PBM, PHARMACY shall continue to provide Covered Drugs to Covered Persons confined in hospitals, skilled nursing facilities, intermediate care facilities, or home health agencies at the time of insolvency until the earlier of discharge or 90 days following the insolvency or, for Covered Persons of federally qualified health maintenance organizations, for that period of time required by federal standards for confinement coverage. PHARMACY shall continue to provide Covered Drugs to all other Covered Persons for a period of 30 days following the insolvency. R.I. Gen. Laws R.I. §§ 27-41-13(h)(1), (2).
6. PHARMACY agrees that Covered Persons shall not be liable to PHARMACY for charges for covered health services, except for amounts due for copayments or deductibles billed in accordance with the terms of Plan Sponsor's subscriber agreement. Code of R.I. Rules § 14 000 022.5.2.1.
7. The following shall apply with respect to PBM's MAC Lists:
    a. PBM will update pricing information on its MAC Lists at least every 10 calendar days. R.I. Gen. Laws §§ 27-18-33.2(b)(1); 27-20.1-15.1 (b)(1).
    b. PHARMACY locations in Rhode Island subject to PBM's MAC Lists may appeal reimbursement for a drug subject to MAC pricing within 15 days of the PHARMACY submitting the claim for which the appeal is being requested. PBM will investigate and respond to any such appeal within 15 days of receipt.

i. PHARMACY may contact PBM through the MRx web address regarding the appeal process.

ii. If the appeal is denied, PBM will provide the challenging PHARMACY with the reason for the denial and the national drug code of a drug that is available in adequate supply.

iii. If the appeal is upheld, PBM will make the change in the maximum allowable cost within one day after the date of determination.

R.I. Gen. Laws §§ 27-18-33.2(d); 27-20.1-15.1 (d).

c. This Section 7 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.42 South Carolina

SOUTH CAROLINA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This South Carolina Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, health benefit plans, insurers, or carriers under South Carolina law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Covered Persons or persons acting on their behalf, for Covered Drugs rendered to Covered Persons by PHARMACY, and which are covered under the Covered Person's Benefit Plan. This agreement extends to all Covered Drugs furnished to the Covered Person during the time he is enrolled in, or otherwise entitled to benefits promised by the Plan Sponsor. This agreement further applies in all circumstances including, but not limited to, non-payment by PBM or Plan Sponsor and insolvency of PBM or Plan Sponsor. This agreement shall not prohibit collection of copayments from Covered Persons by PHARMACY in accordance with the terms of the Benefit Plan. PHARMACY further agrees that this agreement shall be construed to be for the benefit of Covered Persons and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and such Covered Persons, or persons acting on their behalf. PHARMACY further agrees to complete any

additional forms or certifications in support of this agreement as may be required by the Department of Insurance. S.C. Code Ann. § 38-33-130(B).

2. In connection with Covered Drugs provided to Plan Sponsors that are employers with more than 50 eligible employees and utilizing a closed panel health plan to provide major medical, hospitalization, and surgical coverage, in the event PHARMACY terminates its participation under the Agreement, PHARMACY shall, if requested, continue to provide Covered Drugs to Covered Persons, subject to the terms of the Agreement, for a period of 90 days or the anniversary date of the Benefit Plan, whichever occurs first. S.C. Code Ann. § 38-71-1730(A)(3).

3. In the event PHARMACY's participation under the Agreement is terminated or non-renewed and PHARMACY is then providing Covered Drugs to Covered Persons with a serious medical condition, PHARMACY agrees to continue to provide Covered Drugs to such Covered Persons for 90 days or until termination of the Covered Person's benefit period, whichever is greater. During this period of continued care, PHARMACY shall accept as payment in full the rates set forth in the Agreement and, except for applicable deductibles or copayments, shall not bill or otherwise hold a Covered Person financially responsible for Covered Drugs rendered in the continuation of care. For purposes of this paragraph, "serious medical condition" means a health condition or illness, that requires medical attention, and where failure to provide the current course of treatment through PHARMACY would place the person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. The provisions of this paragraph shall not apply in the event PHARMACY's license is suspended or revoked. S. C. Code Ann. §§ 38-71-243; 38-71-246

12.43 South Dakota

SOUTH DAKOTA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICPATING PHARMACY AGREEMENT

This South Dakota Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under South Dakota law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. To the extent PHARMACY services Covered Persons of a health carrier offering a managed care plan under South Dakota law, PHARMACY agrees:

    a. In accordance with the Agreement, related attachments, and any applicable government program addenda to the Agreement, PHARMACY shall make health records available upon request so that PBM can process claims, perform necessary quality assurance or quality improvement programs, or comply with any lawful request for information from appropriate state authorities. S.D. Codified Laws § 58-17F-11(6).

    b. Notwithstanding anything in the Agreement to the contrary, either party shall provide at least 60 days written notice to each other before terminating the Agreement without cause. If PHARMACY either gives or receives notice of termination without cause, PHARMACY agrees, upon PBM's request, to continue to provide Covered Drugs to Covered Persons and to follow all applicable requirements of the Agreement for the following time periods, whichever is applicable: (i) for a period of 90 days following the effective date of the termination; or (ii) for Covered Persons who have entered the second trimester of pregnancy at the time of termination, until the completion of postpartum care directly related to the delivery. S.D. Codified Laws § 58-17F-11(7).

    c. PHARMACY acknowledges and agrees that Plan Sponsor retains the right to disapprove PHARMACY's participation status in Plan Sponsor's network. S.D. Codified Laws § 58-17F-12(2).

    d. PHARMACY agrees that in the event of PBM's insolvency Plan Sponsor may require the assignment to Plan Sponsor of the provisions of the Agreement addressing PHARMACY's obligation to provide Covered Drugs. S.D. Codified Laws § 58-17F-12(7).

2. To the extent PHARMACY services Covered Persons of a discount medical plan under South Dakota law, PHARMACY agrees:

    a. PBM's Participating Pharmacy Agreement for discount medical plans contains: (1) PBM's requirements concerning the services and products to be provided by PHARMACY at a discount; (2) PHARMACY's applicable discounted rates and (3) the requirement that PHARMACY will not charge Covered Persons more than the discounted rates. S.D. Codified Laws §§ 58-17E-27; 58-17E-28; 58-17E-29.

12.44 Tennessee

TENNESSEE ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Tennessee Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, prepaid limited health service organizations, third-party prescription programs, health maintenance organizations and health care service corporations, under Tennessee law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY will in no event (including, but not limited to, non-payment by PBM or any Plan Sponsor, PBM or any Plan Sponsor's insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items. Tenn. Code § 56-32-105(c).
2. Provided that sufficient payment has been received by PBM from Plan Sponsor and provided the applicable Copayment has been collected by PHARMACY, PBM will pay PHARMACY for Covered Drugs provided to Covered Persons in accordance with the payment rate information and timelines set forth in the Agreement. Tenn. Code § 63-10-103(1) and (2).
3. Any and all disputes, controversies, or claims (including without limitation tort claims, requests for provisional remedies or other interim relief and issues as to arbitrability of any matter) arising out of, in connection with, or relating to this Agreement, or the breach hereof, that cannot be settled through negotiation shall be settled as set forth in the Provider Manual. Tenn. Code § 63-10-103(3).
4. PHARMACY must comply with PBM and Plan Sponsor's quality improvement activities, including, but not limited to the credentialing and quality assurance initiatives required by PBM, and any special quality management requirements and programs established by PBM or Plan Sponsors. PBM and Plan Sponsor shall have access to PHARMACY's records relating to claims and services to Covered Persons as set forth in the Agreement. Tenn. Admin. Code § 1200-8-33-.06(1)(i)(7).

5. To the extent Covered Drugs are provided to Covered Persons of a prepaid limited health service organization, the Agreement may be canceled upon issuance of an order by the Tennessee Department of Insurance pursuant to Tenn. Code § 56-51-129(c).

12.45 Texas

TEXAS ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Texas Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, preferred provider plan carriers, exclusive provider benefit plan issuers, health maintenance organizations, and managed care entities under Texas law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. Upon request by any reasonable and verifiable means, PHARMACY is entitled to all information necessary to determine that PHARMACY is being compensated in accordance with the Agreement. PHARMACY may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment methodology and fee schedules applicable to payment for specific services that PHARMACY will receive under the Agreement. PBM may provide the required information by any reasonable method. PBM shall provide the information not later than the 30th day after the date PBM receives the request. The information shall include a level of detail sufficient to enable a reasonable person with experience and competence in claim processing to determine the payment to be made according to the terms of the Agreement for Covered Drugs that are rendered to Covered Persons. PBM will provide notice of changes to information that will result in a change of payment to PHARMACY not later than the 90th day before the date the changes take effect and shall not make retroactive revisions to the coding guidelines and fee schedules. The Agreement may be terminated by PHARMACY on or before the 30th day after the date PHARMACY receives information requested in this paragraph without penalty or discrimination in participation in other health care products or plans. Upon receipt of information described in this paragraph, PHARMACY may only: (1) use or disclose the information for the purpose of practice management, billing activities, and other business operations and (2) disclose the information to a governmental agency involved in the regulation of health care or insurance. PBM shall, on PHARMACY's request, provide the name, edition, and model version of the software that PBM uses to determine bundling

and unbundling of claims, if applicable. This provision may not be waived, voided, or nullified by contract. Tex. Ins. Code §§ 843.321, 1301.136; 28 Tex. Admin. Code §§ 3.3703(20), 11.901(a)(11).

2. If PHARMACY voluntarily terminates its participation under the Agreement, PHARMACY shall provide reasonable advance notice to each Covered Person under PHARMACY's care. PBM shall provide assistance to PHARMACY in ensuring that the notice requirements are met. Tex. Ins. Code §§ 843.309, 1301.160; 28 Tex. Admin. Code § 3.3703(18). If PBM terminates the Agreement, reasonable advance notice shall be given by PBM or Plan Sponsor, as applicable, to Covered Persons currently being treated by PHARMACY as permitted by law. Tex. Ins. Code §§ 843.308, 843.309; 28 Tex. Admin. Code § 11.901(a)(4).
3. Notwithstanding anything to the contrary in the Agreement, PHARMACY shall not be required to hold harmless Plan Sponsor or otherwise assume tort liability resulting from Plan Sponsor's acts or omissions. Tex. Ins. Code §§ 843.310, 1301.065; 28 Tex. Admin. Code §§ 3.3703(9), 3.9204(h), 11.901(a)(7).
4. Neither PBM nor Plan Sponsor shall engage in any retaliatory action against PHARMACY, including terminating PHARMACY's participation under the Agreement or refusing to renew the Agreement, because PHARMACY has reasonably filed a complaint against Plan Sponsor on behalf of a Covered Person or appealed a decision by Plan Sponsor. Tex. Ins. Code §§ 843.281, 1301.066; 28 Tex. Admin. Code § 11.901(a)(2).
5. PHARMACY shall post in its place of business a notice to Covered Persons on the process for resolving complaints with Plan Sponsors. The notice must include the Texas Department of Insurance's toll-free telephone number for filing a complaint. Tex. Ins. Code § 843.283; 28 Tex. Admin. Code §§ 3.9204(k), 11.901(a)(6).
6. Notwithstanding anything to the contrary in the Agreement, PBM and Plan Sponsor shall adhere to all applicable statutes and rules in Texas regarding the prompt payment of claims and submission of clean claims, including those set forth in Tex. Ins. Code, Title 6, Subtitle C, Chapter 843, Subchapter J, Title 8, Subtitle D, Chapter 1301, Subchapters C and C-1, and Texas Admin. Code, Title 28, Sections 21.2801 to 21.2820. Tex. Ins. Code § 1301.107; 28 Tex. Admin. Code §§ 3.3703(11), 11.901(a)(8).
7. PBM shall provide PHARMACY written reasons for the termination of the Agreement at least 90 days prior to the effective date of the termination. Within 30 days following receipt of the written termination notice, PHARMACY may request a review by PBM or Plan Sponsor's advisory review panel. Within 60 days of PHARMACY's request and before the effective date of the termination, PHARMACY shall be entitled to a review of the proposed termination by the advisory review panel, except in a case in which there is imminent harm to patient health or an action by a state pharmacy board, or other licensing board or governmental agency, that effectively impairs PHARMACY's ability to practice, or in a case of fraud or malfeasance. The advisory review panel shall be composed of physicians and

providers, including at least one representative in PHARMACY's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Plan Sponsor or PBM, as applicable. Within that same 60-day period, the advisory review panel must make its formal recommendation and PBM shall communicate the decision regarding termination to PHARMACY. The decision of the advisory panel must be considered but is not binding on Plan Sponsor or PBM. PBM or Plan Sponsor, as applicable, shall provide PHARMACY, on request, a copy of the recommendation of the advisory review panel and the determination of Plan Sponsor or PBM. On PHARMACY's request, PHARMACY is entitled to an expedited review process. Tex. Ins. Code §§ 843.306, 843.307, 1301.057; 28 Tex. Admin. Code §§ 3.3703(19), 3.3706, 3.9204(e), (g), 11.901(a)(5).

8. PHARMACY agrees that PHARMACY may bill Covered Persons based only on the discounted rate and provisions set forth in the Agreement. Tex. Ins. Code § 1301.060; 28 Tex. Admin. Code § 3.3703(10).

9. PHARMACY agrees that in no event, including, but not limited to non-payment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Person or a person, other than Plan Sponsor or PBM, acting on their behalf for Covered Drugs provided pursuant to the Agreement. This provision shall not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Benefit Plan. PHARMACY further agrees that this provision shall survive termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Covered Persons. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the Texas Insurance Commissioner has received written notice of such proposed changes. Tex. Ins. Code §§ 843.361, 1272.055; 28 Tex. Admin. Code §§ 3.9204(i), 11.901(a)(1), 11.2604(b)(7).

