PROCARE PHARMACY BENEFIT MANAGER, INC.
PHARMACY MANUAL

Confidential and Proprietary

Pharmacy agrees to not copy, distribute, or share information included in this Manual, except as required for business or contract purposes only.

GENERAL INFORMATION:

As a participating Network Pharmacy ("Pharmacy"), you have agreed to provide pharmaceutical Services to persons covered by Plan Sponsors for whom ProCare Pharmacy Benefit Manager, Inc. ("ProCare") provides pharmacy benefit management or pharmacy benefit administration Services.

This Pharmacy Manual ("Manual") is intended to serve as a guide to assist with submitting claims to ProCare, as well as providing general terms, conditions, procedures, and policies for adherence as a Participating Pharmacy ("Pharmacy"). This Manual is incorporated into your Participating Pharmacy Agreement, along with any applicable Amendments or Addenda (collectively the "Agreement"). Pharmacies are responsible for reviewing and complying with all changes to the Manual. Failure to comply with any terms of the Agreement, which include this Manual, as well as all other applicable documents, will be considered a breach of the Agreement. The information provided in this Manual is current as of the time of publication. This Manual will be updated as necessary and is subject to change without notice.

The current version of this Manual is posted at https://www.mc-rx.com. ProCare, at its sole discretion, may modify this Manual at any time. Changes to the Manual will be communicated via, email and posted online via https://www.mc-rx.com. Please refer to the online claims adjudication system for the most current messaging and benefits information. For additional Network participation requirements, please refer to your most recent Agreement.

Any updates to your Pharmacy's mailing/remit or physical address, telephone number, fax number, license number(s), DEA number, or any other data must be submitted to the National Counsel for Prescription Drug Programs (NCPDP). ProCare will not make manual updates to Pharmacy demographic or licensure information unless it can be verified via NCPDP. ProCare is not responsible for lost/late payments or delayed notifications due to incorrect Pharmacy affiliation or mailing addresses.

Please visit ProCare's Pharmacy Portal (https://mc-rx.com) to create an account to access important information, forms, and notifications.

ProCare appreciates your participation in our Pharmacy Networks and your role delivering quality Services to persons covered by our Plan Sponsors.

CONTACT INFORMATION:

Pharmacy Help Desk Support

- Help Desk Phone Number, 7/24/365 800-699-3542
- PA Help Desk Phone Number 866-965-3784
- Help Desk Fax Number 678-281-7586

Network Development Department

Network Development Hours of Operation: Monday – Friday 8:00 am to 5:00 pm EST.

- Phone Number: 800-277-2480
- Fax Number: 678-207-5090
- Email Address: network@procarerx.com
- Credentialing Department Email Address: credproject@procarerx.com

Mailing Address

ProCare Pharmacy Benefit Manager, Inc.
Attn: Network Development
1267 Professional Parkway
Gainesville, GA 30507

Other Important Contact Information

- Claims-related Issues or Questions: 800-699-3542
- Member Eligibility: 800-699-3542
- Report Fraud, Waste, & Abuse (FWA) Anonymous: 678-248-3180
- FWA Anonymous Email: hotline@procarerx.com
- Pharmacy Dispute Resolution: network@procarerx.com
- Generic Pricing Appeals (MAC) Inquiries: reimbursement@procarerx.com
- Payment, Remit (835 Files), and EFT Questions: payremit@procarerx.com

ProCare Pharmacy Websites

- ProCare Website: https://www.mc-rx.com
- ProCare HospiceCare Website: https://phc.procarerx.com
- ProCare Pharmacy Portal: https://mc-rx.com

PHARMACY RESPONSIBILITIES:

The following terms are the Pharmacy's basic responsibilities as a Participating Pharmacy ("Pharmacy"). Please refer to the Participating Pharmacy Agreement ("Agreement") for additional information.

In accordance with the Agreement, Pharmacy has agreed:

1. To comply and adhere to all provisions set forth herein this Manual. Failure to abide by the provisions and/or terms set forth shall be considered a breach of the Agreement;
2. To provide professional Pharmacy Services to Covered Persons, according to applicable local, state, and federal laws and regulations, the Agreement, and the Manual;
3. To comply with all applicable state and federal privacy and security laws;
4. To verify, before dispensing Drug Products, whether an individual is a Covered Person by reviewing a valid Prescription Identification Card AND verifying the Covered Person's eligibility on the date of service via online processing system (the "System"), OR by verifying eligibility by telephone in situations where online eligibility verification is unavailable;
5. To collect the applicable copayment, coinsurance, and deductible on each prescription as specified by ProCare's online processing System, unless approved otherwise by ProCare;
4. Pharmacy shall not waive the copayment, coinsurance, or deductible on part of a Covered Person without the written consent of ProCare, or as specified below, or as required by applicable state or federal law, and that the copayment, coinsurance, or deductible returned solely from the System is the maximum allowable amount to collect from the Covered Person, and no amount shall be collected above the amount sent back, unless approved by ProCare. Pharmacy shall follow the applicable rules and regulations as specified on discount coupons where applicable (refer to reverse side of coupon or the System);
5. To submit <u>all</u> claims for Drug Products and Services online through the System for adjudication, in either the NCPDP Version D.0 variable format or a more current and approved format, unless Pharmacy has received prior approval from ProCare. Usual and Customary ("U&C") price must be submitted on each claim. Manually submitted claims may require Prior Authorization;
6. To maintain either a manual or electronic signature log or another form of signature verification, as allowed by state or federal law, at each dispensing location that contains the signature of each Covered Person or Representing Agent, fill date, prescription number, and the date the Drug Product was delivered to Covered Person or Representing Agent so that pick up can be ascertained during any Pharmacy audit or review;
7. To complete annual Compliance and Fraud, Waste, and Abuse training in accordance with CMS laws, rules, and regulations pertaining to 42 CFR § 423.504(b)(4)(vi)(c), where and when applicable, and as required by the Network and/or Plan Sponsors, in addition to frequently checking the OIG listing of excluded individuals and entities and removing any such employee from direct administration from applicable federal benefit programs. In support of the above, audits may also be conducted by ProCare, an applicable Payer, or other regulatory agency, as outlined in 42 CFR § 422.504(e) and 42 CFR § 422.503(d)(2);
8. To maintain valid Pharmacy and Pharmacist DEA license(s) in order to dispense a narcotic or controlled substance Drug Product;

9. To comply with all provisions of e.Prescribing standards as stated in the regulation 42 CFR § 423.160(b) when receiving or transmitting electronic prescriptions or prescription related information;
10. To only use e.Prescribing to prescribe and dispense Services if the Pharmacy is a designated dispensing Physician ("Physician Dispensary");
11. To validate the prescribing Physician's NPI prior to submitting a claim via the System;
12. To submit accurate Prescription Origin Codes, Patient Location Codes, and other Coverage Codes (where applicable);
13. To use the "Use as Directed" prescription instructions (SIG) only when an actual dispensing instruction is not available (please refer to the Audit section for further information);
14. To comply with grievance resolution for complaints filed by Covered Persons and/or Plan Sponsors against Pharmacy, in accordance with local, state, or federal laws or regulations;
15. To inform Covered Persons covered under a federal program or a federally backed program, where applicable, of any differential between the price of the lowest-priced, therapeutically equivalent and bio-equivalent generic drug at the point of sale, unless the lowest price drug is being purchased in accordance with 42 CFR § 423.132(a).

NETWORK PARTICIPATION REQUIREMENTS & CREDENTIALING PROCESS:

ProCare has a formal Credentialing process that all Pharmacies must complete for Network participation. ProCare's credentialing process is conducted in accordance with URAC and CMS standards. Pharmacies are required to comply with all Credentialing and attestation policies set forth by ProCare and/or the Plan Sponsor. The Credentialing process may vary depending on Pharmacy type (i.e. independent, chain, PSAO) and service type (i.e. retail, mail service, compounding, LTC, Physician dispensaries, etc.).

ProCare monitors the licensure of its Pharmacies in accordance with ProCare policies and procedures, or as mandated by law. Failure to comply with licensure requirements and/or ProCare's Credentialing process may result in Pharmacy's suspension or immediate termination. Any Pharmacy not eligible to participate in state or federal healthcare program(s) will not be allowed access into any of ProCare's Networks.

Pharmacies must comply with and promptly respond to requests for documentation in order to secure and maintain Network participation status. Failure to respond may result in termination from the Network(s). ProCare reserves the right to request Credentialing documentation at any time during Pharmacy's participation in ProCare's Network(s).

ProCare credentials Pharmacies prior to Network acceptance. ProCare reserves the right, at its sole discretion, to determine eligibility of any Physician and Pharmacy of participation status within any of its Networks.

LICENSURE:

Pharmacy must submit a copy of a valid, current state pharmacy license in good standing. Pharmacy must immediately notify ProCare, in writing, if the Pharmacy's license has been cancelled, suspended, revoked, or has any other action taken against it. The same requirement applies to Pharmacist in Charge ("PIC")

licensure. In the event the Pharmacy fails to notify ProCare or maintain the required licensure, ProCare may immediately terminate the Pharmacy from its Networks.

The Pharmacy and PIC must hold a valid, current Drug Enforcement Administration (DEA) registration certificate and submit copies upon Credentialing. Pharmacy must immediately notify ProCare, in writing, if the Pharmacy and PIC DEA registration has been cancelled, suspended, revoked, or has any other action taken against it. In the event the Pharmacy fails to notify ProCare or maintain the required registration, ProCare may immediately terminate the Pharmacy from its Networks.

INSURANCE:

Pharmacy must maintain professional liability insurance at all times in the amounts required by state or local guidelines. If there are no specified state or local guidelines, Pharmacy must maintain liability amounts of no less than $1 Million (occurrence) and $3 Million (aggregate) or in accordance with state law. If the Pharmacy's liability insurance coverage lapses, Pharmacy agrees to notify ProCare immediately and take action to correct lapse in coverage. If Pharmacy loses liability insurance, Pharmacy shall be terminated from all ProCare Networks until coverage is reinstated and proof of insurance is provided.

MAIL ORDER:

In addition to completing the Pharmacy Credentialing Form and providing the requested documentation, Mail Order Pharmacies must be licensed and provide copies of such licensure in their respective state and all states in which Drug Products are dispensed, mailed, or shipped. Proof of licensure does not guarantee access in ProCare's Mail Order Network. Access must be granted in writing by ProCare.

COMPOUNDING PHARMACIES:

Pharmacies providing Compounded Drug Products will be required to submit additional documentation to validate proof of accreditation from a nationally recognized compounding accreditation agency or provide a state certificate of inspection, or proof, as required by state or federal law, as applicable. Pharmacies providing sterile compounding must meet current USP standards and provide proof from a nationally recognized compounding accreditation agency or provide state inspection documentation before participation with the Compounding Network will be granted. Compounding is Plan Sponsor-specific and may or may not be a covered benefit. Refer to the System for coverage eligibility. Pharmacies may not circumvent the Plan Sponsor's PA process in order to submit Compounded Drug Claims. All Compounded Drug Claims are subject to review by the Plan Sponsor and/or ProCare.

PHARMACY CREDENTIALING PROCESS:

Pharmacy shall provide necessary documentation, licenses, and any other information as required by ProCare, or as applicable law permits. ProCare uses Primary and Secondary Source Verification during the Pharmacy Credentialing process.

The Credentialing process includes, but is not limited to, a review of the following for independent, non-affiliated Pharmacies:

A completed, signed, and dated Pharmacy Credentialing Form with a copy of the following documents:

1. State Pharmacy License
2. State Pharmacist In Charge ("PIC") License
3. DEA License
4. Certificate of Liability Insurance (must not expire within 30 days of receipt)
5. Proof of sterile compounding from a nationally accredited compounding entity, if applicable
6. Any history of disciplinary action, including loss, restriction, or limitation on license
7. Malpractice claims history within the past ten (10) years
8. Fraud or abuse convictions within the past ten (10) years
9. Additional documentation/information, as determined by ProCare

ProCare will verify all submitted documents and review the following:

1. Search of Office of Inspector General ("OIG") Exclusions Database
2. Search of State Department of Licensure for pending/prior Pharmacy and PIC sanctions
3. Search of the U.S. Department of Justice Drug Enforcement Administration (DEA) Diversion Control Division website for verification of licensure status

The Chain/PSAO Credentialing process includes, but is not limited to, a review of the following documents:

1. Credentialing Form, signed and dated (required every two years)
2. Attestation Form, signed and dated (required annually)
3. Chain Contact Form (required annually)
4. Chain Pharmacy roster including each Pharmacy's information
5. Pharmacy information must match NCPDP's records for each Pharmacy location

ProCare will perform random quarterly Credentialing audits of chain-affiliated Pharmacies by requesting the following documentation of the selected stores:

1. Copy of State Pharmacy License
2. Copy of State Pharmacist In Charge ("PIC") License
3. Copy of Verification DEA License
4. Certificate of Liability Insurance (must not expire within 30 days of receipt)
5. Copy of Proof of sterile compounding from a nationally recognized compounding accreditation entity, if applicable
6. Any history of disciplinary action, including loss, restriction, or limitation on license
7. Malpractice claims history within the past ten (10) years
8. Fraud or abuse convictions within the past ten (10) years
9. Additional documentation/information, as determined by ProCare

ProCare will verify all documents submitted and review the following for each selected Pharmacy:

1. Search of Office of Inspector General ("OIG") Exclusions Database
2. Search of State Department of Licensure for pending/prior Pharmacy and PIC sanctions
3. Search of the U.S. Department of Justice Drug Enforcement Administration (DEA) Diversion Control Division website for verification of licensure status

TELEPHARMACY:

The practice of Telepharmacy is governed by the respective state's definition of "practice of pharmacy," unless the governing state specifically provides an exception, and in which case the exception will govern. Pharmacies designated and acting as a Telepharmacy must be licensed in their respective state and each state where Services are performed. Each state's law will dictate recordkeeping requirements for any Pharmacy designated and acting as a Telepharmacy. Electronic transaction data in lieu of physical Pharmacy records may be accepted in accordance with state law.

