

Pharmacy Provider Manual

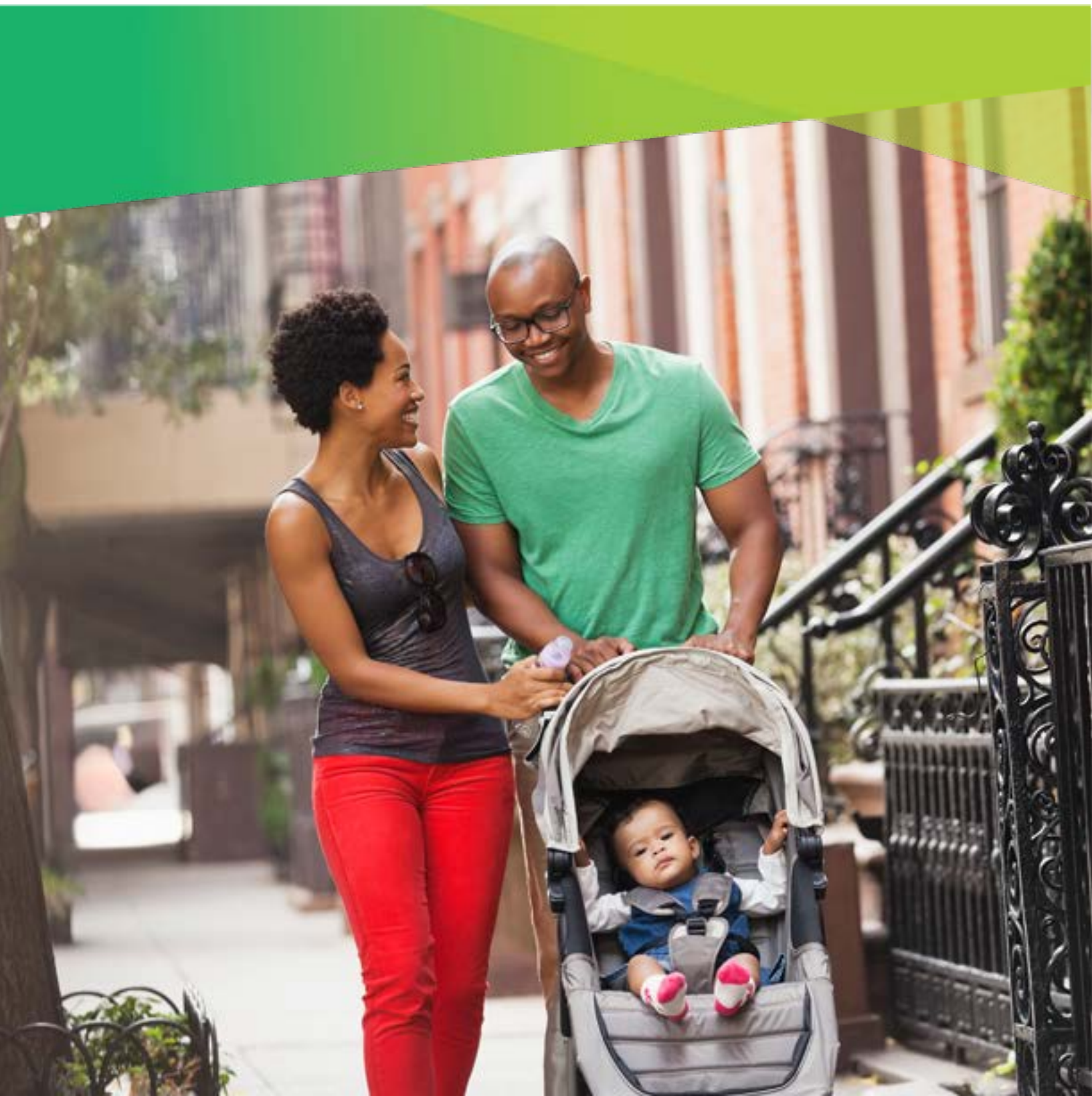


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INTRODUCTION AND CONTACT INFORMATION

Envolve Pharmacy Solutions is a pharmacy benefit manager (PBM) headquartered in Fresno, California. We provide pharmacy benefit design, administration, and management services as well as a sophisticated, state-of-the-art claims processing system to plan sponsors. Programs such as Drug Utilization Review (DUR), clinically based formularies, generic substitution, and disease-oriented managed care allow third-party payers to effectively manage the cost of providing prescription benefits for their members.