10. Termination of the Agreement, unless based on medical competence or professional behavior, does not release Plan Sponsor from the obligation to continue reimbursing PHARMACY for providing medically necessary Covered Drugs at the time of termination to Covered Persons who have special circumstances in accordance with the dictates of medical prudence. Examples of Covered Persons who may have special circumstances include a Covered Person with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy. Plan Sponsor shall provide continued reimbursement at rates no less than the rates set forth in the Agreement for the Covered Persons' care in exchange for continuity of ongoing treatment. For purposes of this provision, "special circumstance" means a condition such that PHARMACY reasonably believes that

discontinuing care by PHARMACY could cause harm to the Covered Persons. PHARMACY shall identify in writing a special circumstance warranting continued service and must request that a Covered Person be permitted to continue treatment under PHARMACY's care and agree not to seek payment from the Covered Person of any amount for which the Covered Person would not be responsible if the PHARMACY continued to participate under the Agreement. Disputes regarding the necessity for continued treatment by PHARMACY shall be resolved directly between PHARMACY and PBM and/or Plan Sponsor, as applicable. This provision does not extend the obligation of Plan Sponsor or PBM to reimburse PHARMACY for ongoing treatment of a Covered Person after: (1) the 90th day following the effective date of termination or (2) if the Covered Person has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination. However, the obligation of Plan Sponsor to reimburse PHARMACY for services provided to a Covered Person who is past the 24th week of pregnancy at the time of termination, extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery. Tex. Ins. Code §§ 843.362, 1272.302; 28 Tex. Admin. Code §§ 3.3703(12), 3.9204(f), 11.901(a)(3).

11. PHARMACY shall be entitled to a waiver of the requirement that claims be electronically submitted under the Agreement in any of the following circumstances:

    a. No method is available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 CFR, Parts 160 and 162) do not support all of the information necessary to process the claim.

    b. The operation of small provider practices. This exception applies to those providers with fewer than ten full-time-equivalent employees, consistent with 42 CFR § 424.32(d)(1)(vii).

    c. Demonstrable undue hardship, including fiscal or operational hardship.

    d. Any other special circumstances that would justify a waiver.

    PHARMACY's request for a waiver must be in writing and must include documentation supporting the issuance of a waiver. Upon receipt of a request for a waiver, PBM shall, within 14 calendar days, issue or deny a waiver in writing to PHARMACY. An issued waiver will contain any restrictions, conditions or limitations related to the waiver. A denial shall include the reasons therefore and provide notice of PHARMACY's right to appeal the waiver determination (including the denial or placement of any restrictions, conditions, or limitations) to the Texas Department of Insurance within 14 calendar days of receipt. PBM shall not refuse to contract or renew the Agreement with PHARMACY because PHARMACY has requested a waiver or appealed a waiver determination.

Notwithstanding anything to the contrary in the Agreement, PBM shall not limit the mode of electronic transmission that PHARMACY may use to submit information to PBM electronically. PBM shall provide PHARMACY 90 calendar day's written notice before requiring PHARMACY to electronically submit any additional claims or equivalent encounter information, referral certifications, or any authorization or eligibility transactions not already required under this Agreement.

In the event of a systems failure or catastrophic event (as defined in 28 Tex. Admin. Code § 21.2803) that substantially interferes with PHARMACY's business operations, PHARMACY may submit non-electronic claims to PBM beginning on the date of the systems failure or catastrophic event and for the number of calendar days during which the substantial interference occurs. PHARMACY must provide written notice to PBM within five calendar days of the systems failure or catastrophic event of PHARMACY's intent to submit non-electronic claims.

28 Tex. Admin. Code § 11.901(a)(13), 21.3701.

12. Nothing in the Agreement shall be construed to extend statutory or regulatory time frames set forth by Texas law or to waive PHARMACY's right to recover reasonable attorney's fees and court costs where provided for by statute. 28 Tex. Admin. Code § 21.2817.
13. PBM's audit procedures are set forth in the Agreement and shall apply to extent not inconsistent with any requirements of Tex. Ins. Code §§ 1369.251 to .270 regarding audits of pharmacists and pharmacies. Tex. Ins. Code § 1369.254(f), .267.
14. PHARMACY agrees to comply with all applicable requirements of Insurance Code § 1661.005 and refund any overpayment received from a Covered Person within 30 days after PHARMACY determines that an overpayment has been made. Tex. Ins. Code§ 1661.005; 28 Tex. Admin. Code § 3.3703(25).
15. The following shall apply with respect to PBM's MAC Lists:
    a. PHARMACY locations in Texas subject to PBM's MAC Lists may appeal reimbursement for a drug subject to MAC pricing on or before the 10th day after the date PHARMACY makes a claim for the pharmacy benefit by submitting an email to the Provider Networks mailbox, detailing the basis for the comment, contest, or appeal of the MAC price, along with supporting information and/or documentation.
    b. This Section 15 applies only with respect to MAC Lists owned and/or controlled by PBM.

12.46 Utah

UTAH ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Utah Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, managed care organizations, insurers, or carriers under Utah law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. During the first 2 years of the Agreement, PBM may terminate the Agreement with or without cause upon providing PHARMACY with the requisite amount of notice provided in the Agreement, but in no case shall it be less than 60 days. Utah Code Ann. § 31A-22-617.1(2)(a).
2. PBM may terminate PHARMACY for cause as provided in the Agreement provided that prior to terminating for cause, PBM shall:
   a. Inform PHARMACY of its intent to terminate and the grounds for doing so; and
   b. Upon PHARMACY's request, PBM shall meet with PHARMACY to discuss the reasons for termination.

   Utah Code Ann. § 31A-22-617.1(2)(b)-(c).
3. Notwithstanding the above, if PBM has a reasonable basis to believe that PHARMACY has engaged in fraudulent conduct or poses a significant risk to patient care or safety, PBM may immediately suspend PHARMACY from further performance under the Agreement, provided that PHARMACY shall be made aware of and allowed to access PBM's internal appeals process before termination may become final. Utah Code Ann. § 31A-22-617.1(c)-(d).
4. PBM and PHARMACY agree to resolve all disputes, controversies and claims in the manner set forth in the Agreement and any related attachments, with the exception that, if arbitration is initiated, the arbitrator shall be jointly selected by the parties, the cost of which shall be jointly shared, and each party shall bear its own additional expenses. Utah Code Ann. §§ 31A-22-617.1(2)(d); 31A-22-617(1)(a)(iii); 31A-8-407; 31A-22-640(7).
5. If Plan Sponsor or PBM fails to pay for Covered Drugs as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM. Utah Code Ann. §§ 31A-8-407(1)(a)(i); 31A-22-617(1)(a)(i).

6. PHARMACY acknowledges and agrees that if Plan Sponsor or PBM becomes insolvent, the rehabilitator or liquidator may require PHARMACY to:

   a. Continue to provide Covered Drugs until the earlier of (a) 90 days after the date of the filing of a petition for rehabilitation or liquidation or (b) the date the term of the Agreement ends; and

   b. Reduce the fees that PHARMACY is otherwise entitled to receive from Plan Sponsor or PBM under the Agreement during the time period described in the paragraph immediately above, provided that the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the Agreement and provided that Covered Persons shall continue to pay the same copayments, deductibles, and other payments for services as before the petition for reorganization or liquidation. PHARMACY shall accept the reduced payment as payment in full and relinquish the right to collect additional amounts from Covered Persons. Utah Code Ann. §§ 31A-8-407; 31A-22-617(1)(c).

7. Notwithstanding anything to the contrary in the Agreement, audits of PHARMACY shall be conducted in accordance with the processes set forth in Section 58-17b-622 of the Utah Code. Utah Code Ann. § 58-17b-622.

8. The following shall apply with respect to PBM's MAC Lists:

   a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by PBM in establishing maximum allowable cost pricing are identified on the PBM MAC Lists.

   b. Instructions for accessing PBM MAC Lists are available to PHARMACY by going to https://magellanrx.com/provider/landing or by emailing MACAppeals@primetherapeutics.com.

   c. This Section 8 applies only with respect to MAC Lists owned and/or controlled by PBM.

   Utah Code Ann. § 31A-22-640(5).

12.47 Vermont

VERMONT ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Vermont Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Vermont law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. To the extent PHARMACY provides services to Covered Persons of a managed care organization under Vermont law, PHARMACY agrees:

    a. PHARMACY's requirements and responsibilities with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, chronic care programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable provisions required by federal or state law are set forth in the Agreement, the pharmacy manual, and any related attachments. PHARMACY shall be allowed to participate in PBM's quality management program, dispute resolution process, and utilization management program to the extent required by law. PHARMACY shall notify PBM of any changes that would impact PHARMACY's credentialing status or ongoing availability to Covered Persons. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(G).

    b. PHARMACY agrees to take those steps necessary, as directed by PBM, to ensure the availability and confidentiality of the health records necessary to monitor and evaluate the quality of care, and to conduct medical and other health care evaluations and audits to determine, on a concurrent or retrospective basis, the necessity and appropriateness of care provided to Covered Persons. PHARMACY shall make its health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons and shall comply with the applicable state and federal laws related to the confidentiality of medical or health records. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(I).

    c. PHARMACY agrees that in no event, including nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than Plan Sponsor) acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. This provision does not prohibit PHARMACY from collecting coinsurance, deductibles, and copayments, as specifically provided in Covered Person's certificate or coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. This provision does prohibit PHARMACY from requesting payment from a Covered Person for any services that have been confirmed by independent external review obtained through the Department of Banking,

Insurance, Securities and Health Care Administration pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(L).

d. In the event Plan Sponsor and/or PBM becomes insolvent or otherwise ceases operations, Covered Drugs to Covered Persons will continue through the period for which a premium has been paid to Plan Sponsor on behalf of the Covered Person or until the Covered Person's discharge from an inpatient facility, whichever period is greater. Covered Drugs to a Covered Person confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Covered Person's continued confinement in the facility is no longer medically necessary. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(M).

e. The provisions of subsections "c" and "d" above shall be construed in favor of the Covered Person; shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of Plan Sponsor and/or PBM, and shall supersede any oral or written contrary agreement between PHARMACY and an Covered Person or an Covered Person's representative if the contrary agreement is inconsistent with the "hold harmless" and continuation of covered services provisions required in those paragraphs. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(N).

f. Notwithstanding anything in the Agreement to the contrary, either party shall provide at least 60 days written notice to each other before terminating the Agreement without cause. Such notices shall not issue unless and until negotiations have concluded and a final decision on termination has been reached. Within 5 working days of the date that PHARMACY either gives or receives final notice of termination, either for or without cause, PHARMACY shall supply PBM with a list of its patients that are Covered Persons of affected Plan Sponsors. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(O).

g. In the event the Agreement is terminated without cause by either party or PBM elects not to renew the Agreement without cause, PHARMACY agrees to continue to provide Covered Drugs and abide by the payment rates, quality-of-care standards, and protocols under the Agreement, and to provide the necessary clinical information to PBM and/or Plan Sponsor, as follows:

    i. For Covered Persons with life-threatening, disabling, or degenerative conditions, PHARMACY shall continue to provide Covered Drugs for 60 days from the date of termination or non-renewal or until accepted by a contracted provider, whichever is shorter; and

    ii. For Covered Persons in their second or third trimester of pregnancy, PHARMACY shall continue to provide Covered Drugs until the completion of postpartum care. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.1(G).

2. To the extent PHARMACY services Covered Persons of an HMO under Vermont law, PHARMACY agrees:

   a. PHARMACY agrees that in no event, including nonpayment by Plan Sponsor or PBM, insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than Plan Sponsor) acting on behalf of the Covered Person for Covered Drugs provided pursuant to this Agreement. 8 Vt. Stat. Ann. § 5102b(d).

   b. In the event of Plan Sponsor's insolvency, PHARMACY shall continue to provide Covered Drugs to Covered Persons after Plan Sponsor's insolvency during the period for which premium payment has been made and until Covered Persons' discharge from inpatient facilities, whichever comes first. 8 Vt. Stat. Ann. § 5102b(f).