PHYSICIANS:

Physicians are required to comply with all Credentialing and Attestation policies set by ProCare and/or the Plan Sponsor. Physicians must provide necessary documentation, licenses, and any other information required by ProCare, or as applicable law permits. Failure to comply may result in removal from ProCare's Network(s). Physicians who are not eligible to participate in any state or federal healthcare program(s) shall not provide Services for any Covered Person. Any Physician with sanctions against their state license(s), dispensary license (if applicable), and/or DEA license will be reviewed by the Credentialing Committee to determine eligibility into ProCare's Network(s). ProCare reserves the right, at its sole discretion, to determine Physician eligibility to participate in ProCare's Physician Network(s).

OIG VALIDATION:

Pharmacy is required to have a process for checking and verifying the Office of Inspector General's ("OIG") List of Excluded Individuals/Entities ("LEIE"); System for Award Management ("SAM") - Excluded Parties Listing System ("EPLS") to confirm entity, employees, and/or contractors have not been excluded from participation in federal programs. Verifications must be completed on a monthly basis. Proof of such validation may be requested at ProCare's and/or Plan Sponsor's discretion. Pharmacy agrees to report all employees/contractors found on the LEIE or EPLS exclusion list, along with any claims associated with the individual(s). In addition, Pharmacy agrees to notify ProCare if Pharmacy is found to be listed on the exclusion list(s).

- OIG: https://exclusions.oig.hhs.gov/
- SAM: https://www.sam.gov/portal/SAM/#1

To report a Pharmacy or Pharmacist exclusion, please send an inquiry to the Network Development team via email: network@procarerx.com.

TERMINATION:

Any Pharmacy terminated from the ProCare Network(s) for reason(s) other than alleged FWA must wait a minimum of three (3) years from the termination date to apply for reconsideration for Network participation. Pharmacy will be required to meet ProCare's Credentialing requirements before Network participation will be granted. Pharmacies terminated for FWA violations will not be allowed to reapply for Network participation at any time.

ProCare reserves the right, at its own discretion, to deny or suspend a Pharmacy's Network participation, with or without a thirty (30) day notice, should Pharmacy be found in material breach of one or more sections of this Manual or any Agreement. ProCare reserves the right, at its sole discretion, to determine eligibility of any Physician and Pharmacy of participation status within any ProCare Network(s).

RE-CREDENTIALING:

ProCare mandates that all Pharmacies must re-credential every other year (i.e. 2-year cycles), to ensure the continuation of Network compliance. Re-Credentialing will be based on Pharmacy's enrollment date ("Effective Date") in ProCare's Network(s). For independent, non-affiliated Pharmacies, ProCare's Credentialing team will notify the Pharmacy in advance via the email address found in the Pharmacy's NCPDP record. For chains/PSAOs and their affiliated Pharmacies, ProCare will notify the point of contact designated by the chain of all re-Credentialing requirements. No credentialing or re-credentialing fee will be charged.

PAYER INFORMATION:

The listing below represents an example of the Plan Sponsors and their respective Bin Identification Numbers ("BIN"), all of which are subject to change. For a specific copy of applicable payer sheets, please email network@procarerx.com.

CASH DISCOUNT CARD BINS		
GENERAL PLAN NAME	**BIN**	**PCN**
Agelity (AGL)	610198, 012965, 009265	BLANK FILL
Allegiance Rx	020826	BLANK FILL
AVIA Discount Card	018778	BLANK FILL
Intelisys Health	022733	POMS
Intelisys Health	022740	AERX
Managed Care Pharmacy (MPC)	013832	BLANK FILL
ProCare Discount Card	900014, 900020	SEE CARD
ProCare Discount Card	017614, 017670, 018372	SEE CARD
RX123, LLC	021056	BLANK FILL
SlashRx	610711	SEE CARD

Note: As of the date of publication, the BIN list above is all-inclusive and is subject to change at any time.

ONLINE PROCESSING SYSTEM:

A Claim Form is prepared in accordance with current National Council for Prescription Drug Programs (NCPDP) standards. The Claim Form, whether paper or electronic, must include all required fields necessary for adjudication ("Clean Claim"). If a claim is determined, at the sole discretion of ProCare, to be discrepant, fraudulent, or not authorized under applicable law or federal regulation, the claim will not be considered a Clean Claim and will be subject to recoupment by ProCare.

Pharmacy is required to submit all claims electronically to ProCare (see individual Payer sheets) via the system ("System") within thirty (30) days of the date of fill. Pharmacies designated as Long Term Care shall submit claims within ninety (90) days of the date of fill, or in accordance with state law. Claims from third-party billing entities submitted on behalf of the Pharmacy will not be accepted, and Pharmacy or its third-party billing entity is not entitled to any payment under this Agreement, unless prior written approval is given by ProCare. Notwithstanding the above, any claim(s) granted such prior approval shall be reimbursed to the Pharmacy directly per the contractual obligations between Pharmacy and ProCare. The System is available to accept electronic transactions 365 days per year.

A transaction is any request and response, such as paid, reversed, rejected, duplicate, or adjusted, transmitted through the System or manually keyed into the System. The claim response governs, unless an overpayment is made. The System, however, may be unavailable during off-peak hours, such as overnight, for short periods of time, or due to scheduled System/file maintenance. Pharmacy has thirty (30) days from the original fill date to submit a claim online (submission window may vary based on line of business and government regulations). Pharmacies designated as Long Term Care shall submit claims within ninety (90) days of the date of fill, or in accordance with state law. If Pharmacy is not able to submit a claim due to System unavailability, Pharmacy should hold the claim for later online resubmission and/or contact ProCare's Help Desk to verify eligibility and resubmit the claim when the System becomes available.

ProCare may charge a Network transaction fee to Pharmacy of up to fifteen cents ($0.15) per online transaction submitted via the System. Out-of-Network or non-preferred Pharmacies may incur a higher Network transaction fee of up to fifty cents ($0.50). The transaction charge assists in the support of Pharmacy Help Desk operations and Pharmacy financial (payment and reconciliation) Services, in addition to Network compliance, communications, education, Geo-Access fees, directory management and notices, and is not Plan Sponsor-specific. In the event of disruptive, excessive, or non-compliant Pharmacy behavior, higher transaction charges or penalty fees may be incurred.

MANUAL CLAIMS SUBMISSION:

Universal Claim Forms ("UCF") will only be accepted for processing if absolutely necessary, with prior approval given by ProCare and at a service fee of $1.00 per transaction, although some specific pre-authorized claims may have this fee waived by ProCare in certain situations. Claims submitted with incomplete information will be rejected and may be charged an additional $1.00 per transaction handling to be deducted from a future Pharmacy remittance. Unauthorized manual claims submitted by Pharmacy may be subject to a $3.00 handling fee. If approved, however, the following information will be required on all manual claims:

Manual Claim Required Information	
Covered Person Identification Number	Prior Authorization Number (if required)
Patient Name	New or Refill Indicator
Patient Date of Birth	Metric Quantity Dispensed
Patient Sex	Days' Supply
Patient Relationship to Cardholder	11-Digit NDC Number
Pharmacy NPI Number	Requested Ingredient Cost
Prescription Number	Requested Dispensing Fee
Appropriate DAW Code (if necessary)	Copay Paid by Covered Person
Date Prescription Was Filled	Requested Tax (if applicable)
Prescriber NPI Number	

All approved UCFs should be submitted to:

ATTN: Claims Department
ProCare Pharmacy Benefit Manager, Inc.
1267 Professional Parkway
Gainesville, GA 30507

Claims must be received by ProCare from Pharmacy within 365 days of the date of fill for manual claims to be entered into the System (this may vary for specific Plan Sponsor and Plan eligibility).

SUBMITTING COMPOUNDED DRUG CLAIMS:

ProCare, at its sole discretion, may require Pharmacy to complete additional Credentialing to process claims for Compounded Drug Claims. Pharmacy will be required to meet all Credentialing standards as established by ProCare, to include, but not be limited to; Pharmacy Compounding Accreditation Board (PCAB) accreditation, proof of federal and/or state registration of sterile compounding, state/federal inspection reports, compliance with Stark and Anti-Kickback laws, and a compliance review, including business operations/practices and on-site review of stability and sterility. Failure to maintain compliance with the requirements may result in removal from applicable Networks or termination of the Agreement. Any evidence of unsafe compounding practices reported to the State Board of Pharmacy, Food and Drug Administration (FDA), or applicable regulatory agency will warrant removal from ProCare's Compounding Network and/or termination of the Pharmacy Agreement, at ProCare's sole discretion. Documented unsafe compounding practices could lead to claim recoupments or non-payment of Compounded Drug Claims.

Pharmacy acknowledges and agrees that the approval of Compounded Drug Claims is based on Plan Sponsor approval and may be subject to quantity limits, dollar thresholds, and/or Prior Authorization ("PA"). Pharmacy understands submitting the level of effort ("LOE") code may not result in a change in the reimbursement of the Compounded Drug Claim. When approved by Plan Sponsor, LOE code reimbursement may differ by Plan Sponsor.

A Compounded Drug Claim contains a Drug Product that is weighed or measured by a licensed Pharmacist who combines, mixes, and/or alters ingredients to create a medication for a Covered Person for which a commercial Drug Product is not available. This excludes reconstitution and/or dilution of a Drug Product according to manufacturer guidelines. Sweeteners and flavorings are also excluded.

All Compounded Drug Claims must be submitted through the System using the compounding code indicator "2" in NCPDP field .0 406-D6 with each ingredient NDC, cost, and quantity used. If LOE code is approved for use, the appropriate LOE code must be submitted in field 474-8E of the NCPDP D.0 claim format.

PHARMACY OBLIGATIONS

Pharmacy agrees to the following:

1. To follow the PA process as required by Plan Sponsor and ProCare for all Compounded Drug Claims.
2. Not to engage in acts of resubmitting a Compounded Drug Claim multiple times with the same quantity and different U&C until the claim is paid to circumvent the PA process, also known as price rolling.
3. Not to bill a different NDC or dosage than what was used.
4. Not attempt to obtain higher reimbursement by replacing ingredients (unless Prescriber authorizes or a new Prescription with different ingredients is received).
5. Not to increase dispensing fees, ingredient cost, quantities, and/or days' supply amounts.
6. Not to submit a Compounded Drug Claim for a drug that is equivalent to a commercially available drug (such claims are subject to full recovery in an audit).
7. Not to submit a Compounded Drug Claim for a single NDC pre-made compound or compound kit.
8. Not to submit reconstituted preparations as compound drugs (i.e. mixing water or saline with other Federal Legend Drugs prior to dispensing).
9. Not to submit prescriptions sub-divided into unit dose(s) as compound drugs.
10. Not to submit injectable drugs drawn into syringes for administration as compound drugs.
11. Not to charge for ancillary supplies, such as flavorings/sweeteners, equipment depreciation, and/or labor under the terms of the Agreement.
12. To submit all Compounded Drug Claims via the System using compounding code indicator "2" and use the appropriate level of effort (LOE) code.
13. The following acts may result in termination from ProCare's Network(s): (1) waiving the Covered Person's copayment/coinsurance amount, (2) charging the Covered Person a higher copayment/coinsurance amount, (3) charging for non-covered ingredients, (4) refusing to fill due to reimbursement, unless otherwise specified under state law, (5) engaging in acts of questionable billing practices, (6) using inappropriate LOE code.

Pharmacy is expected to observe all applicable state and federal laws pertaining to U.S. Pharmacopoeia ("USP") Chapter Guidelines, Federal Drug Administration (FDA) communications, and professional standards when dispensing Compounded Drug Products. If, for any reason, evidence of unsafe/unprofessional compounding is found, said evidence will be reported to the FDA and applicable State Board of Pharmacy, which may result in termination of the Agreement.

GENERAL CLAIMS, PRICING, AND PAYMENT INFORMATION:

Claims submitted by Pharmacy through the System will be reimbursed at the lesser of the Pharmacy's U&C charge or cash price; submitted ingredient cost; submitted total amount due; maximum allowable cost ("MAC"); or AWP minus the applicable Network rate, plus the applicable dispensing fee (including any applicable state or local tax). The reimbursement rates may vary by Plan Sponsor. Tax will be calculated based on available and approved state or local tax on prescription drugs when submitted by Pharmacy.

ProCare utilizes Medi-Span, First Databank, or any other such nationally accepted database as its pricing source. AWP pricing for Drug Products shall be calculated using the current AWP benchmark and methodology on aggregate, where applicable, at an individual Plan Sponsor level. Plan Sponsor participation may vary in the implementation, application, and utilization of the post AWP methodology at point-of-sale via the System. Should AWP become obsolete or market conditions warrant a change in pricing methods, other nationally recognized referenced based pricing sources, such as WAC based pricing or suggested wholesale price, may be implemented and utilized. Upon the return of a paid claim response to the Pharmacy via the System, Pharmacy has agreed to accept terms, rates, and participation. Pharmacy may not bill a Covered Person in excess of the applicable copayment amount returned on a paid claim via the System, unless allowed by state and/or federal law.

The Agreement does not exclude or guarantee access into all Networks, and Plan Sponsors may utilize alternative, limited, or restricted Networks. ProCare's Pharmacy Network and reimbursement includes, but is not limited to, commercial, Medicare Part D, Medicaid, Long Term Care, home infusion, hospice, consumer operated and orientated plan programs, worker's compensation, discount cards, cash cards, coupon vouchers, reward and restricted programs, vaccinations (including professional allowance), specialty, mail order, healthcare cooperatives, or other custom Plan Sponsor Networks. Pharmacy acknowledges and agrees the acceptance of a successfully adjudicated claim means:

1. Pharmacy agrees to participation in applicable Network(s).
2. Pharmacy agrees to accept rates and reimbursement of claim for applicable Network(s).

In the event of a conflict between the Agreement, Addenda, Exhibits, Amendments, Manual, or the System adjudication response, the System response shall govern, unless an overpayment error occurs. ProCare shall recoup overpayments on behalf of the Plan Sponsor, or in accordance with state law.

Pharmacy agrees and understands contacting a Plan Sponsor who utilizes ProCare's Networks directly for any pricing disputes or claim processing issues, unless permitted by ProCare in writing, is strictly prohibited. Furthermore, Pharmacy also agrees and understands ProCare submits payments to the Pharmacy for approved claims and Pharmacy will not pursue a Plan Sponsor for any additional financial payments or incentives. Such violation is considered prohibited and may be subject to financial penalties of one thousand dollars ($1,000) per incident/per day and Pharmacy's termination from the Network(s).