Envolve Pharmacy Solutions is a wholly owned subsidiary of CenCorp Health Solutions™ (CenCorp), a subsidiary of Centene Corporation® (Centene).

With corporate headquarters in St. Louis, Missouri, Centene Corporation® (Centene), a Fortune 500 Company, is a leading, multi-line healthcare enterprise that provides programs and related services to the rising number of under-insured and uninsured individuals. Many of these individuals receive benefits provided under Medicaid, including the Children’s Health Insurance Program (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care and long-term care, in addition to other state-sponsored programs, and Medicare (Special Needs Plans). Centene’s CeltiCare subsidiary offers states unique “exchange-based” and other cost-effective coverage solutions for low-income populations. The Company operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including behavioral health, life and health management, managed vision, telehealth services, and pharmacy benefits management.

Contact Information

For questions, submission of suggestions or other information regarding information in the Envolve Pharmacy Solutions Pharmacy Provider Manual, please send inquiries to the following:

Envolve Pharmacy Solutions, Inc.
Attn: Chief Operating Officer
5 River Park Place East, Suite 210
Fresno, CA 93720

GENERAL INFORMATION

Information in the Envolve Pharmacy Solutions Provider Manual is considered proprietary and intended for use only by providers credentialed in the Envolve Pharmacy Solutions Pharmacy Network. Providers cannot copy, reproduce, distribute or share information included in this provider manual except as authorized by provider agreement.

Envolve Pharmacy Solutions Provider Services Call Center

The Envolve Pharmacy Solutions Provider Services Call Center is staffed with Customer Service Representatives during the following hours (Pacific Standard Time):

Phone: (800) 460-8988

Hours: Monday through Friday	5:00 AM to 6:00 PM
Saturday	6:30 AM to 3:00 PM

Calls are answered by Customer Service Representatives 24 hours a day, 7 days a week, 365 days a year.

Envolve Pharmacy Solutions Prior Authorization Help Desk

The Envolve Pharmacy Solutions Prior Authorization (PA) Help Desk is staffed with PA Triage Specialists during the following hours (Pacific Standard Time):

Phone: (866) 399-0928

Hours: Monday through Friday	6:00 AM to 5:00 PM
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During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist providers. Envolve PeopleCare's call-in nurse triage and support system is available to assist providers outside regular business hours.

Envolve Pharmacy Solutions Pharmacy Claim Submission

Envolve Pharmacy Solutions, Inc.

Attn: **Envolve Pharmacy Solutions Pharmacy Claim Submission**

5 River Park Place East, Suite 210

Fresno, CA 93720

Provider Enrollment and Participation

To participate in the Envolve Pharmacy Solutions Pharmacy Network, the applicant must contact Envolve Pharmacy Solutions at (877) 935-8026. Applicants should be prepared to provide the provider name, corresponding NCPDP number, contact name, business address, telephone number, fax number, email address, and the purpose for the call. Following this initial contact, the Envolve Pharmacy Solutions pharmacy network representative will send the Envolve Pharmacy Solutions Pharmacy Credential Application and Participating Pharmacy Agreement.