12.48 Virginia

VIRGINIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Virginia Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization, health plan, or carrier licensed under Virginia law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. In the processing of any payment of claims for Covered Drugs rendered by PHARMACY under the Agreement and in performing under the Agreement, the parties shall adhere to and comply with the minimum fair business standards required under Va. Code Ann. § 38.2-3407.15(B), (see also Va. Code Ann. § 38.2-4319 and 4214) which include the following:

   a. Claims shall be paid within 40days of receipt of the claim, except where the obligation to pay the claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by PHARMACY that:

      i. The claim is determined not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the

responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

ii. The claim was submitted fraudulently. Va. Code Ann. § 38.2-3407.15(B)(1).

b. PBM shall maintain a written or electronic record of the date of receipt of a claim. PHARMACY shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim. Va. Code Ann. § 38.2-3407.15(B)(1).

c. PBM shall, within 30 days after receipt of a claim, request electronically or in writing from PHARMACY the information and documentation that PBM believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection, claims shall be paid in compliance with this section. PBM shall not refuse to pay a claim for Covered Drugs rendered pursuant to this Agreement if PBM fails timely to notify or attempt to notify PHARMACY of the matters identified above unless such failure was caused in material part by PHARMACY; however, nothing herein shall preclude PBM from imposing a retroactive denial of payment of such a claim if permitted by the Agreement unless such retroactive denial of payment of the claim would violate subsection (h) set forth below. Nothing in this subsection shall require PBM to pay a claim that is not a clean claim. Va. Code Ann. § 38.2-3407.15(B)(2).

d. Any interest owing or accruing on a claim under § 38.2-3407.1 or § 38.2-4306.1 of Title 38.2 of the Virginia Code, under the Agreement, or under any other applicable law shall, if not sooner, be paid without necessity of demand at the time the claim is paid or within 60 days thereafter. Va. Code Ann. § 38.2-3407.15(B)(3).

e. PBM and/or Plan Sponsor, as applicable, shall establish and implement reasonable policies to permit PHARMACY (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the Plan Sponsor's requirements applicable to PHARMACY (or to the type of health care services which PHARMACY has contracted to deliver under this Agreement) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) PHARMACY-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other PHARMACY-specific applicable claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a clean claim. PBM does not routinely, as a matter of policy,

bundle or downcode claims submitted by PHARMACY. If, however, PBM routinely, as a matter of policy, bundles or downcodes claims submitted by a PHARMACY, PBM shall clearly disclose that practice in each PHARMACY contract. Further, PBM shall either (i) disclose in its PHARMACY contracts or on its website the specific bundling and downcoding policies that PBM reasonably expects to be applied to PHARMACY or PHARMACY's services on a routine basis as a matter of policy or (ii) disclose in each PHARMACY contract a telephone or facsimile number or email address that PHARMACY can use to request the specific bundling and downcoding policies that PBM reasonably expects to be applied to that PHARMACY or PHARMACY's services on a routine basis as a matter of policy. If such request is made by or on behalf of PHARMACY, PBM shall provide the requesting PHARMACY with such policies within 10 business days following the date the request is received. Va. Code Ann. § 38.2-3407.15(B)(4)(a).

f. PBM shall make available to PHARMACY within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies that are applicable to PHARMACY or to the particular health care services identified by PHARMACY. In the event the provision of the entire policy would violate any copyright law, PBM may instead comply with this subsection by timely delivering to PHARMACY a clear explanation of the policy as it applies to PHARMACY and to any health care services identified by PHARMACY. Va. Code Ann. § 38.2-3407.15(B)(4)(b).

g. PBM and/or Plan Sponsor shall pay a claim if PBM and/or Plan Sponsor has previously authorized the health care service or has advised PHARMACY or Covered Person in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

    i. The documentation for the claim clearly fails to support the claim as originally authorized; or

    ii. The refusal is because (i) another Plan Sponsor is responsible for the payment, (ii) PHARMACY has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to PBM or Plan Sponsor by PHARMACY, Covered Person, or other person not related to PBM or Plan Sponsor, as applicable, or (iv) the person receiving the health care services was not a Covered Person eligible to receive them on the date of service and PBM and/or Plan Sponsor did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status. Va. Code Ann. § 38.2-3407.15(B)(5).

h. Neither PBM nor Plan Sponsor may impose any retroactive denial of a previously paid claim unless PBM or Plan Sponsor has provided the reason for the retroactive denial

and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because PHARMACY was already paid for the services identified on the claim or the health care services identified on the claim were not delivered by PHARMACY, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which PBM and/or Plan Sponsor requires under the Agreement that a claim be submitted by PHARMACY following the date on which a health care service is provided. PBM or Plan Sponsor shall notify PHARMACY at least 30 days in advance of any retroactive denial of a claim. Va. Code Ann. § 38.2-3407.15(B)(6).

i. Neither PBM nor Plan Sponsor may impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless PBM or Plan Sponsor specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and provides a written explanation of why the claim is being retroactively adjusted. Va. Code Ann. § 38.2-3407.15(B)(7).

j. This Agreement shall include, at the time it is presented to PHARMACY for execution, (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid which is applicable to PHARMACY or to the range of health care services reasonably expected to be delivered by PHARMACY on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subsection e above) applicable to PHARMACY or to the range of health care services reasonably expected to be delivered by PHARMACY under the Agreement. Va. Code Ann. § 38.2-3407.15(B)(8).

k. No amendment to the Agreement or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit or policy) applicable to PHARMACY (or to the range of health care services reasonably expected to be delivered by PHARMACY) shall be effective as to PHARMACY, unless PHARMACY has been provided with the applicable portion of the proposed amendment (or the proposed new addenda, schedule, exhibit or policy) at least 60 calendar days before the proposed effective date and PHARMACY has failed to notify PBM in writing within 30 calendar days of receipt of the documentation of PHARMACY's intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement. Va. Code Ann. § 38.2-3407.15(B)(9).

l. In the event that PBM's or Plan Sponsor's provision of a policy required to be provided under subsection j or k above would violate any applicable copyright law, PBM or Plan Sponsor may instead comply with this subsection by providing a clear, written explanation of the policy as it applies to the PHARMACY. Va. Code Ann. § 38.2-3407.15(B)(10).

m. PBM and/or Plan Sponsor, as applicable, has established in writing its claim payment dispute mechanism and shall make this information available to PHARMACY upon request. Va. Code Ann. § 38.2-3407.15(B)(11).

2. To the extent that the Agreement requires PHARMACY to submit claims electronically, PHARMACY shall be entitled to electronic payment of clean claims, as defined in subsection A of Section 38.3-3407.15, Va. Code Ann., if the claims are submitted in the form required by PBM, in compliance with 45 CFR Part 142, as amended, if PHARMACY agrees to accept claims details for such payments electronically, in compliance with 45 CFR Part 142, as amended, and if PHARMACY has provided accurate electronic funds transfer information to PBM. Va. Code Ann. § 38.2-3407.9:03.

3. Notwithstanding anything in the Agreement to the contrary, in the absence of fraud PBM shall not:

   a. Recoup audit amounts calculated from or arising out of any of the following: (a) probability sampling, extrapolation, or other mathematical or statistical methods that allegedly project an error; (b) clerical errors by the PHARMACY; (c) an act or omission of the PHARMACY that was not specifically prohibited or required by the Agreement when the claim was adjudicated unless the act or omission was a violation of applicable law or regulation; (d) the refusal of PBM or Plan Sponsor to consider during an audit or audit appeal a pharmacy record in electronic form to validate a claim; (e) dispensing fees or interest on the claim, except in the event of an overpayment, if the prescription was dispensed in accordance with applicable law or regulation; (f) any claim authorized and dispensed more than 24 months prior to the date of the audit unless the claim is adjusted at the direction of the Insurance Commission, except that this time period shall be tolled while they denial of the claim is being appealed; (g) an alleged breach of the any auditing requirements that are different than the auditing requirements applied to other pharmacies in the same setting; (h) the refusal of PBM or Plan Sponsor to consider during an audit or audit appeal a pharmacy record, a prescriber or patient verification, or a prescriber record to validate a claim; or (i) the alleged failure of PHARMACY to supply during an audit or audit appeal a pharmacy record not specifically identified in the Agreement. Va. Code Ann. § 38.2-3407.15:1(B).

   b. Terminate or fail to renew the Agreement with PHARMACY for invoking its rights under Section 3.a. above. Va. Code Ann. § 38.2-3407.15:1(C).

4. The following shall apply with respect to PBM's MAC Lists:

   a. PBM shall update, not less than frequently than once every 7 days, the MAC List, unless there has been no change to the maximum allowable cost of any drug on the MAC List since the last update.

b. PBM shall verify, not less frequently than once every 7 days, that the drugs on the MAC List are available to PHARMACY locations in Virginia from at least one regional or national pharmacy wholesaler and that the amount for each drug is not obsolete. PBM will promptly revise the MAC List if necessary to comply with this requirement.

c. PBM MAC Lists are available to PHARMACY locations in Virginia subject to such MAC Lists. Instructions for accessing PBM MAC Lists are available to Pharmacy by going to https://magellanrx.com/provider/landing or by emailing MACAppeals@primetherapeutics.com.

d. Neither PBM nor Plan Sponsor will terminate or fail to renew the Agreement with PHARMACY for invoking its rights under this Section 4.

e. PHARMACY locations in Virginia subject to MAC Lists may appeal MAC List pricing within 14 calendar days of the initial adjudication of the claim for which the appeal is being requested by going to MACAppeals@primetherapeutics.com, detailing the challenge to the MAC List pricing, and submitting supporting information and/or documentation. PHARMACY locations in Virginia may obtain the phone number of the individual who is responsible for processing appeals by emailing MACAppeals@primetherapeutics.com. PBM will investigate and resolve any appeal initiated by PHARMACY under this section, within 14 calendar days.

   i. If the appeal is denied, PBM will provide the challenging PHARMACY with the reason for the denial and the national drug code of the drug subject to the appeal that may be purchased by PHARMACY at a price that is equal to or less than the maximum allowable cost.

   ii. If the appeal is upheld, PBM will update the maximum allowable cost within 5 calendar days after the date of determination.

   Va. Code Ann. § 38.2-3407.15:2(B) and (C).

f. This Section 4 applies only with respect to MAC Lists owned and/or controlled by PBM.

5. To the extent PHARMACY provides services to Covered Persons of an HMO, PHARMACY agrees to the following:

   a. PHARMACY hereby agrees that in no event, including, but not limited to nonpayment by Plan Sponsor or PBM or the insolvency of Plan Sponsor or PBM, or breach of the Agreement, shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Covered Person other than the Plan Sponsor for Covered Drugs provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of Plan Sponsor's subscriber agreement. PHARMACY further agrees that (i) this provision shall survive the

termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Plan Sponsor's Covered Persons and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on such Covered Person's behalf. Va. Code Ann. § 38.2-5805(C)(4), (9), and (10); Va. Code Ann. § 38.2-4301(C)(2).

b. If PHARMACY terminates this Agreement, PHARMACY shall give PBM and Plan Sponsor at least 60 days advance written notice of termination. Va. Code Ann. § 38.2-5805(C)(1), (7).

c. Neither PHARMACY nor its agent, trustee, or assignee thereof, may maintain any action at law against a Covered Person to collect sums owed by Plan Sponsor or PBM. Va. Code Ann. § 38.2-5805(C)(2), (5).

12.49 Washington

WASHINGTON ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

In the event any provision of this Addendum conflicts with the terms of the Agreement (including documents incorporated by reference therein, the terms of this Addendum shall control to the extent of the conflict with respect to Benefit Plans subject to the applicable Washington law or regulation.

To the extent that PHARMACY provides Pharmacy Services to Covered Persons of a health carrier, health carrier service contractor, health maintenance organization ("HMO"), or other insurer licensed under Washington law (collectively and/or individually, "Plan Sponsor"), PHARMACY agrees to comply with any requirements for participation as a PHARMACY in Washington as required by applicable law.

Without limiting the generality of the foregoing and notwithstanding anything to the contrary in the Agreement, PHARMACY agrees as follows:

1. PHARMACY hereby agrees that in no event, including, but not limited to nonpayment by PBM or Plan Sponsor, PBM or Plan Sponsor's insolvency, or breach of this Agreement shall PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Person or other persons acting on their behalf, other than Plan Sponsor, for services provided pursuant to the Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance, and/or noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of

benefits, from Covered Persons in accordance with the terms of the Covered Person's Benefit Plan. WAC § 284-170-421(3)(a).

2. PHARMACY agrees, in the event of insolvency of PBM or Plan Sponsor, to continue to provide the services promised in the Agreement to Covered Persons for the duration of the period for which premiums on behalf of the Covered Person were paid or until the Covered Person's discharge from inpatient facilities (if applicable), whichever time is greater. RCW §§ 48.44.055(2); 48.46.245(2); WAC § 284-170-421(3)(b).
3. Nothing in the Agreement shall be construed to modify the rights and benefits contained in the Covered Person's Benefit Plan. WAC § 284-170-421(3)(c).
4. PHARMACY may not bill the Covered Person for covered services (except for deductibles, copayments, or coinsurance) where payment is denied because PHARMACY has failed to comply with the terms or conditions of the Agreement. WAC § 284-170-421(3)(d).
5. PHARMACY further agrees that (i) Sections 1-4 above shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Covered Persons, and (ii) these Sections supersede any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and Covered Persons or persons acting on their behalf. WAC § 284-170-421(3)(e).
6. To the extent permitted by the Agreement, if PHARMACY contracts with other providers or facilities who agree to provide covered services to Covered Persons with the expectation of receiving payment directly or indirectly from PBM or Plan Sponsor, such providers or facilities must agree to abide by the provisions of Sections 1-5 above. WAC § 284-170-421(3)(f).
7. PHARMACIES that willfully collect or attempt to collect an amount from a Covered Person knowing that collection to be in violation of the Agreement constitutes a Class C felony under RCW § 48.80.030(5). WAC § 284-70-421(4).
8. PHARMACY's responsibilities with respect to applicable administrative programs, including but not limited to payment, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements are specified in the Agreement and/or pharmacy manual. WAC § 284-70-421(5).
9. PBM shall provide reasonable notice of not less than 60 days of changes that affect PHARMACY compensation or health care service delivery under the Agreement, unless changes to federal or state law or regulations make such advance notice impossible, in which case notice will be provided as soon as possible. Subject to any termination and continuity of care provisions in the Agreement and Section 12 below, PHARMACY may terminate this Agreement without penalty if it does not agree with the changes. Material

amendments, as defined in RCW § 48.39.005, to the Agreement may be rejected by PHARMACY without affecting the terms of the existing Agreement. No amendments to the Agreement will be made retroactive without the express written consent of PHARMACY. WAC § 284-70-421(6).