If Pharmacy is affiliated with a third-party contracting/purchasing group, Pharmacy is subject to all terms and conditions of this Manual and the third party's Agreement, Addenda, Amendments, and Exhibits. If affiliated Pharmacy is found to be in breach of any terms or conditions of said Agreement, Addenda, Amendments, Exhibits, and/or Manual, Pharmacy may be terminated from all ProCare Networks at ProCare's sole discretion.

ProCare processes Pharmacy payments twice per month, or sooner, as required by state or federal law and/or requirements. Financial cycles may be changed or altered because of a contractual obligation to a Plan Sponsor, or in accordance with state Prompt Pay regulations or federal laws. In these situations, ProCare will notify Pharmacy in the next subsequent check issuance of any future financial cycle modifications, if applicable.

CLAIM ADJUSTMENTS AND REVERSALS:

Pharmacy may adjust a claim when it has been submitted incorrectly, or if the Covered Person wishes a switch to Brand or Generic Drug dispensing. To request a paid claim be adjusted, Pharmacy should submit the claim online (reversal and re-submission), or, under limited circumstances, submit a Manual Claim Form indicating "REVERSAL" or "ADJUSTMENT".

For *online claims*, all requests for claim adjustments must be received and processed by ProCare within thirty (30) days of the fill date, or as required by applicable federal or state law. Pharmacies designated as Long Term Care shall submit claims within ninety (90) days of the date of fill, or in accordance with state law.

For *manual claims* (when allowed*)*, all requests for claim adjustments must be received and processed by ProCare within ninety (90) days of the date of fill to be eligible for an adjustment. However, ProCare may, at its own discretion, approve submission outside of the ninety (90) day window.

Pharmacy agrees to reverse claims within fourteen (14) days of original submission for all medications not picked up by a Covered Person. Failure to reverse claims not picked up by a Covered Person are subject to claim reversal plus a five hundred dollar ($500.00) penalty per claim, if found via Pharmacy audit.

GENERAL CLAIM DISPUTES:

In the event a Pharmacy wishes to dispute a claim due to an alleged discrepancy, error, or noncompliance with regard to terms of the Pharmacy Agreement, Pharmacy must notify ProCare in writing within sixty (60) days of the date of fill, or in accordance with the Agreement or state or federal laws, if applicable. The claim dispute notification must include Pharmacy's NCPDP or NPI number, Covered Person's ID number, prescription number, date of fill, claim reference number and detailed information stating the reason for the dispute. ProCare shall have thirty (30) business days to respond to the notification, provided all documentation/information is obtained from the Pharmacy. In the event ProCare requests additional documentation/information, the Pharmacy must comply in a timely manner to provide ProCare the requested information. Once the additional requested information is received from the Pharmacy, ProCare has thirty (30) business days to research and respond to the Pharmacy's appeal. Claim dispute notifications should be emailed to network@procarerx.com.

ProCare's appeals process provides three (3) levels of review:

1. First Level Appeal – ProCare's Clinical team
2. Second Level Appeal – ProCare's Clinical team [2]
3. Third (and final) Level Appeal – a contracted external review organization ("ERO")

Expedited appeals are determined and verbal notification to the Member and Prescriber is provided within 72 hours from receipt of request and written notification within three (3) calendar days of request.

Non-expedited (standard) appeals are responded to within 30 calendar days of request.

This policy is available to Members and Prescribers upon request.

CLAIM APPEALS PROCEDURE:

If the initial coverage decision is denied and First Level Appeals are not delegated to ProCare, the notification will refer the Member to their respective health plan.

The First Level Appeals process shall be as follows:

1. When the appeal is received in writing or telephonically, the request shall be forwarded to ProCare's Clinical team for review.
2. ProCare's Clinical team may obtain additional information from the treating Prescriber and or claim information, and other such clinical materials, including FDA approved package inserts, industry clinical journals, and other information that may be relevant to making an impartial decision.
3. ProCare's Clinical team shall review the appeal and document their decision in writing.
4. If the decision is to deny, the Member and Prescriber are notified of the denial in writing, along with the process to file a secondary appeal if the Member/Prescriber does not agree with the findings. If secondary appeals are not delegated by the Client to ProCare, the appeal letter will refer the Member to their health plan.

If the appeal is overturned, the Member and Prescriber are notified in writing. ProCare's Clinical team will add a rule into the System allowing the claim to pay.

The Second Level Appeals process shall be as follows:

1. The case, including all documentation in the previous steps, shall be submitted to ProCare's Clinical Pharmacist.
2. ProCare's Clinical team [2] may obtain additional information from the treating Prescriber and or claim information and other such clinical materials, including FDA approved package inserts, industry clinical journals, and other information that may be relevant to making an impartial decision.
3. A review shall be performed by ProCare's Clinical Pharmacist, and their decision is documented in writing.
4. If the First Level Appeal is overturned, the Member and Prescriber are notified in writing.
5. If the decision is to uphold the original denial, the Member and Prescriber are notified of the denial in writing, along with the process to file a final appeal if the Member/Prescriber does not agree with the findings.

The Third (and final) Level Appeals process shall be as follows:

1. The case, including all documentation in the previous steps, will be submitted to a contracted external independent review company for review.
2. A review shall be performed by the contracted external independent review company, and their final decision is documented in writing.
3. Client shall be notified in a summary document of the final decision by the contracted external independent review company.
4. In accordance with the arrangement between ProCare and the Client, the Member shall be notified of the final decision of the contracted external independent review company.
5. For health plan Clients and other approved entities that may accept PHI, the documentation provided by ProCare may include Patient-specific information.

Appeal documentation is managed electronically. The documentation of appeals includes the following:

- Consumer demographics.
- Correspondence from the Consumer/Prescriber.
- Dates (open, reviewed, and closed).
- Name and credentials of clinical peer.
- Clinical review criteria if a non-certification is determined.

Appeal reports are submitted to the Quality Committee on a quarterly basis.

NOTE: *All appeals are reviewed by Pharmacists or Physicians as permitted by state appeal laws, who were not involved in the original denial decision. Neither the individual who made the original non-certification, nor the subordinate of such individual is involved in the appeal.*

ProCare is committed to using good clinical practice guidelines, and uses information derived from a review of currently available clinical information, including clinical outcome studies in the peer-reviewed published literature, regulatory status of the procedure, evidence-based guidelines of public health research agencies, views of practitioners practicing in relevant clinical areas, and other relevant factors. ProCare makes no representation and accepts no liability with respect to the content of any external information cited or relied upon in establishing the clinical practice guidelines. The description, background, and positions reflected in the clinical practice guidelines, including any reference to a specific Provider, product, process, or Service by name, trademark, or manufacturer, constitutes ProCare's opinion and are made without intent to defame. ProCare further makes no representation that these opinions are endorsed by any healthcare Provider or healthcare Provider society, and reserves the right to revise the clinical practice guidelines as clinical information changes.

The conclusion that a particular drug or Service is acceptable does not constitute a representation or warranty that this Drug Service is covered for a Member's benefit plan. The Member's benefit plan determines coverage.

GENERIC DRUG (MAC) APPEALS:

ProCare's MAC list(s) are considered proprietary and confidential and are updated by ProCare, at its sole discretion. ProCare utilizes multiple sources to ensure the MAC list(s) reflect market pricing and Generic Drug Product availability. ProCare is committed to reviewing fully completed and submitted MAC appeals in a timely manner, or in accordance with state guidelines. Requirements for MAC appeals may be found on the *Generic Pricing Appeal Form* located on the Pharmacy Portal.

Pharmacy agrees not to delay, withhold, or affect Covered Person access to Services in the event a MAC appeal is generated by Pharmacy. In addition, Pharmacy shall not involve the Covered Person or Covered Person's Plan Sponsor of such reimbursement disputes.

An independent Pharmacy holding a direct Agreement with ProCare may submit a MAC appeal directly to ProCare via reimbursement@procarerx.com.

An independent Pharmacy under a third-party affiliation ("PSAO") or chain agreement must direct all MAC inquiries to their affiliation for proper handling, unless otherwise indicated by ProCare. A MAC appeal sent to ProCare by an affiliated independent Pharmacy will not be reviewed unless prior permission has been granted solely by ProCare. It is the expectation of ProCare that all MAC appeals sent by a chain affiliation are fully reviewed and screened prior to submitting to ProCare for review.

Appeals will not be reviewed for claims reimbursed at U&C, submitted ingredient cost, claims reimbursed at AWP discounts, or Brand Drug Claims. Duplicate claims will not be reviewed and are limited to one (1) individual claim reference number per appeal. Appeals submitted without the required supporting documentation, such as Pharmacy name, Pharmacy NCPDP/NPI, BIN, prescription number, fill date, Drug Product NDC, and acquisition cost shall be considered incomplete and will not be reviewed until all information is received.

All completed appeals must be emailed to reimbursement@procarerx.com within sixty (60) days of actual claim fill date, or per federal and state guidelines.

Reviews and final determination of accepted MAC appeals shall average five (5) to seven (7) business days, or in accordance with state law. Where applicable, upon final decision and determination of an accepted MAC appeal submission, ProCare will provide Pharmacy a reason for denial of the MAC appeal. If Pharmacy is located in a state that requires a different timeframe to submit/resolve MAC appeals, ProCare will abide by state requirements.

Upon written request, and as required by law, ProCare will make MAC lists available to Pharmacy. Pharmacy agrees ProCare's MAC list is considered confidential and proprietary and may not be distributed or discussed.

PRESCRIPTION IDENTIFICATION CARD:

The Covered Person's eligibility must be verified through the System or by contacting the specific telephone number listed on the back of the applicable Prescription Identification (ID) Card. Covered Persons are instructed to provide their ID Card(s) when obtaining a Drug Product and/or Service from a participating Pharmacy.

Covered Persons in nursing homes, Long Term Care (LTC) facilities, and hospices are not required to present ID Card(s). ProCare's Help Desk phone number is found either by referencing the back of the ID Card or by referring to the online claims response, when applicable.

Please Note: For same-sex twins, enter in first names and date of birth.

Sample ID Card

ProCare Rx

PLAN SPONSOR NAME HERE
PLAN SPONSOR INFORMATION HERE

BIN #: **009430**
GROUP #: **123456789**
ID: **123456789**
NAME: **SAMPLE MEMBER**

PHARMACY HELP DESK: (800) 699-3542

Member: Drugs that are covered by your plan may be filled by participating Pharmacies per your plan requirements. This card is for identification purposes only, and you may be required to provide additional ID at the time your prescription is filled. Presentation of this card does not guarantee eligibility. Unauthorized or fraudulent use of this card is punishable by law and ProCare reserves the right to revoke this ID card at any time for cause.

Pharmacy: ProCare is not responsible for payment of Claims to a non-participating pharmacy. For Prior Authorizations, please call: **1-800-211-8592.**

PROCARE
1267 Professional Parkway
Gainesville, GA 30507
Pharmacy Help Desk 1-800-699-3542

COORDINATION OF BENEFITS ("COB"):

Coordination of Benefits (COB) with a Covered Person's other coverage may vary between Plan Sponsors and may or may not be allowed. Please refer to System or applicable payer sheet for proper direction and facilitation of all COB claim submissions after validation of all other information is initially made with the Covered Person.

REMITTANCE ADVICE:

ProCare will provide Pharmacy with remittances (either paper or electronic) for claims processed, where applicable, within their respective payment cycle. Additional fees may apply for remittance recreations or additional Services where original remittances have already been delivered to Pharmacy or its authorized agent, without error, as confirmed by ProCare. The below outlines the applicable fees.

Type	Fee*
Paper and electronic remittance recreation	$25 (per Pharmacy, per cycle)
Stop payment on check	$35 per check
Remittance research or documentation request	$25 per half-hour (minimum 1 half-hour)

*Fees shall be charged and withheld through future billing cycle withholds to Pharmacy or its authorized agent.

CLINICAL P&T COMMITTEE:

ProCare's P&T Committee will review the use and therapeutic effects of several classes of Drug Products within the same therapeutic class to identify preferred agents based on safety, efficacy, effectiveness, and dramatic cost variances. However, cost will not be a primary consideration in determining the safety and/or efficacy of a drug.

In general, the procedure for therapeutic class review will be as shown below. ProCare's P&T Committee will not be specifically bound by the procedure below in determining which therapeutic classes to review, or under what time schedule, if additional factors such as new drugs entering the market, loss of patent, or FDA warnings occur.

1. The P&T Committee will approve inclusion or exclusion of individual therapeutic classes in the printed formulary on an annual or as needed basis.
2. Each of the top twenty (20) therapeutic classes, which are determined by utilization and general medical practice by the acting P&T Committee chairman, will be reviewed annually at ProCare's annual onsite P&T Committee meeting. Annual reviews will always be performed on the following primary therapeutic classes periodically, regardless of utilization or general medical practice priority:
    - Diabetes
    - Hypertension (Cardiovascular)
    - High Cholesterol
    - Blood Modifiers
    - Rheumatoid Arthritis
    - Multiple Sclerosis
    - Respiratory Agents
    - Oncology
3. Based on the outcomes of the therapeutic class reviews, and given current good medical practice, the P&T Committee will recommend the development of new drug use criteria, new treatment guidelines, or changes to the formulary, including change in tier placement, implementation of any Prior Authorization requirements, and/or implementation of step edit protocols or prescription quantity limits.
4. Formulary therapeutic categories and classes may be changed based on the guidance of the P&T Committee, which will include the addition of new drug entities and new therapeutic uses, or the reclassification or further breakdown of a specific therapeutic category or class listed to provide better guidance to practitioners and Prescribers.

DRUG FORMULARY:

ProCare may manage Drug Formularies for payers of healthcare, such as, employer groups, universities, regional HMOs, and other plan types, through its online claims adjudication system (the "System"). ProCare's Pharmacy and Therapeutics ("P&T") committee meets at regular intervals to review which Drug Products are appropriate for inclusion in the drug formulary, based primarily on clinical efficacy and secondarily on payer cost. If a submitted claim is non-compliant with the drug formulary and the Plan Sponsor has opted for a closed formulary benefit, the claim will reject and an online message will be returned to the Pharmacy indicating the preferred Drug Product. For selective Formularies, the Covered Person's copayment may be higher, again with an indication of the preferred Drug Product. Printed Pocket Drug Formularies are available upon request by contacting the phone number listed on the back of the Covered Person's ID Card.