Pharmacy Credentialing Application

The applicant is required to complete, sign, and return the Pharmacy Credential Application to the Credentialing Department at Envolve Pharmacy Solutions. Complete documentation of the following pharmacy-specific criteria is required:

- > Pharmacy profile information
- > Pharmacy hours of operation
- > Pharmacy services provided
- > License and policy maintenance

Documentation of the following pharmacist-in-charge-specific criteria is required:

- > Any misdemeanors, felony convictions, or charges pending against them
- > History of loss of pharmacy license anywhere (e.g., limited, suspended, revoked, or reprimanded)
- > History of disciplinary action including restriction/limitation on license or ability to otherwise practice
- > Malpractice claims history within the past 5 years
- > Fraud or abuse convictions within the past 5 years

Certain other accessibility requirements integral to Envolve Pharmacy Solutions' application process include, but are not limited to the following:

- > Eligible plan member must have access to a pharmacy-employed pharmacist 24 hours a day, 7 days a week via phone, pager, or answering service/machine.
- > Pharmaceutical products are dispensed in an acceptable business facility subject to an onsite visit by Envolve Pharmacy Solutions.

Pharmacy-employed pharmacists must be proficient in reading, writing and speaking the English language, demonstrating proficiency in communicating clinical advice, and providing clinical services to eligible plan members in the English language.

Credentialing Standards

Credentialing and recredentialing initiatives exist to ensure that participating providers abide by the criteria established by Envolve Pharmacy Solutions as well as governmental regulations and standards. The applicant must comply with the credentialing and recredentialing initiatives required by Envolve Pharmacy Solutions, and agree to provide Envolve Pharmacy Solutions with documentation and other relevant information that may be required in association with such initiatives. Envolve Pharmacy Solutions recredentials providers every three years in accordance with applicable law and contractual obligations.

Envolve Pharmacy Solutions has developed a standardized process for the receipt, review, documentation, and verification of applicants' credentials for participation in the Envolve Pharmacy Solutions Pharmacy Network. All applicants are subject to this review and verification process. Envolve Pharmacy Solutions has the right to determine whether an applicant meets and maintains the appropriate credentialing standards to participate as a provider in the Envolve Pharmacy Solutions Pharmacy Network, and to adjust its credentialing standards and policies without notice.

Licensure

The applicant must meet all standards of operation as described in Federal, State, and local law. The applicant must furnish copies of Federal, State, and local licenses and/or business permits as required by applicable law when applying for enrollment as a provider in the Envolve Pharmacy Solutions Pharmacy Network. The applicant must maintain in good standing with these licenses and/or permits at all times.

Once credentialed to participate in the Envolve Pharmacy Solutions Pharmacy Network, the provider must notify Envolve Pharmacy Solutions immediately in writing if its licenses and/or permits are canceled, revoked, suspended, or otherwise terminated. Failure to immediately notify Envolve Pharmacy Solutions in writing of any such action may result in immediate termination from the pharmacy network. Moreover, failure to maintain the appropriate licenses and/or permits will result in immediate termination from the Envolve Pharmacy Solutions Pharmacy Network.

Insurance

When applying for enrollment as a provider in the Envolve Pharmacy Solutions Pharmacy Network, applicant must furnish copies of policies for general and professional liability insurance, including malpractice, at a minimum in the amount of \$1,000,000.00 per occurrence and \$3,000,000.00 in aggregate, or greater, as otherwise required by Law. The applicant must maintain these policies in amounts necessary to ensure that the provider and any of its personnel are insured against any claims for damages arising from the provision of pharmacy services at all times.

Once credentialed to participate in the Envolve Pharmacy Solutions Pharmacy Network, the provider must notify Envolve Pharmacy Solutions immediately in writing if its insurance is canceled, suspended, or otherwise terminated. Failure to immediately notify Envolve Pharmacy Solutions in writing of any such termination of insurance coverage may result in immediate termination from the pharmacy

network. Additionally, failure to maintain the minimum coverage will result in immediate termination from the pharmacy network.

Drug Enforcement Agency Controlled Substance Registration Certificate

The applicant must furnish a copy of Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate as required by applicable law when applying for enrollment as a provider in the Envolve Pharmacy Solutions Pharmacy Network. The applicant must keep registration in good standing at all times.