10. No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service. Further, no health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier. WAC § 284-70-421(7).
11. PHARMACY shall make records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of Covered Persons subject to applicable state and federal laws related to the confidentiality of medical or health records; and will cooperate with audit reviews of encounter data in relation to the administration of risk adjustment and reinsurance programs. WAC § 284-170-421(8).
12. The parties shall provide at least 60 days' written notice to each other before terminating the Agreement without cause. WAC § 284-170-421(9).
13. PHARMACY shall provide services under the Agreement to Covered Persons without regard to the Covered Persons' enrollment in a plan as a private purchaser of a plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the PHARMACY should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. WAC § 284-170-421(11).
14. PBM will not penalize PHARMACY because PHARMACY, in good faith, reports to state or federal authorities any practice by a Plan Sponsor that jeopardizes the health or welfare of a Covered Person, or that may violate state or federal law. WAC § 284-70-421(12).
15. PHARMACY is entitled a fair dispute resolution mechanism. In addition to the dispute resolution process set forth in the Agreement, PHARMACY shall contact PBM at the address listed in the "Notice" provision of the Agreement for the procedures for processing and resolving disputes. WAC § 284-170-421(13). In all events, the following shall apply.

a. With respect to billing disputes, PBM shall render a decision within 60 days of receipt of a written complaint from PHARMACY. WAC § 284-170-440(5).

b. In all events, PHARMACY shall have not less than 30 days after the action giving rise to a dispute for PHARMACY to complain and initiate the dispute resolution process. WAC § 284-170-440(3).

16. Except as otherwise permitted in RCW § 48.46.243(2), in the event PBM or Plan Sponsor fails to pay for services as provided in the Agreement, the Covered Person shall not be liable to the PHARMACY for sums owed by PBM or Plan Sponsor. PHARMACY and its agents, trustees, or assignees may not maintain any action against a Covered Person to collect sums owed by PBM and/or Plan Sponsor. RCW § 48.46.243.

17. For amounts due PHARMACY under the Agreement:

    a. PHARMACY shall be paid in accordance with the following minimum standards:

        i. 95% of monthly volume of a Plan Sponsor's clean claims shall be paid within 30 days of receipt by PBM; and

        ii. 95% of the monthly volume of all of a Plan Sponsor's claims shall be paid or denied within 60 days of receipt by PBM, except as agreed to in writing by the parties on a claim-by-claim basis. WAC § 284-170-431(2)(a).

    b. The receipt date of a claim is the date PBM receives either written or electronic notice of the claim. PBM has established a reasonable method for confirming receipt of claims and responding to PHARMACY inquiries about claims via the online adjudication system and PHARMACY Help Desk. WAC §§ 284-170-431(b), (c).

    c. Plan Sponsor or PBM, as applicable, shall pay interest on undenied and unpaid clean claims more than 61 days old until Plan Sponsor or PBM, as applicable, meets the standards established in this section. Interest shall be assessed at the rate of 1% per month and shall be calculated monthly as simple interest prorated for any portion of a month. Interest shall be added to the amount of the unpaid claim without the necessity of the PHARMACY submitting an additional claim. Any interest paid under this section shall not be applied to a Covered Person's deductible, copayment, coinsurance, or any similar obligation of a Covered Person. WAC § 284-170-431(2)(d).

    d. A "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section. WAC § 284-170-431(3).

    e. Denial of a claim will be communicated to PHARMACY, including the specific reason why the claim was denied. If the denial is based upon medical necessity or similar

grounds, PBM or Plan Sponsor, as appropriate, will provide PHARMACY with the supporting basis for the decision. WAC § 284-170-431(4).

f. The standards set forth in this section do not apply to claims about which there is a substantial evidence of fraud or misrepresentation by PHARMACY or Covered Persons, or instances where PBM has not been granted reasonable access to information under the PHARMACY's control; or where failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute. WAC §§ 284-170-431(6), (7).

18. PHARMACY may make a pharmacy prior authorization request. If an authorization number is required to be transmitted on a claim for Covered Drugs, PBM shall provide the authorization number to PHARMACY after approval of the preauthorization request and upon receipt of a claim for that authorized medication. WAC § 284-170-470(5).

19. Emergency fills by PHARMACY will be authorized and the claim payment for the emergency fill will be approved when: (a) PHARMACY cannot reach the applicable prior authorization department (e.g., Plan Sponsor or PBM, as applicable) by phone because it is outside of that department's business hours; or (b) PHARMACY reaches the applicable prior authorization department, but the prescriber cannot be reached for full consultation. WAC § 284-170-470(7).

20. The provisions of Sections 18 and 19 shall not apply in the event of an act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute. WAC § 284-170-470(9).

21. To the extent permitted by the Agreement, in the event PHARMACY subcontracts with providers in connection with the Agreement, PHARMACY shall require that its subcontracts comply with the provisions set forth in this addendum. WAC § 284-170-401.

22. The audit of records by PBM shall be limited to Covered Persons and shall be limited to the extent necessary to perform the audit. To the extent required by law, PHARMACY shall have the right to audit denials of claims. WAC § 284-170-460.

12.50 West Virginia

WEST VIRGINIA ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICPATING PHARMACY AGREEMENT

This West Virginia Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, carriers, health maintenance organizations, hospital and medical

service corporations, and prepaid limited health service organizations under West Virginia law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY agrees as follows:

1. PHARMACY shall render to Covered Persons any service as it may be entitled to under the terms and conditions of the Benefit Plan and shall submit only such charges to PBM as are set forth in the fee schedule of the Agreement, and any related attachments. W.Va. Code § 33-24-7.
2. In the event Plan Sponsor or PBM fails to pay fees for services rendered to Covered Persons by PHARMACY, the Covered Persons shall not be liable to PHARMACY. PHARMACY shall not collect or attempt to collect from Covered Persons any money for Covered Drugs. Neither PHARMACY nor its representative may maintain any action at law against Covered Persons to collect money owed to PHARMACY by Plan Sponsor or PBM. This provision shall not be construed to apply to the amount of any deductible or copayment. W.Va. Code §§ 33-25A-7a, 33-25D-10.
3. PHARMACY shall provide 60 days' advance written notice to PBM and the West Virginia Commissioner of Insurance before canceling the Agreement for any reason. Nonpayment for goods or services rendered by PHARMACY to Covered Persons is not a valid reason for avoiding the sixty-day advance notice of cancellation. W.Va. Code §§ 33-25A-7a, 33-25D-10.
4. PBM shall adhere to the following standards in the processing and payment of claims:
    a. PBM shall either deny, pay, or require Plan Sponsor to pay a clean claim, as defined in W.Va. Code § 33-45-1, within 40 days of receipt if submitted manually or within 30 days if submitted electronically, except when: (a) another party is responsible for the claim; (b) PBM is coordinating benefits within another Plan Sponsor; (c) PHARMACY has already been paid for the claim; (d) the claim was submitted fraudulently; or (e) there was a material misrepresentation in the claim.
    b. PBM shall maintain a written or electronic record of the date of receipt of a claim. PHARMACY shall be entitled to inspect the record on request and to rely on that record or any other relevant evidence as proof of the fact of receipt of the claim. If PBM fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by PHARMACY.

c. Within 30 days after receipt of a claim, PBM shall request electronically or in writing from PHARMACY any information or documentation that PBM believes will be required to process and pay the claim or to determine if the claim is a clean claim. PBM shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within 15 days of receipt of the information from the first request, only seek or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested which PBM reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, PBM shall either deny, pay, or require Plan Sponsor to pay the claim within 30 days. PBM or Plan Sponsor may not refuse to pay a claim for Covered Drugs if PBM fails to timely notify PHARMACY within 30 days of receipt of the claim of the additional information requested unless such failure was caused in material part by PHARMACY. Provided, that nothing herein precludes PBM from imposing a retroactive denial of such claim where otherwise permitted by the Agreement unless such retroactive denial would violate subparagraph (h) of this paragraph 4.

d. Interest shall accrue at a rate of 10% per annum after the claims payment period set forth in subparagraph (a) above. At the time the claim is paid, or within 30 days thereafter, Plan Sponsor shall pay interest owing, without necessity of demand. The interest payment shall be accompanied by an explanation of the assessment on each claim of interest paid.

e. PBM shall establish and implement reasonable policies to permit PHARMACY to promptly confirm in advance during normal business hours whether the health care services to be provided are Covered Drugs and to determine requirements applicable to PHARMACY for: (i) precertification or authorization of coverage decisions; (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (iii) specific payment and reimbursement methodology; and (iv) claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a clean claim.

f. PBM shall make available to PHARMACY within 20 business days of receipt of a request, reasonable access either electronically or otherwise, to all policies that are applicable to PHARMACY.

g. Plan Sponsor or PBM shall pay a clean claim if PBM or Plan Sponsor has previously authorized the services or has advised PHARMACY or the Covered Person in advance of the provision of the services that the services are Covered Drugs unless the

documentation for the claim provided by PHARMACY clearly fails to support the claim as originally authorized or unless the refusal is because:

i. Another party is responsible for the payment;

ii. PHARMACY has already been paid for the services;

iii. The claim was submitted fraudulently, or the authorization was based in whole or material part on erroneous information provided to PBM or Plan Sponsor by PHARMACY or another person not related to PBM or Plan Sponsor;

iv. The person receiving the services was not a Covered Person on the date of service and neither PBM nor Plan Sponsor knew or with the exercise of reasonable care could have known, of the person's eligibility status;

v. There is a dispute regarding the amount of charges submitted; or

vi. The services were not Covered Drugs and neither PBM nor Plan Sponsor knew or with the exercise of reasonable care could have known, at the time of the certification that the services were not covered.

h. A previously paid claim may be retroactively denied only if:

i. The claim was submitted fraudulently;

ii. The claim contained material misrepresentations;

iii. The claim payment was incorrect because PHARMACY was already paid on the claim or the services were not delivered by PHARMACY; or

iv. PHARMACY was not entitled to reimbursement;

v. The service was not a Covered Drug; or

vi. The person to whom the service was rendered was not a Covered Person.

i. Upon receipt of notice of a retroactive denial, PHARMACY shall notify PBM within 40 days of its intent to pay or demand written explanation of the reasons for the denial.

j. Upon receipt of explanation for retroactive denial, PHARMACY shall reimburse PBM within 30 days for allowing an offset against future payments or provide written notice of dispute.

k. Disputes shall be resolved between the parties within 30 days of receipt of notice of dispute.

l. Upon resolution of dispute, PHARMACY shall pay any amount due or provide written authorization for an offset against future payments.

m. PBM may retroactively deny a claim for the reasons set forth in section subparagraph (h)(iii)-(vi) above within one year from the date the claim was originally paid. There

shall be no time limit for retroactively denying a claim for the reasons set forth in subparagraph (h)(i)-(ii) above.

n. PHARMACY acknowledges that at the time the Agreement was presented to PHARMACY for execution it included or was accompanied by (i) a fee schedule, reimbursement policy, and statement as to the manner in which claims will be calculated and paid and the range of services reasonably expected to be delivered by PHARMACY; and (ii) all referenced addenda, schedules, and exhibits.

o. An amendment to the Agreement that relates to payment or the delivery of care by PHARMACY shall not be effective as to PHARMACY unless PHARMACY has been provided with the proposed amendment and has failed to notify PBM within 20 business days of receipt of PHARMACY's intent to terminate the Agreement at the earliest date thereafter permitted under the Agreement.

p. PBM shall complete its initial credentialing process and accept or reject PHARMACY within four months after submission of PHARMACY's completed application. This time frame may be extended for an additional three months because of delays in primary source verification. PBM shall make available to PHARMACY a list of all information required to be included in the application. If PHARMACY is permitted by PBM to provide services during the credentialing period, PHARMACY shall be paid for the services pursuant to the terms and conditions of the Agreement if PHARMACY's application is approved.

q. If provision of any policy required to be provided by PBM to PHARMACY under this Section 4 would violate any applicable copyright law, PBM may instead provide a clear explanation of the policy as it applies to PHARMACY.

r. PBM and Plan Sponsor shall not be violation of any requirement of this Section 4 if its failure to comply is cause in material part by PHARMACY or if PBM's or Plan Sponsor's compliance is rendered impossible due to matters beyond its control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by PBM or Plan Sponsor.

W.Va. Code § 33-45-2.

5. PHARMACY agrees to participate in and adhere to all quality improvement activities of PBM or Plan Sponsor and will allow PBM and Plan Sponsor access to PHARMACY records as required by law. W.Va. Admin. Code § 114-53-5(5.4).

6. PBM and Plan Sponsor allow open PHARMACY-Covered Person communication regarding appropriate treatment alternatives and will not penalize PHARMACY for discussion of medically necessary or appropriate care for Covered Persons. W.Va. Admin. Code § 114-53-5(5.4).

7. Notwithstanding anything to the contrary in the Agreement, to the extent PHARMACY provides Covered Drugs to Covered Persons of a discount medical plan organization under West Virginia law, the Agreement shall contain: (1) PBM's requirements concerning the services and products to be provided by PHARMACY at a discount; and (2) PHARMACY's applicable discounted rates. PHARMACY agrees that PHARMACY will not charge Covered Persons more than the discounted rates. W.Va. Code §§ 33-15E-10, 33-15E-13.

12.51 Wisconsin

WISCONSIN ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Wisconsin Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of a limited-service health organization, preferred provider plan, defined network plan, health maintenance organization, or insurer licensed under Wisconsin law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. If PHARMACY's participation under the Agreement terminates for reasons other than misconduct on the part of PHARMACY or PHARMACY's cessation of practice in the applicable geographic service area, PHARMACY agrees to continue to provide care to Covered Persons undergoing a course of treatment for the shorter of the following time periods:
    a. For the remainder of the course of treatment or for 90 days after PHARMACY's participation under the Agreement terminates, whichever is shorter; or
    b. If the Covered Person is a woman in the 2nd or 3rd trimester of pregnancy when PHARMACY's participation under the Agreement terminates, until the completion of postpartum care for the woman and infant.

    Wis. Stat. Ann. § 609.24(1)(c).

    PHARMACY agrees to accept as reimbursement for services provided under this continuity of care provision the contracted rate set forth in the Agreement. Wis. Stat. Ann. § 609.24(1)(d)(2).

    When providing services under this continuity of care provision, PHARMACY shall be subject to the hold harmless requirements of Wis. Stat. Ann. § 609.91. Wis. Stat. Ann. § 609.24(3).