ANCILLARY CHARGES:

Ancillary Charges are charges incurred beyond the standard copayment/coinsurance charge (i.e. deductible(s) and/or DAW penalties) and may vary by Plan Sponsor. If any Ancillary Charges have been applied to the Covered Person, Plan Sponsor, or the Pharmacy, such charges will be noted via the System.

340(B) PROGRAM:

In the event the Pharmacy is contracted, owned, or operated by an eligible 340(B) participating entity, allowing the purchase of Drug Products at a reduced cost under the Public Health Service Act, Section 340(B) program, Pharmacy shall immediately inform ProCare with written notice of eligibility. Failure to provide such documentation shall constitute a material breach of the Agreement.

ORIGIN CODE REQUIREMENTS:

Prescriptions, including refills, must contain an Origin Code value according to the chart below on all claims submitted. Claims without a value will be rejected/denied at the point-of-sale.

VALUE	VALUE TYPE
00	Original dispensing — the first dispensing
01-99	Refill number — number of the replenishment
ALL NEW PRESCRIPTIONS MUST CONTAIN ONE OF THE FOLLOWING NUMERIC VALUES:	
1	Written
2	Telephone
3	Electronic
4	Fax
5	Used when a new prescription number needs to be created from an existing valid prescription (i.e. traditional/intra-chain transfers, file buys, and system/software upgrades). Also appropriate to use for over-the-counter, Plan B, Pharmacist's authority to prescribe, etc.

DISPENSE AS WRITTEN (DAW):

ProCare utilizes all DAW/Product Selection Codes as specified by NCPDP. The matrix below serves only as a guide and may be used when dispensing a multi-source Brand Drug Product where an Orange Book 'A' rated Generic Drug Product is available. Additionally, these values are Plan Sponsor benefit-specific and may vary by Plan Sponsor. Valid DAW values are as follows.

DISPENSE AS WRITTEN (DAW) PAYMENT MATRIX

DAW	REASON	ACTION	WHO PAYS PENALTY*	CO-PAY BASIS
0	No Product Indicator	Pay	Pharmacy	Brand
1	Physician Requested Product	Pay	None	Brand
2	Covered Person Requested Product	Pay	Covered Person	Brand
3	Pharmacist Requested Product	Pay	Pharmacy	Brand

DAW	REASON	ACTION	WHO PAYS PENALTY*	CO-PAY BASIS
4	Generic Drug Not in Stock	Pay	Pharmacy	Brand
5	Brand Drug Used as Generic	Pay	Pharmacy	Brand
6	Override	Pay	Pharmacy	Brand
7	Brand Mandated by State Law	Pay	Pharmacy	Brand
8	Generic Not in Marketplace	Pay	Pharmacy	Brand
9	Other	Reject	Pharmacy	Brand

*Offered as a general guideline. May vary between Plan Sponsors. Penalty values may also vary per Plan.
Invalid or incorrect DAW submissions may result in inaccurate reimbursement.

DRUG PRODUCT QUANTITY LIMITS:

*Maximum Days' Supply Parameters **

DISPENSORY	LIMITATIONS
RETAIL:	30-34 Days' Supply. Refills Limited by State Law.
MAIL SERVICE:	90 Days' Supply for Maintenance Drugs. Refills Limited by State Law.

*Refill Parameters **

ISSUE	LIMITATIONS
Prescription Utilization Required Before Refill Allowed	RETAIL: 80% MAIL SERVICE: 85%

* The examples above are the most commonly utilized at ProCare; however, both the maximum days' supply and refill parameters vary by Plan Sponsor and benefit.

SIGNATURE LOGS:

Pharmacy shall maintain, at each dispensing location, either a manual or electronic signature log, or other electronic proof of pickup. The log must contain the Covered Person's name, date of fill, prescription number, and the date the Drug Product or Service is received by Covered Person or Representing Agent.

Home Delivery Logs: If Pharmacy delivers a Drug Product to a home or business address, the log must include: Covered Person's name, address of delivery, prescription number, date of fill, signature of Covered Person or Representing Agent, date of delivery, time of delivery, and delivery person's signature, or any other required information in accordance with state law.

Mail Order Pharmacy Logs: For Pharmacies licensed and authorized by ProCare to act as a Mail Order Pharmacy, shipping logs must include Covered Person's full name, Covered Person's mailing address, prescription number, date prescription filled, date prescription mailed, and delivery confirmation of each prescription, or in accordance with state law.

Failure to comply with signature log requirements may result in full recoupment of Drug Product or Service reimbursement and/or penalty. Signature Logs must be maintained for all claims submitted through the System.

PRIOR AUTHORIZATION AND PROCEDURES:

Prior Authorizations ("PAs") may be required for eligibility, age restriction overrides, fast refill, vacation supply, compounds, maximum days' supply, and several other drug categories, as well as certain prescriptions filled at retail with a drug cost greater than five hundred dollars ($500.00) or any prescription filled at Mail Order, when allowed, with a drug cost greater than one thousand dollars ($1,000.00). To obtain a PA number, the Pharmacy must contact the Pharmacy support number listed on the back of the Covered Person's ID card**.**

PA numbers are specific to the Covered Person's ID number, prescription number, 11-digit NDC, fill date, and Pharmacy NCPDP/NPI. PA numbers may only be used once and are not applicable to any impending refills of the same prescription.

Standard timeframe coverage determinations (including medical necessities, plan benefit reviews, appeals, and reconsiderations):

1. The maximum timeframe from initial fax to final determination will not exceed fourteen (14) calendar days for initial determinations, and thirty (30) calendar days for standard appeals.
2. Once an initial fax is sent out, the Provider will have at least seven (7) calendar days to respond with a completed Prior Authorization (PA) form. If the Provider fails to complete a PA form, the request may be denied due to insufficient information within fifteen (15) total calendar days from the initiation of the Prior Authorization.

Expedited timeframe coverage determinations (including medical necessities, plan benefit reviews, appeals, and reconsiderations):

1. Expedited appeals are completed with verbal notification of determination within seventy-two (72) hours of the request, followed by a written confirmation of the notification within three (3) calendar days to both the Member and the Prescriber.

GENERAL COVERAGE FOR PLAN SPONSORS:

Inclusions – Drug Product(s) and/or Service(s) must meet the following criteria:

1. Have been prescribed by a licensed Prescriber.
2. Be a Drug Product or device approved by the Food and Drug Administration (FDA).
3. Be a designated Federal Legend Drug Product.
4. Not be excluded from coverage under the Exclusions below.

Exclusions – The following products are *generally* not covered under a Covered Person's benefit plan, but may vary by Plan Sponsor:

1. Disposable and Durable Medical Supplies (DME), non-insulin products.

2. Applicators or devices.
3. Products used solely for cosmetic purposes (i.e. Rogaine and Propecia).
4. Anorexiants.
5. Drug Efficacy Study Implementation (DESI drugs).
6. Agents used for diagnostic purposes.
7. Experimental or investigational drugs (Drug Products & Services without FDA approved indication).
8. Over-the-counter (OTC) products other than insulin, syringes, and those deemed appropriate under a Prescription/Medical benefit plan.
9. Re-packagers outside of CMS accepted programs and procedures.
10. Serum/Allergens and Toxoids, where applicable.
11. Multi-Vitamins (other than prenatal or multi-vitamins with fluoride).
12. Replacement prescriptions resulting from loss, theft, or breakage.
13. Any compounded pharmaceutical Service that does not contain an ingredient that requires a prescription (Legend Drug Product).

FRAUD, WASTE, AND ABUSE ("FWA") PROGRAM:

Healthcare fraud, waste, and abuse (FWA) is a very serious topic and potential offense. FWA is defined as the following and may not be interpreted by any other meaning other than the definitions below:

Fraud: A person who knowingly and willfully executes, or attempts to execute, a scheme or artifice to (i) defraud any healthcare benefit program to obtain, by false or fraudulent pretenses, representations, or promises, healthcare payments under which no entitlement exists; (ii) knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for Services reimbursed by any healthcare benefit program; (iii) making prohibited referrals for certain health Services to any healthcare benefit program; (iv) billing any healthcare benefit program for Services not rendered; (v) falsifying records to show delivery of Services not rendered; (vi) paying for referrals for monetary gain; (vii) billing a higher level of Service than what was provided (i.e. higher compound level of effort or delivery Services not provided); (viii) providing Services without proper licensure.

Some examples of fraud include, but are not limited to: altering a Physician's prescription, submitting bills/claims to multiple payers for the same prescription dispensing Generic Drug Products but billing for a Brand Drug Product, billing a different NDC than dispensed, submitting an invalid DEA or NPI to receive a paid Claim, splitting prescriptions to receive an additional dispensing fee, pill shorting a Covered Person, or filling prescriptions not medically necessary.

Waste: Is considered misuse or overutilization of any Service(s) rendered that may, directly or indirectly, result in unnecessary costs to any healthcare benefit program.

Abuse: A practice that, either directly or indirectly, results in unnecessary costs to any healthcare benefit program, or any practice inconsistent of Services that are not medically necessary. Abuse includes: billing unnecessary or not medically necessary Services, charging or billing excessively for Services and/or

supplies, and misuse of NDCs on claims to obtain higher reimbursement from any healthcare benefit program.

Federal laws governing FWA include:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Social Security Act
- United States Criminal Code, specifically, 18 U.S. § Code 1347. Health Care Fraud

ProCare monitors its Pharmacy Network regularly for compliance and risk (please refer to the Audits section for further detail). Network Pharmacies are required to report any potential or suspected FWA to ProCare and as required by law. Pharmacies must cooperate with and assist in aiding state and/or federal agencies with investigation(s) by providing any documentation requested and access to premises and records upon request. ProCare investigates all claims of FWA activity reported by any of its contracted Pharmacies, Physicians, vendors, associates, contractors, Covered Persons, and/or other business entities capable of potential FWA.

- To report an FWA-related incident anonymously, please call 1-678-248-3180 to leave a confidential voice mail; or
- Email our confidential Hotline anonymously at hotline@procarerx.com.

PHARMACY CLAIM AUDITS

All Claims submitted are subject to audit. Pharmacy agrees to permit either an authorized ProCare representative or an independent third-party auditor designated and approved by ProCare or Plan Sponsor, access to its books, records, logs, and facilities, as well as access to scans and photographs for the sole purpose of conducting an audit to ensure compliance of Pharmacy in dispensing Drug Products and/or Services to Covered Persons within the terms of the Agreement. Pharmacy agrees audits may be completed during normal business hours via phone call, desktop audit, or on-site visit, in accordance with federal, state, and/or local law.

Compounded claims are subject to audit review and may require full disclosure of compound recipe upon request. Pharmacy agrees to provide a copy of the compound recipe worksheet identifying ingredients used in the compounded drug, when requested.

Institutional packaging NDC numbers are not covered.

Pharmacy shall maintain proper prescription and financial records, including, but not limited to, books, records, signature logs, Patient information, hardcopies of prescriptions, Physician information, wholesaler or distributor purchasing invoices, policies and procedures, and any additional information as required by local, state, or federal law, for a minimum of seven (7) years, or as required by applicable law. ProCare reserves the right to audit claims during the term of the Agreement and for two (2) years following termination of the Pharmacy or Agreement, or longer, only if part of a legal case, or in accordance with state or local law.

ProCare may share audit findings with Plan Sponsors, governmental entities, and/or an audit agency acting on behalf of ProCare, as required. If Pharmacy belongs to a third-party affiliation (PSAO), ProCare, at its own discretion, may notify PSAO of audit findings. Pharmacy shall cooperate either with audits conducted by ProCare, or with an agency acting on behalf of ProCare. Pharmacy's failure to cooperate during an audit will be considered a breach of the Agreement and Pharmacy shall be subject to immediate suspension and/or termination of Network participation.

ProCare may offset audit recoupment amounts and/or penalties charged through future payment cycles or via invoicing, at ProCare's sole discretion.

On-Site Audits
ProCare may conduct an audit, provided it is reasonable in scope, and provided that ProCare has notified Pharmacy in writing at least fourteen (14) days prior to the audit, or in accordance with state law.

Pharmacy agrees not to refuse a prescheduled on-site audit at the time of auditor arrival. Pharmacy agrees to provide a work area for the auditor, to be adequately staffed to assist in, and to answer questions, and retrieve information during the audit. Auditors must be given full access to any records, files, logs, copies, invoices, and any documentation pertaining to claims transactions submitted to ProCare. Auditor reserves the right to request copies or take digital images during audit. Failure to assist in audit will be determined a denial of access and a breach of the Agreement, and Network participation shall be terminated immediately.

Please see the Audit Guide posted to Pharmacy Portal for further information on ProCare's audit process.

Desktop Audits
Pharmacy shall provide records or copies of records requested by ProCare, or its designated auditor, within ten (10) days from the date of notification of the request for such records, or in accordance with state law.

In instances where a quantity differs between the actual prescription written by the Physician and the actual amount given to the Covered Person, full detail of the reason for the action and variance must be documented. A hard copy prescription must be kept on file for every prescription and must be accessible upon request, as required by law. For prescriptions labeled "As Directed," only the prescription written by the actual Physician will be accepted as documentation for an appeal consideration.

Please see the Audit Guide posted to Pharmacy Portal for further information on ProCare's audit process.

Investigational Audits
Investigational audits are audits performed by ProCare and may include, but are not limited to: Credentialing documentation, prescription records, signature logs, electronic signature logs, and/or Claims. In the event ProCare requests records pertaining to an investigational audit, Pharmacy must agree to comply with the request for documentation immediately. Investigational audits are small and considered an inspection of the Pharmacy's documentation requested. These audits are necessary when initiated by a Plan Sponsor and/or ProCare.