Once credentialed to participate in the Envolve Pharmacy Solutions Pharmacy Network, the provider must notify Envolve Pharmacy Solutions immediately in writing if the DEA registration certificate is canceled, revoked, suspended, or otherwise terminated. Failure to immediately notify Envolve Pharmacy Solutions in writing of any such action may result in immediate termination from the pharmacy network. Furthermore, failure to maintain the DEA registration certificate may result in immediate termination from the Envolve Pharmacy Solutions Pharmacy Network.

Medicaid Provider Number

When applying for enrollment as a provider in the Envolve Pharmacy Solutions Pharmacy Network, the applicant must furnish its Medicaid Provider Number as required by applicable law. The Medicaid Provider Number must be kept current at all times.

Once credentialed to participate in the Envolve Pharmacy Solutions Pharmacy Network, the provider must notify Envolve Pharmacy Solutions immediately in writing if its Medicaid Provider Number is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Envolve Pharmacy Solutions in writing of any such action may result in immediate termination from the pharmacy network. In addition, failure to maintain the Medicaid Provider Number may result in immediate termination from the Envolve Pharmacy Solutions Pharmacy Network.

Changes in Documentation and Other Information

Provider must notify Envolve Pharmacy Solutions in writing within 10 calendar days of any changes in the documentation and other information provided to Envolve Pharmacy Solutions in connection with any credentialing or recredentialing initiatives.

Ownership or Control Changes of Network Provider

Participating Provider must immediately notify Envolve Pharmacy Solutions in the event of a change of ownership or control.

Network Participation

Applicants become eligible to participate in the Envolve Pharmacy Solutions networks when a Participating Pharmacy Agreement (PPA) with Envolve Pharmacy Solutions is executed by both parties

or by affiliating with a Pharmacy Services Administration Organization/Third Party Administration (PSAO/TPA) that is contracted with Envolve Pharmacy Solutions. As a pharmacy provider, you will receive a fully signed PPA. All Pharmacies are expected to adhere to the PPA terms. Failure to comply could result in the termination of your PPA by Envolve Pharmacy Solutions.

Pharmacy's Affiliation with PSAO/TPA

For a copy of Envolve Pharmacy Solutions' Participating Pharmacy Agreement, a provider should contact their Pharmacy Service Administration Organization/Third Party Administration (PSAO/TPA).

Update Information with NCPDP

Envolve Pharmacy Solutions receives and incorporates NCPDP's updates monthly, which include changes to a Participating Pharmacy address, phone number, and Pharmacy Chain/PSAO affiliation. Envolve Pharmacy Solutions' system supports only one NCPDP affiliation at this time.

To ensure the integrity of Envolve Pharmacy Solutions' data, it is the Provider's responsibility to contact NCPDP when information changes. This ensures that correct data is in Envolve Pharmacy Solutions' database. In the event of a conflict or missing information from Pharmacy and the information on file with NCPDP regarding Pharmacy, Envolve Pharmacy Solutions may rely on the information on file with NCPDP regarding Pharmacy, including for purposes of directories and payments.

Advertising and Promotions

Without the prior written consent of Envolve Pharmacy Solutions, provider must not use words, symbols, trademarks or service marks which Envolve Pharmacy Solutions uses, in advertising or promotional materials or otherwise, and provider must not advertise or publicly display that it is a member pharmacy without the prior written consent of Envolve Pharmacy Solutions. Provider must immediately cease any and all usage of such immediately upon termination of this agreement. Envolve Pharmacy Solutions may list provider by name, address, and telephone number for each of its locations in applicable directories, brochures or other publications for distribution and/or use by Envolve Pharmacy Solutions, payers and eligible persons.