PHARMACY shall post a notification of termination and of Covered Persons' rights to continuity of care under Wis. Stat. Ann. § 609.24 in each of its pharmacies subject to the Agreement the greater of 30 days prior to the termination or 15 days following PBM's receipt of PHARMACY's termination notice. Wis. Stat. Ann. § 609.24(4); Wis. Admin. Code Ins. § 9.35(1m).

2. PHARMACY acknowledges that attached hereto as "Appendix 1" is a summary notice of the statutory limitations and requirements of the hold-harmless provisions of Wis. Stat. Ann. §§ 609.91 to 609.935 and 609.97(1) to which PHARMACY agrees to adhere. Wis. Stat. Ann. § 609.94.

3. The following shall apply with respect to PBM's MAC Lists:

   a. PBM will update pricing information on its MAC Lists at least every 7 business days.

   b. Instructions for accessing PBM's MAC Lists are available to PHARMACY by going to https://magellanrx.com/provider/landing or by emailing MACAppeals@primetherapeutics.com.

   c. PBM will eliminate prescribed drugs or devices from the MAC List or modify MAC in a timely fashion consistent with availability of prescribed drugs or devices and pricing changes in the marketplace.

   d. PHARMACY locations in Wisconsin subject to PBM's MAC Lists may appeal reimbursement for a drug subject to MAC pricing within 21 days of the PHARMACY submitting the claim for which the appeal is being requested. PHARMACY may call (800) 441-6001 to speak to an individual who is responsible for processing appeals. PBM will investigate and resolve any such appeal within 21 days of receipt.

   e. If the appeal is denied, PBM will provide the challenging PHARMACY with the reason for the denial and the national drug code of a drug that may be purchased by retail network pharmacies at a price at or below the MAC price.

   f. PBM will make a pricing adjustment no later than 1 day after the date of the final determination of the appeal.

   g. This Section 3 applies only with respect to MAC Lists owned and/or controlled by PBM.

Wis. Stat. Ann. § 632.865 (2).

APPENDIX "1"

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat. requires each health maintenance organization insurer ("HMO insurer"), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stat.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in." An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS.

An enrollee of an HMO insurer is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO insurer board members who directly or indirectly represent one or more IPAs or affiliates of IPAs.

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.
3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.
4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.
5. The care is required to be provided under the requirements of s. Ins. 9.35 Wis. Adm. Code.

B. "OPT-OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.
2. A physician service, or other provider services, equipment, supplies, or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.
3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).
2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.

3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.
4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.
5. Failure by the HMO insurer to provide notice to providers of the statutory hold-harmless provisions.
6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within 30 days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.
2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least 60 day before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.
3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.
4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.
5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the HMO insurer, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P. O. Box 7873, Madison, WI 53707-7873

HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.

Source: WISCONSIN ADMINISTRATIVE CODE

COMMISSIONER OF INSURANCE

CHAPTER INS 9. DEFINED NETWORK PLANS

SUBCHAPTER III. MARKET CONDUCT STANDARDS FOR DEFINED NETWORKPLANS, PREFERRED PROVIDER PLANS AND LLIMITED SERVICE HEALTH ORGANIZATIONS

APPENDIX C NOTICE

2013 WI ADC Ch. Ins. 9, effective 2-28-2013

12.52 Wyoming

WYOMING ADDENDUM
TO
MAGELLAN PHARMACY SOLUTIONS
PARTICIPATING PHARMACY AGREEMENT

This Wyoming Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Wyoming law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, PHARMACY agrees as follows:

1. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Wyoming law, PHARMACY agrees:
    a. In the event Plan Sponsor fails to pay for Covered Drugs as set forth in the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by Plan Sponsor. PHARMACY shall not collect or attempt to collect from Covered Persons sums owed by Plan Sponsor. PHARMACY and its agents, trustees, or assignees shall not maintain an action at law against Covered Persons to collect sums owed by Plan Sponsor. Wyo. Stat. Ann § 26-34-114(o), (q).
    b. In the event of Plan Sponsor's insolvency, PHARMACY agrees to continue to provide Covered Drugs to Covered Persons after Plan Sponsor's insolvency during the period for which premium payment has been made and until Covered Persons' discharge from inpatient facilities. Wyo. Stat. Ann. § 26-34-114(r)(ii).
    c. Notwithstanding anything in the Agreement to the contrary, PHARMACY shall give PBM at least 60 days advance notice prior to termination of the Agreement. Wyo. Stat. Ann. § 26-34-114(s).

13.0 Appendix D: Magellan Rx Management (MRx) Account

Within this section, you will find specific URLs and information to Magellan Rx Management account.

URL: https://magellanrx.com/provider/landing

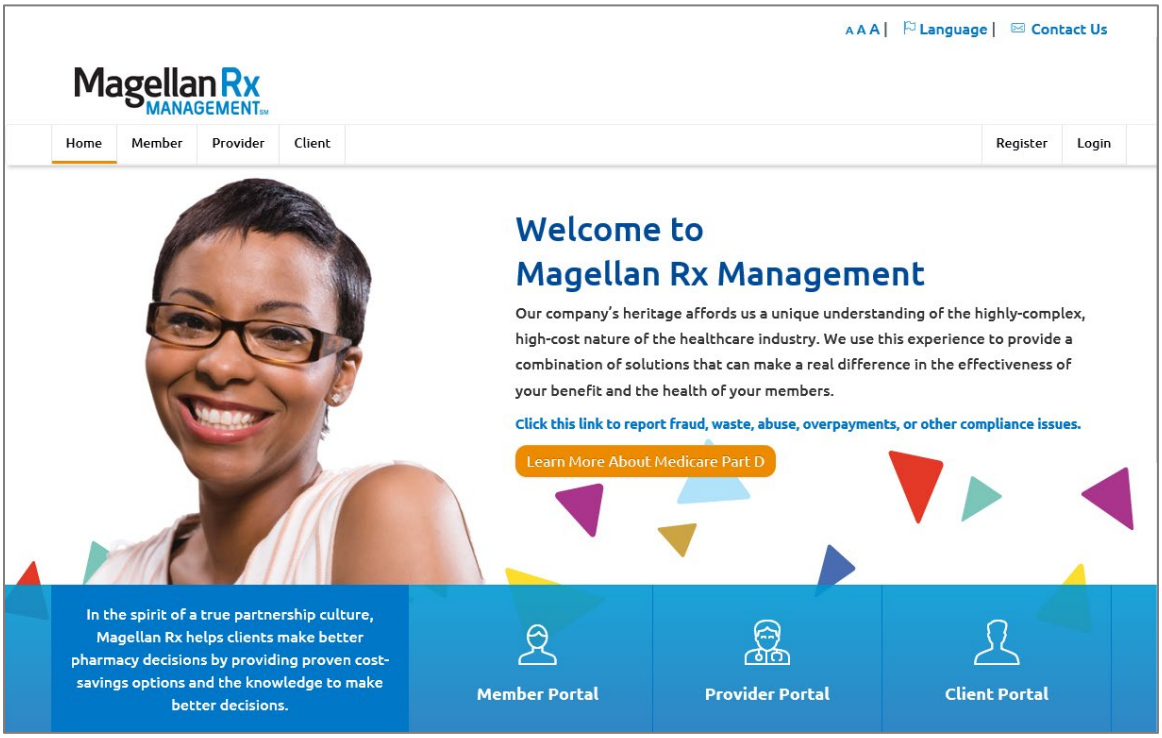

Figure 14.0.1 Magellan Rx Management Account Portal

13.1 Pharmacy Application and Agreement and Pharmacy Disclosure Form

URL: https://magellanrx.com/provider/landing

Return the completed form to PBM to the following address:

Magellan Pharmacy Solutions
11013 West Broad Street
Suite 500
Glen Allen, VA 23060-5939
ATTN: Vice President Pharmacy Network Development
COPY TO: General Counsel

Please refer to Section 2.1.1 – Pharmacy Network Application and Disclosure Process *and* Section 2.1.1.1 – Instructions for Completing the Pharmacy Disclosure Form for more information.

13.2 Website Pharmacy Portal

URL: https://magellanrx.com/provider/landing

For more information about the purpose of the pharmacy portal, please refer to Section 3.2 – MRX Website Pharmacy Portal.

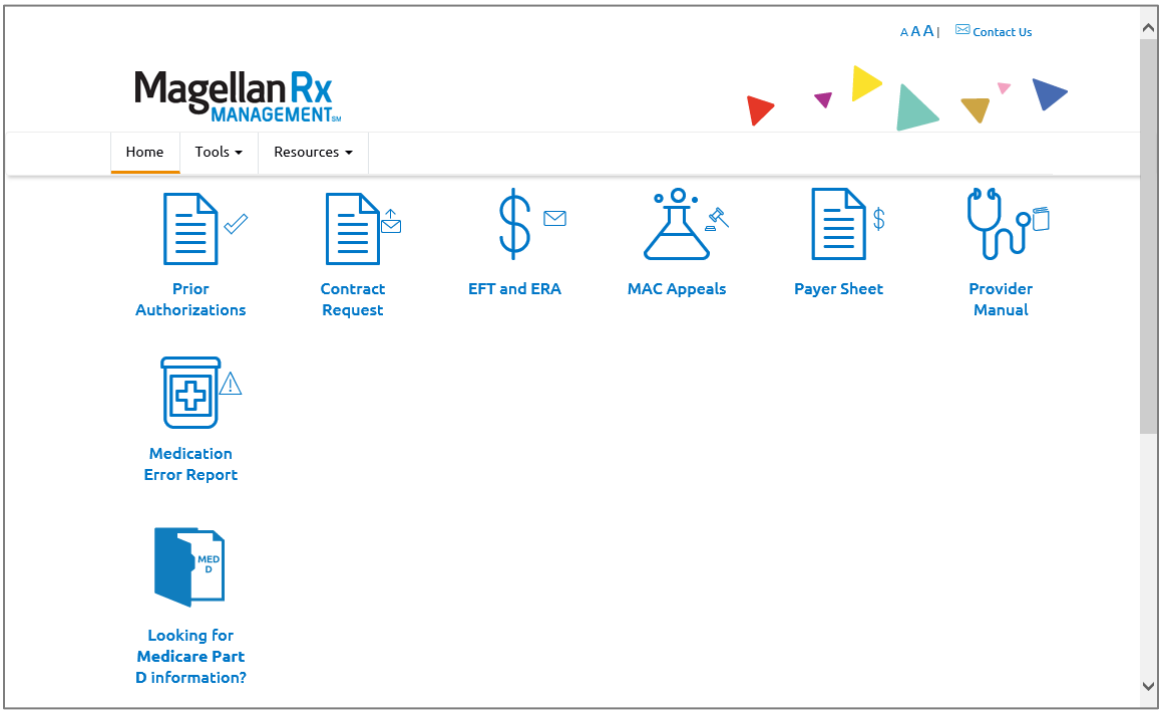

Figure 14.2.1 – Website Pharmacy Portal

13.3 Pharmacy Support Center

1-800-424-8009 (Nationwide Toll-Free Number); option 4, option 2, then option 3 for Pharmacy

For more information about the Pharmacy Support Center, please refer to Section 4.1 – Pharmacy Support Center.

13.4 Clinical Support Center

1-800-424-8009 (Nationwide Toll-Free Number); option 4, option 2, then option 2 for Prescriber

1-888-272-1349 (Fax)

For more information about the Clinical Support Center, please refer to Section 4.2 – Clinical Support Center.

13.5 Web Support

1-800-424-8009 (Nationwide Toll-Free Number); option 3

For more information about the Web Support, please refer to Section 4.3 – Web Support Call Center.

13.6 Universal Claim Form

Please return the completed form to the following address:

Magellan Pharmacy Solutions
Attn: Paper Claims Department
Post Office Box 85042
Richmond, VA 23261-5042

For more information about submitting paper pharmacy claims, please refer to Section 5.3 – Paper Claims or visit http://www.ncpdp.org/products.aspx.

13.7 Request a Contract for Extended Days' Supply Participation

URL: https://magellanrx.com/provider/landing

For more information about days' supply, please refer to Section 8.3.1 – Days' Supply.

13.8 Pharmacy Contracts for Provider Reimbursement Rates

URL: https://magellanrx.com/provider/contractrequest

Please refer to your signed pharmacy agreement or contact the MRx Pharmacy Networks Department at ProviderRelations@primetherapeutics.com.

For more information about provider reimbursement rates, please refer to Section 8.4.1 – Provider Reimbursement Rates.

13.9 Complete List of PA Criteria, Step Therapy Requirements, Quantity Limits, and Duration of Edits

URL: https://magellanrx.com/provider/landing

For more information, please refer to Section 8.6.3 – Preferred Drug List (PDL)/PA/ Quantity/Duration Lists.

13.10 Payer Specification Document

URL: https://magellanrx.com/provider/documents

For more information, please refer to Section 8.11 – Partial Fills, Section 9.1.1 – COB Process, and Section 10.0 – Appendix A – Plan D.0 Payer Specification.

13.11 Contact Information

Please use the contact information below for the MRx client:

Contact/Topic	Contact Numbers	Mailing, Email, and Web Addresses	Purpose/Comments
MRx Services Pharmacy Support Center 24/7/365	800-424-8009; option 4, option 2, then option 3 for Pharmacy		Pharmacy calls for: • ProDUR questions • Non-clinical PA and early refills • Questions regarding Payer Specifications, etc.
MRx Services Clinical Support Center (Prior Authorizations) 24/7/365	800-424-8009; option 4, option 2, then option 2 for Prescriber		Prescriber calls for PA requests and questions
Web Support Center 8:00 a.m. – 8:00 p.m., ET, Monday–Friday	800-424-8009; option 3		Pharmacy calls for: • Assistance with UAC, WebRA, and WebPA; • Password management; • Navigation.
MRx Network Services Department 9:00 a.m. – 6:30 p.m., ET, Monday-Friday Contacts:	800-441-6001 Option 1	ProviderRelations@primetherapeutics.com	Pharmacy Network Relations Issues • Contractual requests, questions, or issues • Network communications questions / clarifications • Secondary issue resolution if not provided by the Pharmacy Support Center
MRx Services Member Support Center 24/7/365	800-424-8009; option 4, option 2, then option 1		
FTP	800-924-6741		NCPDP Batch 1.2

14.0 Appendix E: Community Care Plan (CCP)

Within this section, you will find specific URLs and information to the Community Care Plan (CCP) Network.