Network Recovery Program
Pharmacy agrees that ProCare and/or Plan Sponsor shall have the right to reclaim any money, either full or partial, previously paid to Pharmacy for Drug Products and/or Services found incorrectly billed/paid, or not to be in compliance within the terms of the Agreement or Pharmacy practice in accordance with state or federal law. ProCare shall provide reports in writing for any or all Services stating exact non-compliant details for each Drug Product or Service for which recovery has been determined.

Please see the Audit Guide posted to Pharmacy Portal for further information on ProCare's audit process.

CONFIDENTIALITY:

Pharmacy shall comply with all laws applicable pertaining to confidentiality, use, disclosure, and maintenance of Covered Person's protected health information (PHI). Except as required by law, Pharmacy, on behalf of itself and its employees, contractors, and other representatives, agrees to treat all PHI, Agreements, Addenda, Exhibits, and Manuals as confidential and proprietary, and to take reasonable precautions and care to prevent unauthorized use and/or disclosure of the terms of the agreement, as well as any other information relating to ProCare's business operations/Services in which ProCare considers proprietary information to include, but not be limited to: Pharmacy Agreements, MAC listings, reimbursement, pricing, programs, Services, business practices, software, processes, applications, Systems, technology, files, Exhibits, publications, protocols, information pertaining to Clients, benefit plans, and formularies. All proprietary information remains the exclusive property of ProCare and Pharmacy agrees not to discuss or disclose any proprietary information.

In addition, Pharmacy agrees reimbursement terms are considered proprietary and are not to be discussed with any Client, Plan Sponsor, Covered Person, Covered Person's Representing Agent, or other Pharmacy (participating or non-participating), without prior written authorization from ProCare. Pharmacy acknowledges and agrees any discussions pertaining to the reimbursement of Drug Products and Services with any Client, Plan Sponsor, Covered Person, Covered Person's Representing Agent, other Pharmacy (participating or non-participating) is considered a breach of the Agreement and could result in immediate termination from ProCare's Network(s).

For affiliated Pharmacies (Pharmacies contracted with a chain, PSAO, or a third-party contracting entity), all reimbursement inquires and communications are required to be directed through the Pharmacy's affiliation, unless otherwise specified by ProCare. Affiliated Pharmacies are not permitted to discuss reimbursement with any Client, Plan Sponsor, Plan Sponsor's staff, Covered Person, or Covered Person's Responsible Party. Any discussion pertaining to the Pharmacy's reimbursement with any party other than Pharmacy's chain affiliation, or in some cases, ProCare directly, is considered a breach of the chain affiliation Agreement with ProCare and could result in immediate termination from ProCare's Networks. The chain affiliated Pharmacy is subject to all current terms and conditions of the Agreement between the respective chain and ProCare through the allowance of such sub-contracting during the time the Pharmacy is active with the respective chain affiliation, as reported by NCPDP.

MISCELLANEOUS:

Additional information regarding ProCare's Network, including forms, communications, notices, and updates, may be obtained by visiting https://www.mc-rx.com.

This Manual is updated periodically, at the sole discretion of ProCare. ProCare shall post the most current version of the Manual on the Pharmacy Portal. The Manual applies to all lines of business and is considered an extension on the Pharmacy's Agreement. It is the Pharmacy's responsibility to ensure they are using the most current version of the Manual when referencing.

Pharmacies who leave their affiliated chain entity will not be considered contracted/participating after the date of termination with the chain entity, as reported by NCPDP. The Pharmacy will need to request a direct contract via network@procarerx.com to obtain the applicable contracting documents to apply for participating status within ProCare's Network(s). Agreement effective dates will not be retro-activated unless authorized in writing by Plan Sponsor and/or ProCare.

ProCare updates its files regularly through monthly data feeds from NCPDP, or other nationally recognized Provider data vendors, as determined by ProCare. Such data includes, but is not limited to, Pharmacy NCPDP number, NPI number, Pharmacy chain affiliation, demographics, licenses, Pharmacy status, dispenser types, and chain termination dates, if applicable. It is the Pharmacy's responsibility to contact NCPDP and update any information and/or changes to ensure the integrity of ProCare's files and database. ProCare will not make changes to any Pharmacy record unless NCPDP reflects such change(s). If Pharmacy refuses to update NCPDP, Pharmacy will be responsible for any errors in data provided to Covered Persons, Pharmacy payments, and any reimbursement-related issues. ProCare reserves the right to recoup any monies due on behalf of Plan Sponsors should Pharmacy fail to maintain NCPDP with the correct data.

ProCare is committed to quality surrounding the Network and may at times engage the Pharmacy in Quality Improvement initiatives, activities, or surveys through communications via direct outreach or via the ProCare Provider Portal. Pharmacy may submit suggestions directly to ProCare via email, telephone, or fax.

Pharmacy understands participation in a Network does not grant access into all Networks. ProCare and/or Plan Sponsor reserves the right to limit participation in a Network, at its sole discretion. Furthermore, Pharmacy agrees to participate all in applicable Networks and shall not be allowed to opt-out without written consent from ProCare.

ProCare may immediately terminate or suspend the Agreement or any applicable Amendment, Addendum, or Exhibit pursuant to business needs, Plan Sponsor request, or any of the following reasons, including but not limited to:

- Failure to meet/maintain Credentialing standards, failure to retain liability insurance (i.e. lapse, cancellation, or suspension), loss of state licensure, excluded from federal programs (OIG).
- Fraudulent claim submission activity detected.
- ProCare has reason to suspect Pharmacy is/has engaged in fraudulent practices of federal and state law.
- Covered Person(s) are refused Services as required by the Agreement.
- Any automated reversal process(es).
- Rejecting Covered Persons at the point-of-sale for a non-clinical reason, or steering to other coverage to improve compensation, including discount cards.

- Breach of any term set forth in the Agreement and/or Manual.
- Refusing to provide Services to a Covered Person based on reimbursement.
- Covered Person is charged more than the copayment.

Pharmacy agrees not to advise, counsel, or solicit Covered Persons with Plan Sponsors utilizing ProCare for any reason, including, but not limited to, compensation. Pharmacy agrees not to advise, counsel, or solicit Plan Sponsor to terminate its relationship with ProCare for any reason. Pharmacy agrees such behavior is strictly prohibited and shall be grounds for immediate termination under the Agreement.

ProCare's Pharmacy Manual is considered confidential and proprietary. Pharmacy agrees not to copy, distribute, or share information included in this Manual, except as required for business or contract purposes only.

Continued on next page.

FEDERAL AND STATE STATUTES AND REGULATIONS

ARKANSAS

The following provisions shall apply to Pharmacy Providers in the State of Arkansas:

1. Pursuant to ACA §23-92-507, ProCare Pharmacy Benefit Manager, through the Arkansas dispensing Pharmacy/Pharmacist, will inform Covered Persons, where applicable, of any differential between price of the lowest-priced, therapeutically equivalent and bio-equivalent generic drug at the point of sale, unless the lowest price drug is being purchased. The Pharmacist contract shall not prohibit, restrict, or limit disclosure or information to the Insurance Commissioner, law enforcement, or state and federal governmental officials investigating or examining a complaint or conducting a review of a PBM's compliance with the requirements under Ark. Code § 23-92-507.

2. Pursuant to ACA §17-92-507, "Maximum Allowable Cost List" shall mean a listing of drugs or other methodology used by a pharmacy benefits manager, directly or indirectly, setting the maximum allowable payment to a Pharmacy or Pharmacist for a generic drug, brand-name drug, biologic product, or other prescription drug.

3. Pursuant to ACA §17-92-507, for every drug which ProCare establishes a maximum allowable cost to determine the Drug Product reimbursement, ProCare shall ensure that:

- Reimbursement for a drug subject to maximum allowable cost is based solely on that drug and drugs that are therapeutically equivalent if the therapeutically equivalent drugs are listed in the most recent version of the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.
- Reimbursement for a "B" rated drug subject to maximum allowable cost is based solely on that drug and drugs that are not therapeutically equivalent to a "B" rating in the most recent version of the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.
- Reimbursement for a "NR" or "NA" drug with a similar rating by a nationally recognized reference subject to maximum allowable cost is based solely on that drug and other drugs with a "NR" or "NA" rating or similar rating by a nationally recognized reference that meets criteria for therapeutic equivalence used in the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.
- Reimbursement for a drug subject to maximum allowable cost is based solely on that drug if there is no other therapeutically equivalent drug.
- Reimbursement for a drug subject to maximum allowable cost is not based on a drug that is obsolete, temporarily unavailable, listed on a drug shortage list, or that cannot be lawfully substituted.

Before ProCare places or continues a particular drug on a Maximum Allowable Cost List, the drug:

- If the drug is a generically equivalent drug as defined under Arkansas law, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

- Shall be available for purchase by each Pharmacy in the state from national or regional wholesalers operating in Arkansas; and
- Shall not be obsolete.

ProCare shall:

- Provide access to its Maximum Allowable Cost List to each Pharmacy subject to the Maximum Allowable Cost List;
- Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten percent (10%) or more in the Pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in Arkansas or a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology;
- Provide a process for each Pharmacy subject to the Maximum Allowable Cost List to receive prompt notification of an update to the Maximum Allowable Cost List.

ProCare shall provide a reasonable administrative appeal procedure to allow Pharmacies to challenge maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

- Not meeting the requirements of this section; or
- Being below the Pharmacy acquisition cost.

ProCare's administrative appeal procedure shall include the following:

- A dedicated telephone number, email address, and website for the purpose of submitting administrative appeals;
- The ability to submit an administrative appeal directly to ProCare regarding the Pharmacy benefits plan or program or through a service administrative organization; and
- No less than thirty (30) business days to file an administrative appeal:
    - ProCare shall respond to the challenge in accordance with Arkansas law within thirty (30) business days after receipt of the challenge.
    - If a challenge is made under subdivision (c)(4)(A) of this section, the Pharmacy benefits manager shall within thirty (30) business days after receipt of the challenge either:

If the appeal is upheld:

- Make the change in the maximum allowable cost list payment to at least the Pharmacy acquisition cost;
- Permit the challenging Pharmacy or Pharmacist to reverse and rebill the claim in question;
- Provide the National Drug Code that the increase or change is based on to the Pharmacy or Pharmacist; and
- Make the change pursuant to Arkansas law effective for each similarly situated Pharmacy as defined by the payor subject to the Maximum Allowable Cost List.

If the appeal is denied:

- Provide the challenging Pharmacy or Pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Arkansas that have the drug currently in stock at a price below the maximum allowable cost as listed on the Maximum Allowable Cost List; or

- If the National Drug Code is not available below the Pharmacy acquisition cost from the pharmaceutical wholesaler from whom the Pharmacy or Pharmacist purchases the majority of prescription drugs for resale, then ProCare shall adjust the maximum allowable cost as listed on the Maximum Allowable Cost List above the challenging Pharmacy's acquisition cost and permit the Pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

ProCare shall not reimburse a Pharmacy or Pharmacist in the state an amount less than the amount that ProCare reimburses its affiliate for providing the same Pharmacist services. The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

ProCare shall not pay an Arkansas Pharmacy or Pharmacist less than the Pharmacy's acquisition cost of the Pharmacy providing Pharmacist services.

4. Pharmacy Provider has thirty (30) days from the date of the claim to appeal the initial claim. Pharmacy Provider must fully complete the Generic Pricing Appeal Form (MAC appeal) located on the Pharmacy Provider Portal. ProCare has seven (7) days to investigate and respond to the completed MAC appeal form received. If the MAC appeal is denied, ProCare will provide Pharmacy Provider an NDC of a Drug Product that can be purchased at or below the MAC price determined by ProCare. If the MAC appeal results in favor of the Pharmacy Provider, ProCare will update the MAC accordingly and advise the Pharmacy Provider to resubmit the claim.

5. Pursuant to ACA § 17-92-507, an Arkansas Pharmacy or Pharmacist has discretion to decline providing Pharmacist services to a patient or ProCare if, as a result of a Maximum Allowable Coast List, a Pharmacy or Pharmacist would be paid less than the Pharmacy's or Pharmacist's cost for the services.

6. Pursuant to ACA§23-92-505(b)(2)(c), spread pricing is illegal in the State of Arkansas.

7. Pursuant to ACA §23-92-506, ProCare shall not pay or reimburse a Pharmacy or Pharmacist for the ingredient Drug Product component of Pharmacist services less than the national average drug acquisition cost or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost.

CALIFORNIA

The following provisions shall apply to Pharmacy Providers in the State of California:

1. ProCare or Plan Sponsor, as may be necessary from time to time for compliance by ProCare, must agree to any applicable provisions of the Knox-Keene Act. Pharmacy acknowledges that it shall maintain such records for at least six (6) years from the date of last Service, or six (6) years from the date that a minor Eligible Member has achieved the age of majority. All records will be provided by Pharmacy to ProCare in a manner consistent with data privacy statutes and other applicable laws or regulations. ProCare will have access at reasonable times, upon request, to all books, records, and papers relating to the Pharmacy that have been provided to Eligible Member(s), in addition to those relating to Services provided by Pharmacy to Eligible Member(s). The obligations set forth will survive any Participating Pharmacy ("Pharmacy") agreeing to comply with all applicable laws and regulations, directly or indirectly, including the requirements of the Knox-Keene Health Care Services Plan Act ("Knox-Keene Act") and the Medi-Cal program, as they relate to the Agreement and applicable Plan Sponsors.

2. Pharmacy agrees to adhere to regulations as directed by the California Department of Managed Health Care to assure Eligible Persons have access to Services in a timely manner. Pharmacy also agrees to provide any applicable reporting in a timely fashion, upon request of ProCare Rx ("ProCare"), to ensure compliance with such access standards. CA. H&S §1371.2.

3. Pharmacy shall not collect or charge copayment amounts greater than those calculated and returned to the Pharmacy via the System, unless otherwise directly instructed by ProCare, and Pharmacy acknowledges that an Eligible Member's copayment, when calculated based on a percentage for the Services rendered to the Eligible Member, are calculated from the applicable Pharmacy reimbursement schedule set forth in the Agreement and in accordance with this provision. CA. H&S § 1373.18; CA. Ins. Code § 10133.2, 10133.3.