Office of Inspector General

Providers sanctioned by the Office of Inspector General (OIG) who are not eligible to participate in Medicare, Medicaid, and other Federal health care programs are not eligible to participate in the Envolve Pharmacy Solutions Pharmacy Network.

If sanctioned by the OIG and excluded from participation in Federal health care programs, the provider is immediately terminated from the Envolve Pharmacy Solutions Pharmacy Network.

Reporting of Investigations and Disciplinary Actions

As stated in the foregoing, the provider must notify Envolve Pharmacy Solutions immediately in writing if its license(s) and/or permit(s) have been suspended or revoked, or are in jeopardy of being suspended

or revoked for any reason. The provider must also notify Envolve Pharmacy Solutions immediately in writing if it receives notice of any proceedings that may lead to disciplinary actions, or if any disciplinary actions are taken against the provider or any of its personnel, including actions by Boards of Pharmacy, the Office of Inspector General (OIG), or other regulatory bodies. Failure to immediately notify Envolve Pharmacy Solutions in writing of any such investigations or disciplinary actions may result in immediate termination as a provider.

Confidentiality and Proprietary Rights

All eligible persons' information related to Prescription Drug Benefits and other records identifying eligible persons shall be treated by the provider as confidential and proprietary. The provider shall comply with all applicable federal and state privacy laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the Privacy Rule) and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (the Security Rule), as may be amended from time to time. The provider shall not use eligible persons' information for competitive purposes, nor provide such information to others for provider's pecuniary gain. Further, this information shall not be given to any third party, except to the extent that disclosure may be required pursuant to law, or may be permitted by the plan sponsor or Envolve Pharmacy Solutions.

All materials relating to pricing, contracts, programs, services, business practices and procedures of Envolve Pharmacy Solutions are proprietary and confidential. The provider must maintain the confidential nature of such materials and return them to Envolve Pharmacy Solutions upon termination of the agreement.

The provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Envolve Pharmacy Solutions would cause Envolve Pharmacy Solutions immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if a provider should fail to abide by these provisions, Envolve Pharmacy Solutions is entitled to seek and obtain injunctive relief, monetary remedies or other such damages as available by law against the provider.

Court Orders, Subpoenas, or Governmental Requests

If Envolve Pharmacy Solutions receives a court order, subpoena or governmental request relating to a participating provider, Envolve Pharmacy Solutions may comply with such order, subpoena or request and the provider must indemnify and hold harmless Envolve Pharmacy Solutions for, from and against any and all costs (including reasonable attorney's fees and costs) losses, damages or other expenses Envolve Pharmacy Solutions may incur in connection with responding to such order, subpoena or request.

No Cause Termination

Envolve Pharmacy Solutions may terminate this Agreement at any time by providing at least one hundred eighty (180) days prior written notice of its intention to terminate this Agreement.

Termination for Breach

If there is any material default by either party in the performance of the terms and conditions of this Agreement, the non-defaulting party may terminate this Agreement (in whole or in part with respect to the applicable Plan, network, or Pharmacy location) upon sixty (60) calendar days' prior written notice to the other party, provided, however, that the defaulting party has not cured such default within ten (10) calendar days prior to the end of such sixty (60) calendar day period.