URL: http://ccpcares.magellanrx.com

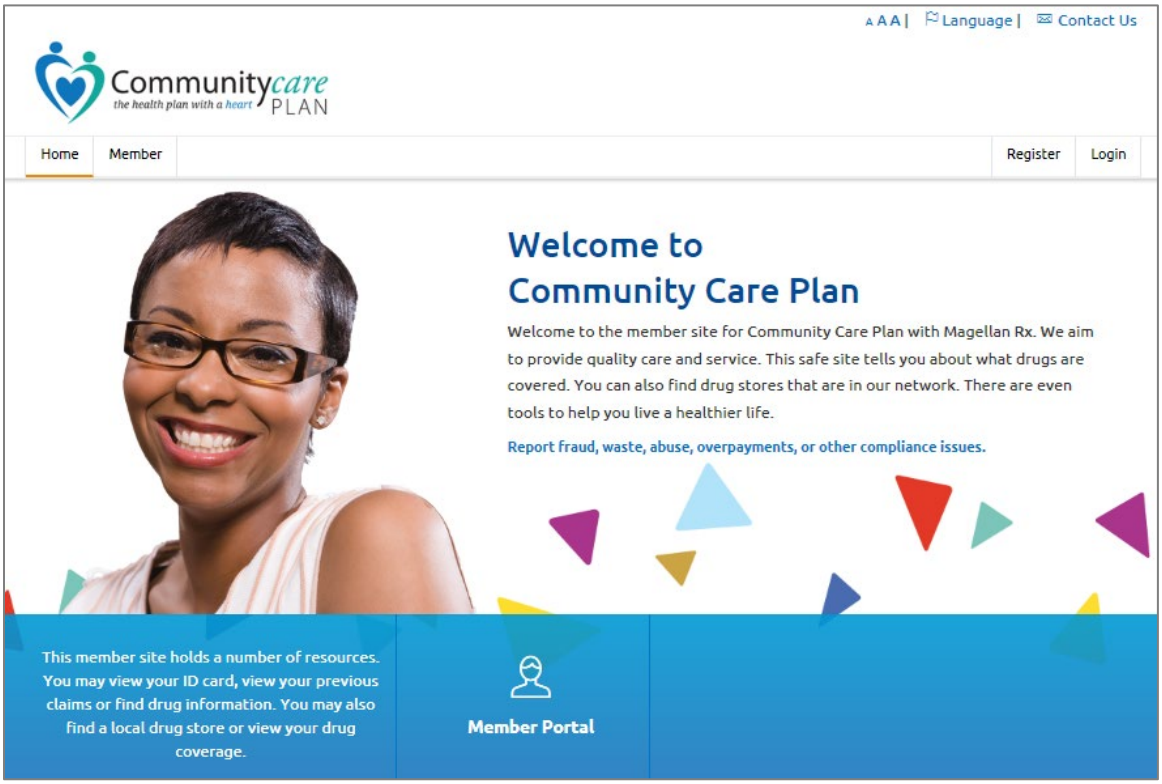

Figure 16.0.1 – Website Pharmacy Portal, Community Care Plan

14.1 Pharmacy Application and Agreement and Pharmacy Disclosure Form

URL: https://ccpcares.magellanrx.com/contact

Return the completed form to PBM to the following address:

Magellan Pharmacy Solutions
11013 West Broad Street
Suite 500
Glen Allen, VA 23060-5939
ATTN: Vice President Pharmacy Network Development
COPY TO: General Counsel

Please refer to Section 2.1.1 – Pharmacy Network Application and Disclosure Process *and* Section 2.1.1.1 – Instructions for Completing the Pharmacy Disclosure Form for more information.

14.2 Website Pharmacy Portal

For more information about the purpose of the pharmacy portal, please refer to Section 3.2 – MRx Website Pharmacy Portal.

14.3 Pharmacy Support Center

1-800-424-7897 (Nationwide Toll-Free Number); option 3 for Pharmacy

For more information about the Pharmacy Support Center, please refer to Section 4.1 – Pharmacy Support Center.

14.4 Clinical Support Center

1-800-424-7897 (Nationwide Toll-Free Number); option 2 for Prescriber

1-800-424-7913 (Fax)

For more information about the Clinical Support Center, please refer to Section 4.2 – Clinical Support Call Center.

14.5 Web Support

1-800-424-7897 (Nationwide Toll-Free Number); option 4

For more information about the Web Support, please refer to Section 4.3 – Web Support Call Center.

14.6 Universal Claim Form

Please return the completed form to the following address:

Magellan Pharmacy Solutions
Attn: Paper Claims Department
Post Office Box 85042
Richmond, VA 23261-5042

For more information about submitting paper pharmacy claims, please refer to Section 5.3 – Paper Claims or visit http://www.ncpdp.org/products.aspx.

14.7 Request a Contract for Extended Days' Supply Participation

URL: https://ccpcares.magellanrx.com/contact

For more information about days' supply, please refer to Section 8.3.1 – Days' Supply.

14.8 Pharmacy Contracts for Provider Reimbursement Rates

URL: https://ccpcares.magellanrx.com/contact

Please refer to your signed pharmacy agreement or contact the Magellan Pharmacy Networks Department at ProviderRelations@primetherapeutics.com.

For more information about provider reimbursement rates, please refer to Section 8.4.1 – Provider Reimbursement Rates.

14.9 Complete List of PA Criteria, Step Therapy Requirements, Quantity Limits, and Duration of Edits

URL: https://ccpcares.magellanrx.com/contact

For more information, please refer to Section 8.6.3 – Preferred Drug List (PDL)/PA/ Quantity/Duration Lists.

14.10 Payer Specification Document

URL: https://ccpcares.magellanrx.com/contact

For more information, please refer to Section 8.11 – Partial Fills, Section 9.1.1 – COB Process, and Section 10.0 – Appendix A: Plan D.0 Payer Specification.

14.11 Contact Information

Please use the contact information below for the **Community Care Plan (CCP)** client:

Contact/Topic	Contact Numbers	Mailing, Email, and Web Addresses	Purpose/Comments
MRx Pharmacy Solutions Pharmacy Support Center 24/7/365	800-424-7897 Option 3		Pharmacy calls for: • ProDUR questions • Non-clinical PA and early refills • Questions regarding Payer Specifications, etc.
MRx Pharmacy Solutions Clinical Support Center (Prior Authorizations) 24/7/365	800-424-7897 Option 2		Prescriber calls for PA requests and questions

Contact/Topic	Contact Numbers	Mailing, Email, and Web Addresses	Purpose/Comments
Web Support Center 8:00 a.m. – 8:00 p.m., ET, Monday–Friday	800-424-7897 Option 4		Pharmacy calls for • Assistance with UAC, WebRA, and WebPA; • Password management; and • Navigation.
MRx Pharmacy Solutions Network Services Department 9:00 a.m. – 6:30 p.m., ET, Monday-Friday	800-441-6001 Option 1	ProviderRelations@primetherapeutics.com	Pharmacy Network Relations Issues • Contract requests, questions, or issues • Network communications questions / clarifications • Secondary issue resolution if not provided by the Pharmacy Support Center
MRx Pharmacy Solutions Member Support Center 24/7/365	800-424-7897 option 1		
Member Appeals 7:00 a.m. – 7:00 p.m., ET	800-424-7914 option 2		
FTP	800-924-6741		NCPDP Batch 1.2

Address	Format
Paper Claims Billing Address: Community Care Plan c/o Magellan Pharmacy Solutions Attn: Paper Claims Department P.O. Box 85042 Richmond, VA 23261-5042	CMS 1500

15.0 Appendix F: Medicare Part D Network

15.1 Services

The terms in this section of the *Magellan Rx Management Provider Manual* shall apply to any Pharmacy (including retail, long-term care, home infusion, and Indian Health Service/Tribal/Urban pharmacies) that provides Medicare Part D services to members whose Medicare Part D benefits are administered by Magellan Rx Management ("MRx").

15.2 Claim Processing

MRx will accept electronically submitted pharmacy transactions in the NCPDP standardized version D.0; lower versions will not be accepted. After submission, MRx will respond, using the same electronic standard, to the Pharmacy with information regarding member eligibility, the applicable co-pay amount, applicable ProDUR messages, and applicable reject messages. ProDUR messages will be returned in the DUR response fields. Other important related information will appear in the free-form message area.

15.2.1 Prescription Origin Code

Pharmacy shall use the Prescription Origin Code for all Medicare Part D claim submissions. The Prescription Origin Code should be placed in the 419-DJ field using the following values:

1 – Written

2 – Telephone

3 – Electronic – used when prescription obtained via SCRIPT or HL7 Standard transactions

4 – Facsimile

5 – Pharmacy

The value of zero will be rejected for a NEW Rx number for Part D claims and is likely to be rejected on refills as well. Pharmacy generated new Rx numbers (store to store transfer within a chain, etc.) are expected to be identified with code 5.

15.2.2 Pharmacy/Prescriber Participation

Pharmacies and prescribers must submit and have valid/active National Provider Identifier (NPI) numbers. Pharmacy must submit accurate prescriber NPI's and are required to retain hard copies of any controlled substance prescriptions in accordance with state and federal law. Any claims submitted to MRx without a genuine NPI or DEA are subject to audit and/or recoupment. Pharmacies are only permitted to submit claims for individual [Type 1] prescribers: organizational NPIs [Type 2] will not be accepted.

15.2.3 Electronic Prescribing

Pharmacy will support and comply with applicable electronic prescription standards developed or adopted by the Centers for Medicare & Medicaid Services (CMS). Pharmacy must use the NCPDP SCRIPT Standard and implementation guidance as specified by CMS. Please refer to http://www.cms.hhs.gov/EPrescribing/ for additional information or Chapter 7 of the Medicare Part D Prescription Drug Manual https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/chapter7.pdf.

15.3 Compliance with Legal Regulations

The Pharmacy must comply with all applicable laws and regulations, including all Medicare Laws, and minimum standards for pharmacy practice established by the states. Pharmacy will provide services in a manner consistent with the Part D Sponsor's contractual commitments to CMS.

The Pharmacy will establish and maintain an effective compliance program in accordance with CMS requirements. Without limiting the generality of the foregoing, Pharmacy will (a) establish, maintain, and distribute written policies, procedures, and a code/standards of conduct that demonstrate the Pharmacy's commitment to comply with all applicable laws (or establish, maintain, and distribute those supplied by PBM), (b) require all Medicare Workers to undergo all necessary compliance and fraud, waste, and abuse (FWA) training within ninety (90) days of hire and annually thereafter, (c) have effective lines of communication relating to, and promptly report to PBM, any actual or suspected noncompliance with Medicare Laws or other laws that relate to the delivery or administration of services to Part D Members, including but not limited to the charging of an incorrect Cost Share, failure to provide required notices to Part D Members, or any act of fraud, waste, or abuse, (d) take appropriate disciplinary actions against Medicare Workers and others for noncompliant or unethical behavior, and (e) cooperate with PBM regarding any necessary corrective actions for the remediation of any noncompliance.

Pharmacy will ensure that no Medicare Worker is excluded or otherwise ineligible to participate in federal healthcare programs. Prior to hiring of any Medicare Worker, Pharmacy will report any issue of actual or suspected noncompliance or FWA to MRx's Medicare Special Investigations Unit (SIU) at fraudtiphotline@primetherapeutics.com.

15.3.1 Fraud, Waste, and Abuse (FWA) Integrity Program

Pharmacy agrees to follow the requirements defined in the CMS Prescription Drug Benefit Manual, Chapter 9 (FWA). This includes the development of written fraud, waste, and abuse training policies, procedures, and creates corrective action plans (CAPS). Training must occur, be available on demand, and be tracked, within the first month of employment and then annually.

15.3.2 Reporting Fraud, Waste, and Abuse

The Pharmacy shall report any suspicion or knowledge of fraud and/or abuse to MRx Medicare Special Investigations Unit (SIU) at fraudtiphotline@primetherapeutics.com**.**

15.4 Pharmacy Help Desk

The MRx Contact Center is available 24/7 to answer Medicare Part D plan-specific calls. Dedicated phone numbers are published on client-specific notifications that are distributed prior to implementation and are also available on the MRx Medicare Provider Portal. Our language line can translate over 200 languages (e.g., French, Spanish, Hopi, and Arabic).

15.4.1 CMS Part D Guidance for Pharmacies

The following web site contains useful information on many different Medicare Part D subjects: http://www.cms.gov/Medicare/Medicare.html.

15.4.2 RxBIN/RxPCN/RxGRP Requirements – Medicare Part D

CMS requires unique RxBIN/RxPCN/RxGRP codes in order to identify Medicare Part D Plans.

15.5 Eligibility Validation

Pharmacies should accept Part D member acknowledgement letters in place of their identification card. If Pharmacy is unable to confirm member is eligible, they may contact the MRx Contact Center (dedicated phone numbers are published on client-specific notifications), CMS at 1-800-Medicare, or submit enhanced E1 transaction to obtain the processing information needed.