4. Pharmacy acknowledges it shall only collect copayments, deductibles, or other charges or payments permitted to be collected or billed for Services covered by the Agreement or Plan Sponsor, as communicated via the System or ProCare directly, as imposed by Section 1379 of the Knox-Keene Act. Pharmacy shall report to ProCare, upon request, or on a monthly or other agreed upon periodic basis, all such other charges collected by Pharmacy.

5. Pharmacy acknowledges that it is prohibited from balance billing or invoicing an Eligible Member for the difference between the Pharmacy's U&C or billed Services and the reimbursement paid by ProCare or Plan Sponsor. Pharmacy will accept payment from ProCare or Plan Sponsor as provided herein as payment in full for all Services rendered to Eligible Members pursuant to the Agreement. In the event ProCare or Plan Sponsor fails to pay for Services, Pharmacy shall not hold any Eligible Member financially responsible for any amount owed to Pharmacy by ProCare or Plan Sponsor, even if ProCare or Plan Sponsor becomes insolvent. Neither Pharmacy nor its agents, trustees, nor assignees may take any legal action against an Eligible Member in an attempt to collect amounts owed by ProCare or Plan Sponsor. CA H&S §1358.10(e)(1)(E); 1379; 28 CCR § 1300.67.8(e), 1300.71(g)(4).

6. Pharmacy acknowledges that it is prohibited from imposing any surcharges or additional fees against Eligible Members for Services administered that are not provided by or under the Plan Sponsor. Any notification of such action received by ProCare will result in appropriate actions taken, and Pharmacy will cooperate with such actions, including, but not limited to, prompt reporting by Pharmacy, in writing to ProCare, that outlines all surcharges or monies paid by Eligible Member directly to Pharmacy. CA. H&S §1379, 1385, 28 CCR § 1300.67.8.

7. Pharmacy agrees to maintain reasonable hours of operation during regular business hours to ensure Eligible Members have access to Services.

8. Pharmacy will maintain records for each Eligible Member under industry standard and accepted practices, and as may be necessary for compliance with provisions and regulations of the Knox-Keene Act. Pharmacy will release, upon appropriate request and consent, such information to termination of the Agreement with ProCare.

9. In the event of termination of the Agreement, or while in the process of termination, Pharmacy agrees that it shall assure continuity of care to Eligible Members, at the request of the Eligible Member or Plan Sponsor, in acute care with a serious chronic condition, or who is pregnant, and can obtain

continuation of care from the terminated Pharmacy for a reasonable transition period of at least ninety (90) days after termination. CA H&S § 1373.96 (e).

10. Pharmacy shall comply with any applicable Quality Improvement or Drug Utilization Management Programs or procedures of ProCare or Plan Sponsor, provided that advance notice is given to Pharmacy. However, ProCare or Plan Sponsor may make changes to Quality Improvement or Utilization Management Programs or procedures at any time, with or without notice, to comply with state and/or federal laws and regulations that may be required.

11. Pharmacy acknowledges and shall comply with ProCare's grievance processes and procedures. ProCare shall be promptly notified of any unresolved dispute with an Eligible Member. Pharmacy also agrees to comply with any final decision made by the applicable grievance committee for any reported grievance by Eligible Member or Pharmacy. 28 CCR 1300.51 (k).

12. Any provisions required to be in the Agreement, by or under Chapter 2.2 of Division 2 of the California Health and Safety Code or Subchapter 5.5 of Chapter 3 of Title of the California Code of Regulations, will be binding upon Pharmacy and ProCare, even if not specifically provided for herein.

13. Pharmacy Provider has fourteen (14) business days following the submission of a claim to submit a Generic Pricing Appeal Form (MAC appeal). ProCare will investigate and resolve the MAC appeal within seven (7) business days after the completed request is received. If the MAC appeal is denied, ProCare will provide Pharmacy Provider an NDC of a Drug Product that can be purchased at or below the MAC price determined by ProCare. If the MAC appeal results in favor of the Pharmacy Provider, ProCare will update the MAC pricing accordingly and advise the Pharmacy Provider to resubmit the claim.

COLORADO

Pharmacy Provider has twenty-one (21) business days following the submission of a claim to submit a Generic Pricing Appeal Form (MAC appeal). ProCare will investigate and resolve the MAC appeal within twenty-one (21) business days after the completed request is received. If the MAC appeal is denied, ProCare will provide Pharmacy Provider an NDC of a Drug Product that can be purchased at or below the MAC price determined by ProCare. If the MAC appeal results in favor of the Pharmacy Provider, ProCare will update the MAC pricing accordingly and advise the Pharmacy Provider to resubmit the claim.

CONNECTICUT

Pursuant to CGS §38-a-477dd, ProCare's Pharmacy Provider Agreement shall not contain any provision prohibiting or penalizing through increased utilization review, reduced payments or other financial disincentives, disclosure of any information to a Covered Person, as defined in Section 38a-591a, concerning: (1) the cost of a covered benefit, including, but not limited to, the cash price of a covered benefit; or (2) the availability and cost of any healthcare Service or product that is therapeutically equivalent to a covered benefit, including, but not limited to, the cash price of any such healthcare Service or product.

Pursuant to CGS § 38a-477f, all ProCare Agreements concerning data or analytical Services to evaluate and manage healthcare Services shall provide for the disclosure of (1) billed or allowed amounts, reimbursement rates, or out-of-pocket costs, or (2) any data to the all-payer claims database program established under section 19a-755a.

DELAWARE

The purpose of this policy is to establish standards regarding Maximum Allowable Pricing for Prescription Drugs.

1 (a) Pursuant to *18 Del. C. § 3323A*, To place a drug on a maximum allowable list, Procare must ensure that the drug meets all of the following requirements:

- **(1)** It is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products and Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference.
- **(2)** It is generally available for purchase by pharmacies in Delaware from national or regional wholesales.
- **(3)** It is not obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage.
- **(4)** If it is manufactured by more than 1 manufacturer, the drug is available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in Delaware from a wholesale distributor with a permit in Delaware, with whom the pharmacy has an existing relationship.
- **(5)** If it is manufactured by only 1 manufacturer, the drug is generally available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in Delaware from at least 2 wholesale distributors with a permit in Delaware.

2 (a) Pursuant to *18 Del. C. § 3324A*, ProCare shall establish a process by which a contracted Pharmacy can appeal the Provider's reimbursement for a drug subject to maximum allowable cost pricing. A contracted Pharmacy has 10 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network Provider paid to the supplier of the drug. ProCare must respond with notice that the challenge has been denied or granted within 10 calendar days of the contracted Pharmacy making the claim for which an appeal has been submitted.

(b) At the beginning of the term of a network Provider's contract, and upon renewal, ProCare shall provide to network Providers a telephone number and email address at which a network Provider can contact ProCare to process an appeal under this section.

(c) If an appeal is denied, ProCare shall provide the reason for the denial and the name and the national drug code number from national or regional wholesalers operating in Delaware that have the drug in stock at a price below the maximum allowable cost.

(d) If the appeal is granted, ProCare shall do the following:

- **(1)** For an appealing Pharmacy, do all of the following:
  - **a.** Adjust the maximum allowable cost for the drug as of the date of the original claim for payment.
  - **b.** Without requiring the appealing Pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with ProCare as follows:
    1. For the original claim, in the first remittance to the Pharmacy after the date the appeal was granted.
    2. For subsequent and similar claims under similarly applicable contracts, in the second remittance to the Pharmacy after the date the appeal was granted.
- **(2)** For a similarly situated contracted Pharmacy in Delaware, do all of the following:
  - **a.** Adjust the maximum allowable cost for the drug as of the date the appeal was determined.

b. Provide notice to the Pharmacy or the Pharmacy's contracted agent of all of the following:
1. That an appeal was granted.
2. That without filing a separate appeal, the Pharmacy or the Pharmacy's contracted agent may reverse and rebill a similar claim.

(e) ProCare shall make available on its website information about the appeal process, including all of the following:
1. A telephone number at which the contracted Pharmacy may contact the department or office responsible for processing appeals for ProCare to speak to an individual specifically or leave a message for an individual or office who is responsible for processing appeals.
2. An email address of the department or office responsible for processing appeals to which an individual who responsible for processing appeals has access.

(f) ProCare may not charge a contracted Pharmacy a fee related to the re-adjudication of a claim resulting from a granted appeal under subsection 2(d) of this section or the granting of an appeal under subsection (h) of this section.

(g) ProCare may not retaliate against a contracted Pharmacy for exercising its right to appeal to the pharmacy benefits manager under subsection2 (a) of this section or to the Commissioner under subsection 2(h) of this section.

(h) 1. If ProCare denies an appeal and a contracted Pharmacy files an appeal with the Commissioner, the Commissioner shall do all of the following:
a. Review ProCare's compensation program to ensure that the reimbursement for Pharmacy benefits management services paid to the Pharmacist or a Pharmacy complies with this subchapter and the terms of the contract.
b. Based on a determination made by the Commissioner under paragraph 2(h)(1)a. of this section, do 1 of the following:
i. Deny the appeal.
ii. Grant the appeal and order ProCare to pay the claim in accordance with the Commissioner's findings.

2. All pricing information and data collected by the Commissioner during a review required by paragraph 2(h)(1) of this section is confidential and not subject to subpoena or the Freedom of Information Act, Chapter 100 of Title 29.

GEORGIA

Pharmacy Provider has fourteen (14) business days following the submission of a claim to submit a Generic Pricing Appeal Form (MAC appeal). ProCare will investigate and resolve the MAC appeal within fourteen (14) business days after the completed request is received. If the MAC appeal is denied, ProCare will provide Pharmacy Provider an NDC of a Drug Product that can be purchased at or below the MAC price determined by ProCare. If the MAC appeal results in favor of the Pharmacy Provider, ProCare will update the MAC pricing accordingly and advise the Pharmacy Provider to resubmit the claim.

HAWAII

Pharmacy Provider has fourteen (14) business days following the submission of a claim to submit a Generic Pricing Appeal Form (MAC appeal). ProCare will investigate and resolve the MAC appeal within fourteen (14) business days after the completed request is received. If the MAC appeal is denied, ProCare will provide Pharmacy Provider an NDC of a Drug Product that can be purchased at or below the MAC price determined by ProCare. If the MAC appeal results in favor of the Pharmacy Provider, ProCare will update the MAC pricing accordingly and advise the Pharmacy Provider to resubmit the claim.

IOWA
If the MAC appeal is found in favor of the Pharmacy Provider, ProCare shall allow retroactive payment.

KENTUCKY
ProCare shall Identify to Kentucky contracted Pharmacies the sources used to calculate the drug reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by ProCare pursuant to KRS 304.17A-162(1)(a). In the event that the commissioner receives a written complaint about ProCare's MAC policies and procedures, the commissioner shall send a copy of the complaint to ProCare and ProCare must respond to the commissioner within fifteen (15) calendar days from the date of the commissioner's letter. At such time, the commissioner shall make a finding to ProCare and the complainant as set forth in KRS 304.2-165.

ProCare follows the process to appeal MAC pricing pursuant to KRS 304.17A-162(1)(a & b) and that an appeal grants result in pricing updates pursuant to KRS 304.17A-162(2).

ProCare shall make available to all contracted Pharmacies information identifying the national drug pricing compendia or sources used to obtain the drug price data in a manner established by the Kentucky Department of Insurance.

ProCare shall review and make necessary adjustments to the maximum allowable cost for every drug at least every seven (7) calendar days and shall immediately utilize the updated maximum allowable cost in calculating the payments made to all Kentucky contracted Pharmacies pursuant to KRS 304.17A-162(6). ProCare shall make available the list of maximum allowable cost for every drug on ProCare's Kentucky Pharmacy Provider Page which can be accessed through the ProCare Pharmacy Provider Portal.

ProCare provides a process for electronically requesting and transmitting Prior Authorizations for a drug by Providers that meet the requirement of the most recent NCPDP SCRIPT standards adopted by HHS.

MISSISSIPPI
Pursuant to the Mississippi Pharmacy Practice Act:

1. Prescription drugs shall be dispensed only pursuant to a valid prescription or a valid order. A pharmacist shall not dispense a prescription which the pharmacist knows or should know is not a valid prescription. A Prescription Drug Order, to be effective, must be issued for a legitimate medical purpose by a Practitioner acting within the course of legitimate professional practice.

   A Prescription Drug Order shall contain the following information at a minimum:
   (1) full name and street address (if required by law) of the patient;
   (2) name, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;
   (3) date of issuance;
   (4) name, strength, dosage form, and quantity of Drug prescribed;
   (5) directions for use;
   (6) refills authorized, if any;
   (7) if a written Prescription Drug Order, prescribing Practitioner's signature;
   (8) if an electronically transmitted Prescription Drug Order, prescribing Practitioner's electronic or digital signature;

2. A Prescription Drug Order must be communicated directly to a Pharmacist, or when recorded, in such a way that the Pharmacist may review the Prescription Drug Order as transmitted. A prescription/order may be accepted by a pharmacist in written form, orally, or electronically unless the order is for a Schedule II controlled substance (refer to ARTICLE XIX) of these regulations. Electronically transmitted prescription drug orders shall meet the following requirements:

   A. Electronically transmitted prescription drug order shall meet the following criteria:
      (1) be transmitted only to the pharmacy of the patient's choice; and
      (2) be transmitted by an authorized Practitioner or his or her designated agent provided that the identity of the transmitting agent is included in the order; and

   B. Prescription drug orders transmitted by facsimile or computer shall include:
      (1) The complete name, address, and DEA Registration Number of the practitioner if required;
      (2) The transmitters telephone number or any other suitable means to contact the transmitter for verbal and/or written confirmation;
      (3) The name, address, and age of the patient;
      (4) The time and date of the transmission; and,
      (5) The full name of the person transmitting the order; and
      (6) The identity of the Pharmacy intended to receive the transmission, as well as any other information required by federal or state law.

   C. An electronically transmitted drug order which meets the requirements of this ARTICLE shall be deemed the original order.

   D. The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of the transmitted prescription drug order consistent with federal or state laws and rules and regulations adopted pursuant to the same.

   E. An electronically transmitted prescription/order from a prescriber to a pharmacist shall be considered a highly confidential transaction and the said transmission shall not be compromised by interventions, control, change, altering or manipulation by any other person or parties in any manner whatsoever.