Immediate Suspension or Termination

Notwithstanding the above, this Agreement may be immediately terminated or suspended (in whole or in part with respect to the applicable Plan, network, or Pharmacy location) by Envolve Pharmacy Solutions in the event of any of the following: (i) Pharmacy breaches any representation or warranty of Pharmacy under this Agreement; (ii) Pharmacy fails to maintain appropriate licensure, registration, certification, and/or good standing as required under this Agreement and/or Law; (iii) Pharmacy's insurance required hereunder is canceled, lapsed, terminated, or otherwise suspended without replacement coverage; (iv) Pharmacy is indicted or convicted of a felony, fraud, and/or submission of false claim information; (v) Pharmacy fails to cooperate with Envolve Pharmacy Solutions in resolving Member complaints or grievances; (vi) Pharmacy is listed on the OIG or US General Services Administration (GSA exclusion lists or is sanctioned under or expelled from participation in the Medicare, Medicaid, or other government programs; (vii) Pharmacy fails to satisfy any or all of the credentialing requirement of Envolve Pharmacy Solutions; (viii) Pharmacy is guilty of any conduct tending to injure the business reputation of Envolve Pharmacy Solutions; (ix) Pharmacy makes an assignment for the benefit of its creditors, becomes unable to pay debts when due, files a petition in bankruptcy, whether voluntary or involuntary, and/or a receiver or trustee is appointed for the transfer or sale of a material portion of Pharmacy's assets; and/or (x) Envolve Pharmacy Solutions or a Plan determines that the health, safety, or welfare of Members is jeopardized by continuation of this Agreement.

Network Termination

Pharmacy may be excluded from participating in a network with respect to any specific Plan, and upon thirty (30) calendar days prior written notice to Pharmacy (or such longer period as required by applicable Law), Pharmacy may be removed from participating in a network with respect to a specific Plan.

Effect of Termination

In the event of termination, suspension, and/or breach of this Agreement, in addition to all other rights and remedies Envolve Pharmacy Solutions may have at law, equity, or under this Agreement, Envolve Pharmacy Solutions shall have the right to: (i) suspend any and all obligations of Envolve Pharmacy Solutions under and in connection with this Agreement; and/or (ii) offset against any amounts owed to Pharmacy under this Agreement or under any other agreement between Envolve Pharmacy Solutions and Pharmacy, any amounts required to be paid by Pharmacy to Envolve Pharmacy Solutions. Pharmacy acknowledges the rights of Envolve Pharmacy Solutions to notify Plans and Members of termination or suspension of this Agreement or Pharmacy's participation in a particular Plan or network. The parties will cooperate in good faith to promptly resolve any outstanding financial, administrative, or Member service issues upon termination of this Agreement.

Dispute Resolution

The parties shall attempt to resolve a dispute through negotiations between designated representatives of the parties who have authority to settle the dispute. The aggrieved party shall notify the other party of its Claim including sufficient detail to permit the other party to respond. The parties agree to meet and confer in good faith to resolve any Claims that may arise under the Agreement.

Quality and Safety Criteria Monitoring

In addition to the identification and monitoring of dispensing errors and reporting of such as facilitated internally through the Pharmacy Services department, Envolve Pharmacy Solutions has entered into an agreement for Pharmacy Auditing Services with an external organization that provides pharmaceutically related auditing services specific to health institutions and the general public.

Eligibility Verification

Prior to filling any Covered Medication, Pharmacy shall require the patient to present his or her Member Identification Card. In addition, Pharmacy shall verify that the Member is Eligible to receive Covered Medications through the Claims Processing System. Pharmacy shall not submit a Claim through the Claims Processing System until it has preliminarily determined that Member is Eligible and that the prescription is valid, dated, and signed by a licensed prescriber, if legally applicable. Envolve Pharmacy Solutions shall not be liable for any item Pharmacy provides to any person who is not Eligible.

Professional Judgment

The provider is required to deliver pharmacy services under the direct supervision of a licensed pharmacist and according to prescriber instructions in accordance with applicable law. The provider must exercise professional judgment at all times in rendering pharmacy services to an eligible plan member. Moreover, the provider may refuse to deliver pharmacy services to an eligible plan member based on that professional judgment.

Nondiscrimination

The provider cannot discriminate against (or make a distinction in favor or against) an eligible plan member on the basis of age, race, color, ethnic group, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, or marital/ family status. Unless professional judgment dictates otherwise, the provider is required to deliver pharmacy services related to covered items to all eligible plan members in accordance with applicable Law.

Identification Cards

Envolve Pharmacy Solutions and/or plan sponsors provide eligible plan members with identification cards. An identification card may show coverage for the eligible plan member only, or it may show coverage for the eligible plan member and his or her dependent(s). Although identification cards vary by plan, a sample of a typical identification card produced by Envolve Pharmacy Solutions is illustrated below.