15.6 Low Income Subsidy (LIS) Change in Status

The Social Security Administration (SSA) and CMS determination whether members who qualify for LIS in a current plan year will continue to qualify in the upcoming plan year (e.g., member qualified in 2015, may or may not qualify in 2016). Members who no longer qualify for LIS will receive a letter from CMS with an explanation and an application to reapply if member feels they still qualify. Members who do qualify for LIS in the upcoming plan year will also be notified by CMS and may experience a change in copay amount. MRx encourages Pharmacies to assist Part D members by (a) helping them submit LICS/LIS application or, (b) referring the Part D member to the Social Security Administration at 1-800-772-1213 or http://www.ssa.gov/medicareoutreach2/index.htm.

15.7 Disaster Declaration

Submission Clarification Code 13 must be used in addition to the following override codes in the Prior Authorization Number Submitted Field (462-EV):

Override Reason	Override Code
Refill Too Soon	911ØØØØØØØ1
Prior Authorization Requirement	911ØØØØØØØ2
Accumulated Quantity	911ØØØØØØØ3
Step Therapy	911ØØØØØØØ4
Value to remove restriction for refill limit, Prior Authorization, Refill Too Soon, Accumulated Quantity and Step Therapy	911ØØØØØØØ5

15.8 Best Available Evidence (BAE)

MRx accepts any of the following forms of evidence to establish the subsidy status of a full benefit dual eligible member when provided by the member or the member's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary:

1. A copy of a member's Medicaid card which includes the member's name and the eligibility date;
2. A copy of a State document that confirms active Medicaid;
3. A printout from the State electronic enrollment file showing Medicaid status;
4. A screen print from the State's Medicaid systems showing Medicaid status;
5. Other documentation provided by the State showing Medicaid status;
6. A letter from the SSA showing that the individual receives Supplement Security Income (SSI) or, an application filed by the deemed eligible individual confirming that the beneficiary is "…automatically eligible for extra help…;" or
7. For individuals who are not deemed eligible but who apply and are found LIS eligible, a copy of the SSA award letter.

MRx accepts any one of the following forms of evidence from members or pharmacists to establish that a member is institutionalized, or a member is receiving home and community-based services Home and Community Based Services (HCBS) and qualifies for zero cost-sharing:

1. A remittance from a long-term care facility showing Medicaid payment for a full calendar month for the member;

2. A copy of a State document that confirms Medicaid payment to a long-term care facility for a full calendar month on behalf of the member;
3. A screen print from Medicaid showing the member's institutional status based on at least a full calendar month stay for Medicaid payment purposes;
4. A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the members name and HCBS eligibility date;
5. A State-approved HCBS plan that includes the member's name and effective date;
6. A State-issued prior authorization approval letter for HCBS that includes the member's name and effective date;
7. Other documentation provided by the State showing HCBS eligibility status; or
8. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the member's name and the dates of HCBS.

Each item listed above must show that the member was eligible for Medicaid or State Medicaid coverage during the month after June of the previous calendar year.

1. If the CMS approved listing for forms of evidence listed in Standard IV. are not provided, the BAE request cannot be processed, and MRx follows the procedures outlined in Standard XI. below to submit the informational inquiry to CMS.
2. If the evidence provided is old and the LIS coverage has been terminated by CMS, the BAE request cannot be processed. MRx outreaches to the member to explain that the documentation is not current and how to go to their local SSA office or state Medicaid office to apply for LIS benefits.
3. If the LIS level matches the BAE provided, MRx outreaches to the member to explain the benefits and cost sharing under their current LIS level.
4. Any outreach is clearly documented in the member record and retained in the membership or customer call center system.

15.9 Medicare Part D Claims Adjustment

If MRx identifies any claims processed in error for Medicare Part D members due to a change or error in eligibility, overpayment may be deducted from future disbursement to the Pharmacy, as permitted under applicable law.

15.10 General Medicare Part D Submission Requirements for COB

If Part D coverage is primary for member, use the RxBIN/RxPCN/RxGRP combination provided in the Payer Sheet. For supplemental coverage, please have member provide details of secondary coverage (e.g., member identification card).

15.11 Emergency Overrides

Should a federal or state issued emergency be declared, MRx will accept overrides of refill too soon edits. Member may need to fill a prescription at an out-of-network pharmacy. If plan benefit allows, the member may be required to submit a paper claim to be processed.

15.12 Marketing

Pharmacy shall not create or distribute any MRx Plan specific information with the express permission of MRx and/or its client(s).

15.13 Tamper Resistant Pads

CMS requires that tamper resistance prescription pads be used for all written claims in order to be eligible for reimbursement. The definition of tamper resistant is defined on the CMS website and includes meeting all the following industry recognized requirements: Using one or more features to prevent copying / replication; using one or more features to prevent erasure or modification and also have features to prevent the usage of counterfeit prescription forms.

15.14 Medication Error Reporting

Pharmacies must notify MRx within 24 hours of a medication error being identified. A medication error includes near misses where the error was caught before the medication(s) were dispensed to the member. Medication error reports must describe the error along with any corrective action steps taken, and can be reported to the MRx Contact Center, fax, mail, or email. The MRx Medication Error Report form can be accessed online at: https://magellanrx.com/provider/mederror.

In addition, MRx encourages Pharmacies to educate themselves on how to use the Food and Drug Administration (FDA) MedWatch reporting mechanisms to report adverse events, issues with products, or product use error. Pharmacies and members can report adverse events and product problems to MedWatch by calling 1-800-FDA-1088, by submitting the MedWatch 3500 form by mail or fax, or by going online to the FDA webpage. Additional information, including MedWatch forms, can be found at http://www.fda.gov/Safety/MedWatch/.

15.15 Formulary Transition Fill Process

MRx maintains a medication transition process consistent with CMS requirements for members whose current prescribed Part D drugs are not on MRx's formulary. A one-time/temporary fill for a medication for new members that may not be on the plan sponsor formulary (drug list) or a one time/temporary fill of a medication when it is restricted in some way. This fill is to allow the member and their doctor time to review the medication and the plan formulary and take the action necessary for future fills (i.e., move to a formulary drug or

obtain Coverage Determination to stay on the medication). Transition supplies are available to members whose current drug therapy may not be covered by the plan, or that are on the formulary but subject to prior authorization (PA), step therapy (ST), or quantity limit (QL) edits based on MRx's utilization management program. Transition supplies will allow members sufficient time to work with their medical provider to switch to a therapeutically appropriate formulary alternative or to request a coverage determination should the medication be medically necessary.

Transition Fill Condition	Description	Allowed TF Supply
Part D member who is newly enrolled in Plan	Includes, but not limited to: • Transition of a new Plan Beneficiary following the annual coordinated election or special enrollment period • Transition of newly eligible Medicare Beneficiaries from other coverage • Transition of Beneficiaries switching from one plan to another after start of contract year.	At least 30 cumulative days' supply within first 90 days of coverage in the new Plan
Some renewing Part D members across Plan contract years	• Renewing Part D Beneficiary impacted by negative formulary change across Plan contract years – has history of utilization of impacted drugs within 120 days from date of claim not TF • If Part D Beneficiary has not transitioned before beginning of new Plan benefit year	At least 30 cumulative days' supply within first 90 days of coverage in the new Plan
Part D members requesting exception and decision still pending	Part D member requesting exception and decision still pending by either end of TF period, or allowed TF days' supply exhausted	At least 30 cumulative dates supply within first 90 days of coverage in the new Plan, or contract year

15.15.1 Rejected Claims and Notice to Appeal

Where a transition fill is not accepted by MRx, a reject message of 569 will be transmitted. This message should trigger the Pharmacy to supply the required Medicare Prescription Drug Coverage and Your Rights (CMS-10147) directly to Part D beneficiary any time this reject occurs. This notice must be provided to Part D members when a prescription cannot be covered ("filled") under the Medicare Part D benefit at the point of sale (POS). The notice must be provided to the member if the Pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D. The notice instructs enrollees about their right to contact their Part D plan to request a coverage determination, including an exception.

15.16 Reject Messaging for Part B versus Part D Drug Coverage Determination

When a drug is rejected because it may be covered under Medicare Part B, a reject message with one or more of the following codes will be transmitted.

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
A5	Not covered under Part D law
A6	This medication may be covered under Part B and therefore cannot be covered under the Part D basic benefit for this beneficiary

This message should trigger the Pharmacy to supply the required Medicare Prescription Drug Coverage and Your Rights (CMS-10147) directly to Part D beneficiary any time this reject occurs. This notice must be provided to Part D members when a prescription cannot be covered ("filled") under the Medicare Part D benefit at the point of sale (POS). The notice must be provided to the member if the Pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D. The notice instructs enrollees about their right to contact their Part D plan to request a coverage determination, including an exception.

15.17 End Stage Renal Disease (ESRD) Custom Reject Messaging

When a drug is rejected because it may be covered under the End Stage Renal Disease (ESRD) prospective payment system, CMS provided instruction to return a more specific reject message.

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A4	This product may be covered under Medicare B bundled payment to an ESRD Dialysis Facility

This message should trigger the Pharmacy to supply the required Medicare Prescription Drug Coverage and Your Rights (CMS-10147) directly to Part D beneficiary any time this reject occurs. This notice must be provided to Part D members when a prescription cannot be covered ("filled") under the Medicare Part D benefit at the point of sale (POS). The notice must be provided to the member if the Pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D. The notice instructs enrollees about their right to contact their Part D plan to request a coverage determination, including an exception.

15.18 Long Term Care Pharmacy Providers

The information to follow applies to Pharmacies participating in the MRx LTC Medicare Part D network.

15.18.1 Claim Types

To receive accurate reimbursement, Pharmacy must submit the appropriate long-term care claim types.

Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) must be submitted to reimburse Pharmacy the appropriate network rate.

MRx Claim Type	Pharmacy Service Type	Patient Residence
Retail	1	1
Home Infusion	3	1
Long-Term Care	5	3
Assisted Living Facility (ALF)	5	4

15.18.2 LTC Override Requests – Short Cycle / Emergency Supply

NCPDP CODE	VALUE	CIRCUMSTANCE	PERMITTED
Submission clarification Code 420-DK	16	Emergency Box/Dose	5-day supply
Submission clarification Code 420-DK	17	First Fill Following Emergency Box/Dose	Written RX Less E.R. Box Dose given
Submission clarification Code 420-DK	14 (use value 3 for ALF)	Leave of Absence Vacation Supply	5-day supply
Submission clarification Code 420-DK	18	LTC Admission/ Level of Care Change	30 Days' Supply with multiple fills within 30 days of admission or change of care

15.18.3 Serving Members in an LTC Setting

In the event a prescription cannot be covered (filled) under the Medicare Part D benefit and the issue cannot be resolved at the point-of-sale (POS), then the Pharmacy must work with the prescriber to resolve the issue. They must also ensure that a CMS-10147 Pharmacy Notice must be provided, and a copy placed in the members file maintained at the facility.

15.18.4 LTC Billing

Submission Clarification Codes (SCC):

NCPDP Field 420-DK

Code	Description
21	LTC dispensing 14 days or less not applicable – 14 days or less dispensing is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (ex. vacation, leave of absence, e-box, spit dose). Medication quantities are dispensed as billed.
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-day supplies
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-day supplies
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-day supplies
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-day supplies
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4 day, then 3-day supplies
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2 day, then 2 day, then 3-day supplies
29	LTC dispensing: Daily and 3-day weekend – Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekend.
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple and med passes)
31	LTC dispensing: Per med class dispensing – Remote dispensing per med pass
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-day supplies
35	LTC dispensing: 8-14 days dispensing not listed above – 8-14 day dispensing cycle not otherwise represented
36	LTC dispensing: Dispensed outside of short cycle. Claim was originally submitted to a payer other than Medicare Part D and was subsequently determined to be Part D.

Special Package Indicator:

NCPDP Field 429-DT

Code	Description
0	Not specified
1	Not Unit Dose – product is not being dispensed in special unit dose packaging

Code	Description
2	Manufacturer Unit Dose – a distinct dose as determined by the manufacturer
3	Pharmacy Unit Dose – when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose.
4	Pharmacy Unit Dose Patient Compliance Packaging – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly.
5	Pharmacy Multi-Drug Patient Compliance Packaging (Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration.
6	Remote device unit dose – drug is dispensed at the facility, via a remote device, in a unit of use package.
7	Remote device Multi-drug compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration.
8	Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only.

15.19 Maximum Allowable Cost (MAC)

15.19.1 MAC List Disputes (Appeal Process)

A pharmacy may submit a MAC pricing appeal via:

- Email at MACAppeals@primetherapeutics.com
- Fax at 877-823-6373. If a fax is sent, an email address is required so a response may be provided.
- Phone Monday through Friday 6:00 a.m. – 2:00 p.m. PST at 888-277-5510, Option 1
- Mail to: Attn: MAC Appeal, 2900 Ames Crossing Road, Eagan, MN 55121
- Forms for submission can be located at https://magellanrx.com/provider/macappeals
- MAC list will be available upon request and can be obtained by sending a request to MACAppeals@primetherapeutics.com.

*If the claim is hitting an Express Scripts contract between the pharmacy and Express Scripts, the appeal must be submitted via: prc.express-scripts.com

The following information must be provided to initiate the appeal process:

- A copy of the original invoice that contains the purchase price of the drug being appealed;
- Pharmacy NPI or NCPDP, member ID, Rx number, and date of fill;

- Generic drug name, and NDC number;
- Brief explanation as to the nature of the appeal.

The sources currently used to determine MAC pricing are Cardinal, Amerisource, and Anda wholesale price lists, and National Average Drug Acquisition Cost (NADAC) published by CMS. Medi-Span average wholesale pricing (AWP) is currently used to calculate MAC rates. Prime reserves the right to change any pricing source at any time.