   F. Any pharmacist that transmits, receives or maintains any prescription or prescription refill either orally, in writing or electronically shall ensure the security, integrity and confidentiality of the prescription and any information contained therein.

   G. To maintain the confidentiality of patient and prescriber records, a computer system shall have security and system safeguards designed to prevent and detect unauthorized access, modification or manipulation of patient records. Once the drug has been dispensed, any alterations in prescription drug order data shall be documented to include the identification of the individual responsible for the alteration.

   H. Electronic transmission of prescription orders for controlled substances must comply with DEA Regulations.

3. Pharmacists must maintain complete and accurate records of all prescription drugs received, disposed of, or dispensed at a permitted facility.
4. A prescription may not be refilled without authorization. When refills are dispensed pursuant

to authorization contained on the original prescription or when no refills are authorized on the original prescription but refills are subsequently authorized by the prescriber, the refill authorization shall be recorded on the original prescription document and the record of any refill made shall be maintained on the back of the original prescription document or on some other uniformly maintained record and the dispensing pharmacist shall record the date of the refill, the quantity of the drug dispensed and his/her initials; however, an original prescription for a controlled substance which contains no refill information may not be authorized to be refilled more than five (5) times or after six (6) months from the date of issuance. Authorization for any additional refill of a controlled substance prescription in excess of those refills originally authorized or after six (6) months from the date of issuance of the prescription shall be treated as a new prescription.

5. When filling a prescription or refilling a prescription which may be refilled, the pharmacist shall exercise professional judgment in the matter. Except as provided below, no prescription shall be filled or refilled with greater frequency than the approximate interval of time that the dosage regimen ordered by the prescriber would indicate, unless extenuating circumstances are documented which would justify a shorter interval of time before the filling or refilling of the prescription. For non-controlled maintenance medications only, a pharmacist, exercising his/her professional judgment, may dispense additional dosage units authorized by the prescriber on the original prescription including refills.

6. The pharmacist who fills or refills a prescription shall record the date of the dispensing and indicate his/her identity as the dispensing pharmacist on the prescription document or some other appropriate and uniformly maintained record. If this record is maintained on the original prescription document, the original dispensing and any refills must be recorded on the back of the prescription.

7. A prescription shall not be refilled after twelve (12) months from the date of issuance.

8. A prescription becomes invalid thirty (30) days after the prescriber/patient relationship is terminated. When the patient is no longer able to seek personal consultation or treatment from the prescriber the prescriber/patient relationship is terminated.

9. A written prescription document prepared by the prescriber or his agent must bear an original signature of the prescriber, facsimile stamps are not acceptable. When an oral prescription or the oral authorization for the refilling of a prescription is received which is transmitted by someone other than the prescriber, the name of the transmitter and the date of the transmission must be recorded on the original prescription document by the pharmacist receiving the transmission.

10. A pharmacist licensed by the Mississippi Board of Pharmacy may dispense a one-time emergency dispensing of a prescription of up to a seventy-two (72) hour supply of a prescribed medication in the event the pharmacist is unable to contact the prescriber to obtain refill authorization, provided that;

    A. The prescription is not for a controlled substance;

B. In the pharmacist's professional judgment, the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort;
C. The dispensing pharmacist notifies the prescriber or his agent of the emergency dispensing within seven (7) working days after the one-time emergency dispensing;
D. The pharmacist properly records the dispensing as a separate non-refillable prescription. Said document shall be filed as is required of all other prescription records. This document shall be serially numbered and contain all information required of other prescriptions. In addition, it shall contain the number of the prescription from which it was refilled; and
E. The pharmacist shall record on the new document the circumstances which warrant this emergency dispensing.

This emergency dispensing shall be done only in the permitted facility which contains the non-refillable prescription.

Nebraska

The following provisions shall apply to Pharmacies and pharmacists in the State of Nebraska:

MAC Price List, pursuant to R.R.S. Neb. §§ 44-4608(1)-(3) and 44-4607

1. ProCare shall:
    A. Update its MAC list at least every seven (7) business days, noting any price change from the previous list and maintaining a historical record of these changes (44-4608(1)(c));
    B. Provide a means by which a Pharmacy may review current MAC pricing in an electronic, print, or telephonic format within one (1) business day at no cost to the Pharmacy (44-4608(1)(a));
    C. Eliminate a product from the MAC list in a timely manner to ensure the MAC list is consistent with any change in the marketplace (44-4608(1)(b));
    D. Provide Pharmacies with access to ProCare's MAC list in a readily accessible format (44-4608(1)(a));
    E. Not place a prescription drug on a MAC price list unless the drug is available for purchase by pharmacies in the State of Nebraska from a national or regional drug wholesaler and is not obsolete (44-4608(2));
2. ProCare's MAC price list is available through ProCare's Pharmacy Portal.

MAC Appeals, pursuant to R.R.S. Neb. § 44-4608

1. ProCare's MAC appeals process shall include:
    A. A fifteen (15) business day limit on the right to appeal following the submission of an initial claim by a Pharmacy (44-4608(3)(a));
    B. An investigation and resolution of the appeal within seven (7) business days from the date ProCare receives the appeal (44-4608(3)(b));
    C. Communication of the reason for any denial of an appeal and identification of the national drug code for the drug that may be purchased by the Pharmacy at a price at or below the price for the denied drug on ProCare's MAC list (44-4608(3)(c));
2. If a Pharmacy's MAC appeal is successful, ProCare shall:
    A. Make an adjustment in the price no later than one day after the appeal is resolved (44-4608(4)); and

B. Permit the appealing Pharmacy to reverse and rebill the claim in question, using the date of the original claim.

Gag Clause Prohibitions, pursuant to R.R.S. Neb. §§ 44-4606 and 4606

1. ProCare will not restrict or penalize Pharmacies and pharmacists from disclosing to any Covered Person any health information that the Pharmacy Provider 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 healthcare service or benefit; or
    E. Information on any financial incentive or structure used by the health carrier (44-4606(1)(a-e));
2. ProCare will not prohibit Pharmacies and pharmacists from discussing information regarding the total cost for a pharmacist's services for a prescription drug or from selling a more affordable alternative to the Covered Person if a more affordable alternative is available (44-4608(2));
3. ProCare will permit Covered Persons to purchase a covered prescription drug by paying the lesser of the Covered Person's cost-sharing amount under the terms of their health benefit plan or the amount the Covered Person would pay for the drug if the Covered Person were paying the cash price (44-4606(5)(a));
    A. ProCare will not exclude any amount paid by a Covered Person for a drug from their deductible or the annual out-of-pocket maximum when the cash price of the drug is less than the Covered Person's cost-sharing amount under the terms of their health benefit plan (44-4606(5)(a));
4. ProCare will permit pharmacists and Pharmacies to disclose information to the Nebraska Director of the Department of Insurance, law enforcement, or a state or federal government 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 the disclosure of information designated as confidential, the Pharmacy or pharmacist:
        (1) Marks as confidential any document in which the information appears; or
        (2) Requests confidential treatment for any oral communication of the information (44-4606(3));
5. ProCare will not terminate a Pharmacy's Participating Pharmacy Agreement or penalize a pharmacist or Pharmacy due to the pharmacist or Pharmacy:
    A. Disclosing information about ProCare, except information determined to be a trade secret, as determined by state law or the Nebraska Director of the Department of Insurance; or
    B. Sharing any portion of ProCare's contract with the Nebraska Director of the Department of Insurance pursuant to a complaint or query regarding whether the contract is in compliance with the Pharmacy Benefit Manager Licensure and Regulation Act (44-4606(4)).

Claim Audits, pursuant to R.R.S. Neb. § 44-4607

1. ProCare has the right to audit claims in accordance with the audit parameters set forth in R.R.S. Neb. §44-4607.

2. ProCare's procedures for appealing preliminary and final audit report findings are described in ProCare's Pharmacy Audit Program Manual.
3. With regard to audits performed by ProCare or its designated auditor, ProCare or its designated auditor will:
    A. Provide the Pharmacy advanced notice of fifteen (15) business days before conducting an initial on-site audit (44-4607(1)(a));
    B. Ensure that audits involving clinical or professional judgment are conducted by or in consultation with a pharmacist (44-4607(1)(b));
    C. Ensure that audits for similarly situated Pharmacies are conducted under the same standards and parameters (44-4607(1)(c));
    D. Refrain from conducting audits on claims that were submitted more than twenty-four (24) months from the date the claims were submitted, unless a longer period is required by state or federal law (44-4607(2)(a));
    E. Use a statistically reliable sample size if the audit includes a random sampling of claims (44-4607(2)(b));
    F. Provide the Pharmacy with a masked list containing the prescription numbers or date range of claims being used for an audit (44-4607(2)(c));
    G. Instruct auditors not to enter any area of the Pharmacy where patient-specific information is available without being escorted by an employee of the Pharmacy and, to the extent possible, each auditor shall remain out of the sight and hearing range of any Pharmacy customer (44-4607(2)(e));
    H. Refrain from performing on-site audits during the first five (5) business days of the month without consent from the Pharmacy (44-4607(2)(d));
    I. Deliver a preliminary audit report within one hundred twenty (120) days after conclusion of an audit;
    J. Allow the Pharmacy at least thirty (30) days following receipt of a preliminary audit report to provide documentation to address any discrepancy found in an audit;
    K. Provide the Pharmacy with a written description of its audit appeal process, which will include procedures for appealing a preliminary audit report and a final audit report; and
    L. Deliver the final audit report to a Pharmacy within one hundred twenty (120) days after receipt of the preliminary audit report or after the appeal process has been exhausted, whichever is later (44-4607(5));
4. Where contractually required, ProCare will provide a copy of the audit, including a list 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.

Interest, recoupment, remits related to audits, pursuant to R.R.S. Neb. § 44-4607(3)(h)

1. ProCare will not allow interest on claims to accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.
2. ProCare may assess a recoupment of a claim when the information is not written on a prescription if:
    A. Such information is required in the provider manual; or
    B. The information is required by the federal Food and Drug Administration or the drug manufacturer's product safety program.
3. Neither ProCare nor its designated auditor will receive payment or pay any person involved in an audit based on a percentage of any recoupment from the audit.

4. ProCare will not deduct from or apply a recoupment against future remittance for the Pharmacy until after the appeal process and both the Pharmacy and ProCare receive the results of the final audit.
5. Before effectuating a recoupment, ProCare will:
    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 Participating Provider 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; and
    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 the Pharmacy, or the identified overpayment is solely based on an extra dispensing fee.
6. ProCare will not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document as fraud without further substantiation. ProCare has discretion to recoup payment for any such error.
7. ProCare will 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 the Pharmacy's failure to comply with a formal corrective action plan may be subject to recoupment.
8. ProCare will remit any money due to a Pharmacy or pharmacist as a result of an underpayment of a claim within forty-five (45) days after the appeal process has been exhausted and the final audit report has been issued.

Documentation reviewed for audits, pursuant to R.R.S. Neb. § 44-4607

1. ProCare will accept 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 Pharmacy's manual to validate the pharmacy and the delivery of a pharmacy service (44-4607(4)).
2. ProCare will permit any legal prescription that meets the requirements in R.R.S. Neb. § 44-4607 in connection with a prescription, refill, or change in prescription, including a medication administration record, fax, e-prescription, or documented telephone call from the prescriber to the prescriber's agent to validate a claim.
3. ProCare will refrain from requiring information be written on a prescription, unless such information is required to be written on the prescription by state or federal law (44-4607(2)(g)).

Tennessee

The following provisions shall apply to Pharmacies in the State of Tennessee:

Pursuant to TCA § 56-7-3206 and Tenn. Comp. R. & Regs. Ch. 0780-01-95:

Definitions:

1. "Actual Cost" means the amount a Pharmacy paid as evidenced by documentation that includes, but is not limited to, the invoice price minus discounts, price concessions, rebates or other reductions, but not including a Cash Discount.
2. "Allowed Amount" means the cost of a prescription drug or device after applying ProCare's or the Covered Entity's pricing discounts available at the time of the prescription claim translation.
3. "Cash Discount" means a deduction from the invoice paid by a Pharmacy for a prescription drug or device if the invoice is paid on or before a specified date or in cash.
4. "Commissioner" means the commissioner of the Department or the commissioner's designee.
5. "Department" means the Tennessee Department of Commerce and Insurance.
6. "Initial Appeal" means the process required under T.C.A. § 56-7-3206(c)(2) and administered by ProCare by which a Pharmacy, or a pharmacy services administrative organization acting on behalf of a Pharmacy, may appeal a reimbursement received from ProCare that is not at least the Actual Cost to the Pharmacy for a prescription drug or device.
7. "Majority Wholesaler" means the wholesaler from whom a Pharmacy purchased the majority of its prescription pharmaceutical products for resale in the calendar year preceding the calendar year during which the claim that is the subject of an Initial Appeal is processed.
8. "Pharmacy" means pharmacy as defined in T.C.A. § 56-7-3102 and includes an agent acting on behalf of a pharmacy, including but not limited, to a pharmacy services administrative organization that is also a Network Pharmacy as defined above.
9. "Similarly Situated Pharmacy" means a Pharmacy in ProCare's pharmacy network that purchases a particular drug or medical product or device to which the finding applies from the same pharmaceutical wholesaler as the Pharmacy that prevailed in an Initial Appeal; and to which ProCare applies the challenged rate of reimbursement or Actual Cost.

This section applies when a Pharmacy files an Initial Appeal asserting that ProCare did not reimburse the Pharmacy for a prescription drug or device at an amount that is equal to or greater than the Pharmacy's Actual Cost.