As illustrated, the identification card is designed and produced using the National Council for Prescription Drug Programs (NCPDP) format, and contains the Eligible plan member identification number, the bank identification number (RxBIN) and the group (RxGRP) and/or processor control number (RxPCN). Plan sponsors may distribute identification cards that do not include all of the information highlighted above.

The provider is required to request the identification card from the eligible plan member and utilize the information on the identification card to submit claims through the Envolve Pharmacy Solutions claims processing system. The provider will not be paid for rendering pharmacy services to a plan member whose eligibility was not correctly submitted.

Eligible Plan Member Fees

The provider is required to submit claims only for the eligible plan member for whom a prescription for a covered item was written by the prescriber and dispensed to the eligible plan member.

The provider is required to collect any administrative, transaction, access or other types of fees at the point of service from the eligible plan member, when applicable. The total amount collected from the eligible plan member for providing pharmacy services related to a covered item is transmitted through the Envolve Pharmacy Solutions claims processing system, and may be debited from the provider's claims payment account.

Collection of Eligible Plan Member Pay Amounts

Plan sponsors determine the copayment amounts which provider is required to collect from an eligible plan member for the pharmacy services related to a covered Item. The eligible plan member copayment amounts vary by plan sponsor and/or plan. Unless otherwise directed by Envolve Pharmacy Solutions, the provider is required to collect from the eligible plan member the copayment amount as indicated by the Envolve Pharmacy Solutions claims processing system. The provider cannot waive, discount, reduce or increase the plan member copayment amount determined by the claims processing system. Moreover, if Envolve Pharmacy Solutions determines that the provider has charged or collected from an eligible plan member in excess of the member copayment amount determined by the claims processing system, the provider must promptly reimburse the eligible plan member for the excess amount upon request from Envolve Pharmacy Solutions. Otherwise, Envolve Pharmacy Solutions retains the right to recover any excess amounts or unauthorized fees from the provider (including by offset against other amounts owed to the provider) and return the recovered amounts to the appropriate eligible plan member.

Payer of Last Resort

Under Federal law, the Medicaid program is intended to be the payer of last resort. That is, Medicaid is properly responsible for payment of medical costs, including prescription drug costs, only after other third-party sources have met their legal obligations.

Limitation on Collection

The provider cannot bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against an eligible plan member for the provision of pharmacy services related to a covered item in any event, including nonpayment by or bankruptcy of a plan sponsor or Envolve Pharmacy Solutions. However, this does not prohibit the provider from collecting the authorized copayment amount or charging the eligible plan member for non-covered items disclosed and agreed to in advance by eligible plan member.

Refills

The provider shall not process an automatic refill for a prescription for an eligible plan member unless and until such refill has been authorized by the eligible plan member.

Submitting a Claim

The provider is required to submit pharmacy claims electronically through the Envolve Pharmacy Solutions claims processing system for all covered items. The provider must also submit all necessary information requested in the Payer Sheet, Pharmacy Service Agreement and required by the claims processing system for each claim. Each claim submitted by the provider constitutes a representation by the provider to Envolve Pharmacy Solutions that the pharmacy services were provided to the eligible plan member, and that the information transmitted is accurate and complete.

All claims must be submitted accurately and completely, online in the current NCPDP (vD.0) HIPAA-approved format.

Claim Definition

A claim is an electronic request for reimbursement for any covered prescription transaction. A claim is either paid or denied. For each claim processed, a claims detail report is provided to the pharmacy that submitted the original claim.