Once a MAC pricing appeal is submitted, the MAC Pricing Specialist will investigate the claim and proceed based on the following situations:

- ALL submitted and verified MAC related appeals will receive an email confirmation that the appeal has been entered into the database and will be reviewed for a MAC pricing change within 7 business days, unless another time period for review is specified by applicable law.
- Appeals submitted for drug NDC's that are not on the MRx Therapeutics MAC list or a claim that has been entered as usual and customary and/or submitted will be returned as a non-MAC related issue and appeal will be closed.
- The appeal will remain on file for continual review for up to 90 days.

For questions concerning Reimbursement appeals please contact:

Scott Verley
Director of Financial Modeling
Scott.Verley@primetherapeutics.com
612-777-2532

16.0 Appendix G: Discrepancy Code List

Claims will be flagged with one or more of the following discrepancy codes. Those codes are further defined below with instructions concerning how they may be mitigated. A time frame for submitting mitigating documentation in response to your audit's results will be provided in the accompanying letter. Documentation meeting the guidelines below, submitted during the applicable response window, may be considered to overturn outlined discrepancies in your Pharmacy Audit Report.

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
BMN Dispense as Written	Brand medication billed, but patient or prescriber's "brand-only" order is not documented. DAW 1 or 2 to circumvent Program edits.	Partial Recovery	DAW 1 – Prescriber statement* accepted including all required elements listed on the last page of this discrepancy code list in addition to validating that the dispensing of Brand name product was medically necessary. DAW 2 – Member/facility statement** accepted including all required elements listed on the last page of this discrepancy code list in addition to validating that the member requested Brand form of drug
CPDW Compound Worksheet Required	Compound Worksheet not provided for preliminary review. Required for claim validation.	Full Charge Back	Compound Worksheet with Ingredients Listed (NDC, Qty & AWP Cost)
CPDF Compound Incorrectly Billed	A compounded prescription is incorrectly billed resulting in an overpayment.	Full Charge Back	Compound Worksheet with Ingredients Listed (NDC, Qty & AWP Cost)
CPDP Compound Incorrectly Billed	A compounded prescription is incorrectly billed resulting in an overpayment.	Re-price RX	Compound Worksheet with Ingredients Listed (NDC, Qty & AWP Cost)
CPDD Billed for non-covered Part D drug	Rx is submitted for a compound containing a non-covered Part D drug	Full Charge Back	No Post Audit Documentation Accepted

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
CPDI Billed without indicator or using Push #	Rx is submitted without a compound indicator or push NDC # is used.	Part D - Full Charge Back Comm. - Reprice	Part D – No Post Audit Documentation Accepted Comm. - Compound Worksheet with NDCs, Quantities and Pricing
DDB Wrong Drug Billed	Pharmacy billed for a different medication than the one ordered by the prescriber with no documentation on RX or Patient Profile. Must have Pharmacist Notes on RX.	Full Charge Back	If discrepant due to therapeutic exchange, Prescriber Statement* is accepted, otherwise No Post Audit Documentation Accepted.
DEA No DEA	The hard copy prescription does not contain a DEA number on the script or sticker (CII-CV drugs only).	Full Charge Back for CII-CV	State/Federal Mandate No Post Audit Documentation Accepted
DID Wrong Prescriber	The claim submitted contains an ID number; however, it is not the ID number of the physician who authorized the prescription. Pharmacy submits an ID or Physician identifier different from the number printed on the prescription blank.	Non-Monetary	Prescriber Statement* New Prescriber Document accepted including all required elements listed on the last page of this discrepancy code list, from a non-sanctioned prescriber which shows the prescriber billed is a member of the same practice as correct prescriber. CII-CV, No Post Audit Documentation Accepted.
DN-1 Wrong Patient Billed	The patient identified on a hard-copy prescription is not the correct patient. Wrong suffix codes.	Full Charge Back	No Post Audit Documentation Accepted
DNR Did Not Respond	Pharmacy did not respond to initial audit request	Full Charge Back	Pharmacy may respond with documentation within the permitted response window referenced in the attached results Letter.
DUP Duplicate Claim	Multiple claims for the same prescription fill were paid.	Full Charge Back	No Post Audit Documentation Accepted

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
EQB Exceeds QTY Limits) (Overfilled QTY	Quantity billed exceeds the quantity authorized by the prescriber/plan. No Documentation	Partial Recovery	No Post Audit Documentation Accepted
EQBR Total Over Billed Quantity	Total units billed (with refills) exceed the total units authorized by prescriber	Partial Recovery	No Post Audit Documentation Accepted
EXP Exceeds Time Limit	The prescription is filled or refilled for a time period longer than that allowed by the Plan or applicable regulations.	Full Charge Back	No Post Audit Documentation Accepted
FRD Fabricated Document	Prescription copy provided for audit appears to have been fabricated by pharmacy	Full Charge Back	No Post Audit Documentation Accepted
FBW Filled before Written	Filled before written: Rx was filled before date written.	Full Charge Back	Prescriber Statement* accepted, including all required elements listed on the last page of this discrepancy code list in addition to validating that the prescriber indicated the incorrect date. For CIIs, No Post Audit Documentation Accepted.
ICS Wrong Pack Size	The package size submitted on the claim differs from the package size dispensed by the pharmacy. Pharmacy bills multiple of small size NDC when a stock larger size is available resulting in excess margins.	Difference in Payment	Documentation Showing Reason for Exchange
IDSP Wrong or Incorrect Day Supply	The days' supply value submitted by the pharmacy is not consistent with the quantity and directions.	Non-Monetary	Not Applicable
IHC Ineligible Hard Copy	An ineligible hard-copy prescription was submitted for documentation	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
INV No Date Written	CII-CV Drugs – hardcopy prescription contains no original written date. Regular Rx – date on label is acceptable.	Full Charge Back for CII-CV	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
INVD No Drug Name	The hard-copy prescription does not contain the name of the drug to be dispensed.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
INVN No Patient Name	The hard-copy prescription contains no patient name.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
INVP No Doctor Name	The hard copy prescription does not identify the prescriber by printed name. No MD name CII- CV, Label with MD accepted for General Rx	Full Charge Back for CII-CV	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
INVS No Strength	The hard-copy prescription, for a drug available in more than one strength, fails to identify the strength to be dispensed.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
INVX No Doctor Signature	The hard copy prescription is not signed by the prescriber.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
ISL Incomplete/Invalid Signature Log	Incomplete/Invalid Signature Log Provided	Full Charge Back	Member/facility statement** OR acceptable Shipment Delivery Confirmation**** accepted including all required elements listed on the last page of this discrepancy code list
IVT Invalid Transfer Rx	The transfer prescription is missing required documentation as per state rules	Full Charge Back	An updated copy of the state code with reference code number
LAWF Law Not Followed	The prescription was not filled in accordance with State/Federal law.	Full Charge Back	An updated copy of the state code or federal regulation with reference code number

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
LTC Miscellaneous LTC Issues	Physician Order submitted does not cover date of service of claim requested.	Full Charge Back	Physician's Order, signed by prescriber, for current or most recent date of service with a validating Start Date or an Original Order with authorized refill documentation, both signed by the prescriber, for the charting period in question
LSL Late Signature Log	Signature Log submitted shows Pick Up Date more than allowable per MRx Pharmacy agreement.	Full Charge Back	No Post Audit Documentation Accepted
MDC Member Denied Claim	MRx has received confirmation from billed member that services were not requested/delivered	Full Charge Back	No Post Audit Documentation Accepted
MP-1 Can't Find Missing Prescription	Original hard-copy prescription cannot be found on file during the audit. Physician Order sheet not provided in LTC	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
MSL Signature Not Found/ Missing Info	The signature log or delivery confirmation documenting receipt of pharmacy services cannot be found.	Full Charge Back	Member/facility statement** OR shipment delivery confirmation*** accepted including all required elements listed on the last page of this discrepancy code list
MSLC Cycle Filling or Post Consumption Billing	Cycle filling with no documentation. Fraudulent billing after medications are consumed by patient.	Full Charge Back	No Post Audit Documentation Accepted.
MSLD Not Dispensed	Prescription is billed but not dispensed to patient. Drugs are not returned to stock. Partial fills not picked up and not reversed	Full Charge Back	Electronic documentation of claim reversal.
NCI Drug Not Covered	Pharmacy billed and was paid for a "non- covered" item.	Full Charge Back	May appeal if system was down.

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
NQY No Quantity	The hardcopy prescription does not indicate the quantity of the drug to be dispensed.	Full Charge Back / Partial	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
NRPL Non-Resident Pharmacy License	Pharmacy does not have a non-resident pharmacy license on file with state in which medications are being shipped to.	Full Charge Back	Copy of Non-Resident Pharmacy license on file with state in which medications are being shipped to
NSI No Directions For use	The hard-copy prescription does not indicate directions for use or dosage.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
OTHF Miscellaneous Discrepancies	'Miscellaneous' is assessed when an issue has been cited that is not listed elsewhere on the Discrepancy Sheet. Note will be given with explanation.	To Be Decided	Depends upon Discrepancy – Refer to Pharmacy Report
OTHP Miscellaneous Discrepancies	'Miscellaneous' is assessed when an issue has been cited that is not listed elsewhere on the Discrepancy Sheet. Note will be given with explanation.	To Be Decided	Depends upon Discrepancy – Refer to Pharmacy Report
PDC Provider Denied Claim	MRx has received confirmation from billed provider that services were not ordered/authorized	Full Charge Back	No Post Audit Documentation Accepted
REMS Missing Required REMS/iPLEDGE Authorization and/or Confirmation Number	Drug with REMS (Risk Evaluation and Mitigation Strategy) program missing required authorization and/or confirmation number.	Full Charge Back	If missing required authorization number from prescriber: No Post Audit documentation Accepted If missing pharmacy confirmation number: Print out from REMS/iPLEDGE system showing confirmation was obtained prior to dispensing.

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
RTS Refill Too Soon - No documentation of Override Codes	Prescription is refilled sooner than appropriate with respect to quantity and directions for use.	Full Charge Back	No Post Audit Documentation Accepted.
RXC Altered/Rx - Drug, Quantity, Date or Refills Altered	Drug, Quantity, Date or Refills altered with no documentation on RX.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
RXCQ Cut Quantity	Quantity cut with no documentation on RX.	Additional Dispensing Fee/ unless Member Requested	Member Statement** accepted including all required elements listed on the last page of this discrepancy code list in addition to reason for request for smaller supply
UAR Unauthorized Refill	Prescription is refilled more often than prescribed.	Full Charge Back	Prescriber Statement* accepted including all required elements listed on the last page of this discrepancy code list
UHC Unclear Hard Copy	Pharmacy provided hard copy documentation that contained an unclear or illegible prescription image	Full Charge Back	A clear hard copy prescription image
VR Outside Scope of Practice	The prescriber ID billed belongs to a practitioner not authorized to prescribe medication	To Be Decided	Case by Case Basis
WHC Wrong Hard Copy	Pharmacy provided a hard copy prescription for the incorrect Rx number/date	Full Charge Back	Hard copy prescription for the correct Rx number/date
XDEA Missing XDEA Qualifier	The hardcopy prescription is missing the XDEA qualifier required for certain medications.	Full Charge Back	No Post Audit Documentation

*All prescriber statements must be written by prescriber on prescriber's own letterhead or their preprinted prescription blank. The statement must include the following:

(1) the name, address, and telephone number of the physician; and

(2) in the form of a statement, clearly reference the patient's name, medication(s), date(s) of service, strength, directions, quantity ordered and refills (if applicable), and all other

requirements specific to drug prescribed; and

(3) indicate the date the prescriber's statement was signed; and

(4) include the prescriber's handwritten signature.

Please Note: Copies of new prescriptions or updated original documentation is not accepted as a prescriber statement.

**All member/facility statements must be a new document and must include all the following:

(1) The member's name, address, and telephone number;

(2) a clear reference to the medication(s) or Rx number(s);

(3) the date(s) of service;

(4) member's signature; and

(5) date the member signed the statement.

Please Note: If signed by a caregiver, relationship to member must be listed in statement.

If medication is delivered to a facility, the statement must include the patient's name, date(s) of service, prescription number(s), facility to which it was delivered, date of delivery, signature of the person who received the delivery and the date the member/facility signed the statement.

***All shipment delivery confirmations must include or make reference to through additional, supporting documentation:

(1) prescription number,

(2) date of service of claim,

(3) patient name/address,

(4) receipt signature/proof of delivery

Please Note: All information, excluding receipt signature, must be presented in an electronic format.

17.0 Definitions

Acronym/Term	Definition
ACEI	Angiotensin Converting Enzyme Inhibitor
BAE	Best Available Evidence
CII	Schedule 2 drug
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
DEA	Drug Enforcement Agency
DHHS	Department of Health and Human Services
DOJ	Department of Justice
DRA	Deficit Reduction Act
DUR	Drug Utilization Review
EIN	Employee ID Number
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
FTP	File Transfer Protocol
FWA	Fraud, Waste and Abuse
GPO	Group Purchasing Organization
GSA	General Services Administration
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Health
HAS	Hernandez Settlement Agreement
LEIE	List of Excluded Individuals and Entities
LIS	Low Income Subsidy
LTC	Long Term Care
MAC	Maximum Allowable Cost
MFCU	Medicaid Fraud Controls Unit
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
OIG	Office of Inspector General
PA	Prior Authorization

Acronym/Term	Definition
PAC	Predictive Acquisition Cost
PBM	Pharmacy Benefit Manager
PDL	Preferred Drug List
PHI	Protected Health Information
POS	Point-of-Sale
ProDUR	Prospective Drug Utilization Review
PSAO	Pharmacy Services Administration Organization
QIC	Quality Improvement Committee
QL	Quantity Limits
SAM	System for Award Management
SIU	Special Investigation Unit
SSA	Social Security Administration
SSI	Supplement Security Income
ST	Step Therapy
TPL	Third Party Liability

18.0 Index