1. The Pharmacy will include with its appeal a copy of invoice(s) demonstrating the Pharmacy's Actual Cost as of the date of filing the Initial Appeal.
2. Consideration of discounts, price concessions, rebates or other reductions in drug or device price reductions, excluding Cash Discounts, received by the Pharmacy:
    A. **At the time of the appeal.** The Pharmacy will provide ProCare with information regarding any discounts, price concessions, rebates, or other reductions, excluding Cash Discounts, during the pendency of an Initial Appeal, the Pharmacy received for the drug or device.
    B. **During the pendency of the appeal**. The Pharmacy will notify ProCare during the pendency of the Initial Appeal of any additional discounts, price concessions, rebates, or other reductions, excluding Cash Discounts that it receives for the drug or device.
    C. **After conclusion of the appeal**. Additional discounts, price concessions, rebates, or other reductions received after the resolution of an Initial Appeal will not be grounds for reconsideration of any Initial Appeal previously considered and resolved.
3. When submitting an Initial Appeal, the Pharmacy will provide ProCare with:
    A. The name and contact information of the wholesaler or manufacturer from which it purchased the prescription drug or device at issue.
    (1) If ProCare denies an Initial Appeal as otherwise permitted by law or Tennessee regulation and the Pharmacy fails to provide this information, ProCare may presume the prescription drug or device at issue is available at a lower cost from the wholesaler or

manufacturer from which the Pharmacy purchased the prescription drug or device at issue.

(2) Failure of the Pharmacy to provide this information will not constitute grounds for ProCare to deny an Initial Appeal.

4. Within seven (7) business days after receiving a Pharmacy's appeal for reimbursement of a drug or device that was less than the Pharmacy's Actual Cost, ProCare:
   A. May consider additional discounts, price concessions, rebates or other reductions in the price paid by the Pharmacy, when calculating the Pharmacy's Actual Cost;
   B. Will make the necessary change to the challenged rate or reimbursement or Actual Cost;
   C. If the appeal is a drug, ProCare will provide the Pharmacy or its agent with the national drug code number for the drug on which the change is based;
   D. Will permit the challenging pharmacy to reverse and rebill the claim upon which the appeal is based;
   E. Will pay or waive the cost of any transaction fee required to reverse and rebill the claim; and
   F. Will apply the findings from the Initial Appeal as to the rate of reimbursement and Actual Cost or challenged cost for the particular drug or device to other Similarly Situated pharmacies.
5. If the Pharmacy prevails in its appeal:
   A. ProCare will:

   (1) Provide the Pharmacy with a written statement granting the appeal with a summary outlining the basis for its decision;

   (2) ProCare will notify the Pharmacy in writing that it has adjusted the challenged rate of reimbursement;

   (3) ProCare will provide detailed written instructions for how to reverse and rebill the claim upon which the Initial Appeal was based; and

   (4) Reimburse the Pharmacy for at least Actual Cost.

   B. ProCare will apply the findings from the Initial Appeal to Similarly Situated Pharmacies as the rate of reimbursement and actual price for the drug, medical produce, or device.

   (1) Within seven (7) business days of resolution of an Initial Appeal, ProCare will apply the findings of an Initial Appeal retroactively to all Similarly Situated Pharmacies that received the challenged rate of reimbursement for the drug or medical product, or device was at issue in the Initial Appeal, including any appeals pending where the challenged rate of reimbursement is the subject of the Initial Appeal by:

   (i) Notifying all Similarly Situated Pharmacies of the adjusted rate of reimbursement in writing. The written notice will contain the applicable national drug code number or the unique device identifier at issue, as appropriate, and the rate of reimbursement to which the Similarly Situated Pharmacy is now entitled for the drug or medical product or device; and

   (ii) Paying all Similarly Situated Pharmacies the difference in the original rate of reimbursement the Similarly Situated Pharmacy received and the adjusted rate of reimbursement that resulted from the Initial Appeal resolved in favor of a pharmacy. ProCare will not charge any fees or require any additional documentation from Similarly Situated Pharmacies for reimbursement at the price determined during the Initial Appeal.

   (2) The findings from an Initial Appeal resolved in favor of a Pharmacy shall be applied retroactively by applying the adjusted rate to all Similarly Situated Pharmacies beginning on the date of services of the claim that was the subject of the Initial Appeal and continuing to apply that rate going forward until the appealing pharmacy and the

Similarly Situated Pharmacy or Pharmacies were no longer entitled to the same rate of reimbursement for the drug or medical product or device at issue.

(3) ProCare will track Initial Appeals such that it can reasonably determine if an adjusted rate of reimbursement applies.

6. If the Initial Appeal is resolved against the Pharmacy:
   A. ProCare will provide:

   (1) A written statement that the Initial Appeal is denied, along with a summary outlining the basis for its decision;

   (2) If applicable, evidence ProCare has adjusted the challenged rate of reimbursement;

   (3) If applicable, detailed instructions for how to reverse and rebill the claim upon which the Initial Appeal is based; and

   (4) Instructions on how to make an external appeal of ProCare's decision to the Commissioner by:

   (i) Explaining how to submit an appeal, including the appropriate phone number or website address for the Department where appeals are accepted.

   (a) ProCare is responsible for ensuring that the information provided to Pharmacies regarding appeals with the Department are accurate; and

   (b) ProCare will include the following statement with instructions on how to make and external appeal: "Pursuant to T.C.A. § 56-7-3206(g)(2), you have the right to appeal this decision to the Commissioner of the Tennessee Department of Commerce and Insurance."

   B. ProCare will determine whether the product associated with a national drug code number or the unique device identifier is available at a cost that is less than the challenged rate of reimbursement from a pharmaceutical wholesaler in Tennessee, within seven (7) business days after receiving notice of the appeal, ProCare will provide the Pharmacy or its agent with:

   (1) The name of the national or regional pharmaceutical wholesalers operating in this state that have the particular drug or medical product or device currently in stock at a price that is less than the amount of the challenged reimbursement; and

   (i) A drug, medical product, or device shall be deemed available if, at the time the Initial Appeal was received by ProCare, the product was in stock with a wholesaler operating in Tennessee.

   (ii) If after reasonable effort ProCare is unable to make a determination of whether the drug, medical product, or device was reimbursed at or above the Pharmacy's Actual Cost because the wholesalers contacted by ProCare failed to provide the information needed by ProCare within the timeframe within which ProCare must resolve Initial Appeals, ProCare shall presume that the product associated with the national drug code number or unique device identifier at issue was not available at a cost that is less than the challenged rate of reimbursement from a pharmaceutical wholesaler in Tennessee as of the date the Initial Appeal was received from the appealing Pharmacy.

   (iii) If ProCare does not provide the Pharmacy with a determination that the drug, medical product, or device is available from a pharmaceutical wholesaler in Tennessee within seven (7) business days after receiving the appeal, it shall be deemed to have determined there is no pharmaceutical wholesaler operating in this state that offered the product associated with the national drug code number or unique device identifier at issue at a coat that is less than the challenged rate of reimbursement as of the date the Initial Appeal was received from the appealing Pharmacy.

(2) The national drug code number for a drug or the unique device identifier for a device.

C. The Pharmacy will provide ProCare with the name of its Majority Wholesaler.

(1) ProCare will then determine whether the prescription drug or device at issue is available from the pharmaceutical wholesaler at a cost that is less than the challenged rate of reimbursement as of the date the Initial Appeal was received from the appealing Pharmacy.

(i) If, after contacting the Pharmacy's Majority Wholesaler, ProCare is unable to make the determination because the wholesaler failed to provide the information needed by ProCare within the timeframe within which ProCare must resolve Initial Appeals, ProCare will presume that the product associated with the national drug code number of unique device identifier at issue was not available at a cost that is less than the challenged rate of reimbursement from the wholesaler as of the date the Initial Appeal was received from the appealing Pharmacy.

(2) If the Pharmacy fails to provide the name of its Majority Wholesaler within two (2) business days of a request by ProCare to provide that name, ProCare may presume the prescription drug or device at issue is available at a cost that is less than the challenged rate of reimbursement from the Pharmacy's Majority Wholesaler and take no further action.

(3) If the product associated with the national drug code number or unique device identifier at issue shall be deemed available if, at the time the Initial Appeal was received by ProCare, the product was in stock from the Pharmacy's wholesaler.

(4) ProCare will not deny an Initial Appeal because the Pharmacy or its Majority Wholesaler did not provide ProCare with the name of its Majority Wholesaler, or the Pharmacy's Majority Wholesaler did not provide ProCare with the information requested.

D. If the product associated with the national drug code number or unique device identifier is not available at a cost that is less than the challenged rate of reimbursement from the pharmaceutical wholesaler from whom the Pharmacy purchases the majority of prescription pharmaceutical products for resale, then ProCare will adjust the challenged rate of reimbursement to an amount equal to or greater than the appealing pharmacy's Actual Cost and permit the Pharmacy to reverse and rebill each claim affected by the inability to procure the pharmaceutical product at a cost a cost that is equal to or less than the previously challenged rate of reimbursement. ProCare will pay or waive the cost of any transaction fee required to reverse and rebill the claim.

E. ProCare will not include within the amount calculated to reimburse a Pharmacy for Actual Cost the amount of any professional dispensing fee that is payable to the Pharmacy.

F. ProCare will follow this appeals process for drugs, medical products, or devices for which a Pharmacy asserts it did not receive reimbursement from ProCare sufficient to cover its Actual Cost, even if Procare has another basis for denying the appeal.

G. If the Pharmacy's Initial Appeal is resolved against the appealing pharmacy, and ProCare determines that the Pharmacy was entitled to reimbursement at Actual Cost for a drug, medical product, or device, ProCare will apply its determination to Similar Situated Pharmacies as though the Pharmacy prevailed in its Initial Appeal.

a. ProCare will notify Similarly Situated Pharmacies within seven (7) business days after it receives a Pharmacy's Initial Appeal regarding reimbursement for Actual Cost of a drug, medical product, or device.

7. Records retention for Initial Appeals.

A. ProCare will retain all records related to an Initial Appeal for the greater of five (5) years or until ProCare is audited by the Department.

8. ProCare will not assess any costs to a Pharmacy for any services provided by ProCare in connection with an Initial Appeal.
9. An Initial Appeal will not result in a Pharmacy, whether the appealing Pharmacy or a Similarly Situated Pharmacy, being required to reimburse or refund ProCare any portion of a payment previously received by the Pharmacy.
10. Timing and notice requirements of Initial Appeal processes. ProCare's Initial Appeal process, or a Pharmacy's participation in an Initial Appeal must meet the following requirements:
    A. The Pharmacy must file its Initial Appeal within seven(7) business days of its submission of the initial claim for reimbursement for the drug or medical product or device.
    B. ProCare must make a final determination resolving the Pharmacy's Initial Appeal within seven (7) business days of ProCare's receipt of an initial appeal that includes the following timeline:
    (1) The timeline begins after ProCare has received all required information sufficient to allow ProCare to conduct a complete analysis of the Initial Appeal.
    (2) ProCare will be deemed to have all required information sufficient to allow ProCare to conduct a complete analysis of the Initial Appeal upon receipt of:
    (a) A complete version of either an Initial Appeal form provided by the Commissioner to be used by a Pharmacy to file an Initial Appeal or ProCare's appeal form submitted and approved by the Department; and
    (b) Certification from the Pharmacy that it has provided ProCare with all invoices or other records demonstrating the Pharmacy's Actual Cost for the drug or medical product or device at issue, which shall take into account all discounts, price concessions, rebates or other reductions received as of the date the Pharmacy filed its Initial Appeal.
    C. If ProCare receives an initial appeal from a Pharmacy that does not contain all information required in Section B above, ProCare will accept the incomplete Initial Appeal and hold it open pending receipt of additional information from the Pharmacy.
    D. ProCare may not delay the start of its review of an Initial Appeal by:
    (1) Requiring additional or different information from a Pharmacy beyond what is required to be submitted to ProCare under its Initial Appeal process approved by the commissioner; or
    (2) Basing the delay on administrative or non-substantive errors or omissions in any of the filings that does not affect the overall validity of the Initial Appeal.
    E. If ProCare does not comply with the timing and notice requirements set forth above, the Pharmacy's Initial Appeal will be resolved by ProCare in favor of the Pharmacy.
    F. If the Pharmacy does not comply with the timing requirements set forth above, ProCare may deny the Initial Appeal.
    G. ProCare's Initial Appeal process is available on its secure website, which includes all deadlines applicable to its Initial Appeal process, a description of the steps contained within its initial appeal process, and clearly state that its Initial Appeal process is available for all prescription drugs or devices in Tennessee for which a Pharmacy alleges it did not receive its Actual Cost.

Wyoming

The following provisions shall apply to Pharmacy Providers in the State of Wyoming:

1. Pursuant to Wyo. Stat. §26-52-104, To place a drug on a maximum allowable cost list, ProCare Pharmacy Benefit Manager, shall ensure:

A. If the drug is a generically equivalent drug as defined under Wyoming law, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by a nationally recognized reference;
B. Shall be available for purchase by each Pharmacy in the state from national or regional wholesalers operating in Wyoming; and
C. Shall not be obsolete or temporarily available.

2. Pursuant to Wyo. Stat. §26-52-104, In formulating the maximum allowable cost price for a drug, Procare will only consider the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book)

3. If a therapeutically equivalent generic drug is unavailable or had limited market presence, Procare will place on a maximum allowable cost list a drug that has:

   A. A "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) or an "NR or "NA" rating or similar rating by a nationally recognized reference,

4. Procare shall provide each Pharmacy at the beginning of the term of the contract and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing. Procare will provide a telephone number at which the pharmacies may contact an employee to discuss pharmacy appeals. Procare will review and update applicable maximum allowable cost price information at least once every seven (7) business days to reflect any modifications of cost pricing and ensure dispensing fees are not included in the calculation of maximum allowable cost.

5. Pursuant to Wyo. Stat. §26-52-104, Procare shall provide a reasonable appeal process to allow Pharmacies to challenge maximum allowable cost list and reimbursements for a drug subject to maximum allowable cost pricing. A pharmacy shall have up to ten (10) business days after dispensing a drug in which to appeal the amount of the maximum allowable cost. Procare shall respond to the appeal within ten (10) business days after the pharmacy makes the appeal.

6. If the maximum allowable cost appeal is denied, Procare shall provide to the pharmacy the reason for the denial and the national drug code number for the drug that is available for purchase by pharmacies in the state from national or regional wholesalers at a price at or below the maximum allowable cost.

7. If the appeal is upheld, Procare shall adjust the applicable maximum allowable cost no later than one (1) day after the date of the determination and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the insurer. Procare shall allow the appealing pharmacy to reverse and rebill the claim, which was the subject of the appeal.

8. Procare may not prohibit or penalize a pharmacy for disclosing information to a covered individual or offering a more affordable alternative if one is available.

End.