Clean Claim Definition

A clean claim refers to a claim received by Envolve Pharmacy Solutions for adjudication in a nationally accepted format and in compliance with standard coding guidelines. A clean claim requires no further information from the provider to be processed and paid by Envolve Pharmacy Solutions. The following exceptions apply to this definition: (a) a claim for which fraud or abuse is suspected and (b) a claim for which a third party resource should be responsible.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions found in non-clean claims result in a request for additional information from the provider and (or) other external sources. The need for additional

information is necessary to resolve discrepancies. Non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines of a plan.

Partial Fill

Pharmacy shall not submit a separate Claim for a Covered Medication which should have been dispensed and covered as one Claim but due to inadequate supplies or other issues is dispensed and covered on different dates or at different times as multiple Claims.

Filing/Reversing a Claim

All claims must be submitted electronically through the Envolve Pharmacy Solutions claims processing system. Failure to submit a claim within Plan's allotted billing window from the date of the fill may result in nonpayment of the claim.

Providers are required to reverse any claim that is not delivered to or received by the eligible plan member within 10 business days of submission, per the terms of the Envolve Pharmacy Solutions Participating Pharmacy Agreement. The provider may only reverse and submit a claim within the same payment cycle in which the claim was originally submitted.

Rejected Claims

Rejected claims may be resubmitted in the same manner as the original claim with corrected information.

Data Fields and Submission Requirements

The following payer sheet includes optimal data elements in NCPDP Version D.0 (vD.0) required by Envolve Pharmacy Solutions for claims processing.

https://www.envolverx.com/Media/Default/docs/PayerSheet_Primary.pdf

Envolve Pharmacy Solutions requires all providers to file claims electronically with the following criteria:

- > All documentation must be legible.
- > Providers must submit claims data for every member's prescription drug transaction.
- > Providers must ensure that all data and documents submitted to Envolve Pharmacy Solutions, to the best of their knowledge, information and belief, are accurate, complete and truthful.
- > All claims data must be submitted by electronic media in an approved format.

Online System Down-Time Transmission Procedures

In the event the claims processing system is temporarily inaccessible; Pharmacy will make reasonable attempts to retransmit the Claim. In the event that the claims processing system is unavailable due to major service disruption, Pharmacy may submit claims for covered medications using a magnetic tape or a paper CMS 1500 form, in accordance with standard NCPDP specifications and requirements until such time as Pharmacy is able to resume electronic claims submission. Prior to submission of non-electronic claims, Pharmacy shall contact Envolve Pharmacy Solutions to verify the status and anticipated duration of any claims processing system service disruption.

Prescription Origin Code

Pharmacy shall utilize NCPDP 5.1 Field 419 DJ – Prescription Origin Code for each claim submitted to Envolve Pharmacy Solutions so that the source of origin for prescriptions can be identified and reported.

Taxes

If any taxes, assessments and/or similar fees (taxes) are imposed on the provider by a governmental authority based on the provider's provision of prescription drugs to eligible persons, the provider may request reimbursement from the payer or eligible plan member for such taxes that are allowed and imposed by applicable law. The provider must transmit the applicable tax amount allowed by law through the claims processing system. In no event does this give the provider any additional or different rights than those allowed by law. In no event shall Envolve Pharmacy Solutions be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments or similar fees.

Submitting Compounds

A compound prescription consists of two (2) or more ingredients one of which is a Federal Legend Drug that is weighted, measured, prepared, or mixed extemporaneously according to the prescription order to make a product that is not commercially available. A prescription is not considered a Compound Prescription if the drug is reconstituted or if the only ingredient added to the prescription drug is water, alcohol or a sodium chloride solution.

Compound prescription claims should be submitted by entering compounding indicator "2" and listing all the NDC's ingredients in the compound, the quantity used for each NDC and the submitted ingredient cost for each NDC. The provider is reimbursed for compound prescriptions based on covered ingredients. The provider will not be reimbursed for the non-covered ingredients (e.g. water, alcohol). Reimbursement for compound drugs dispensed to eligible plan members as covered prescription services is at the provider's agreed upon contract rate for each approved ingredient submitted for the applicable network associated with the claim submission, plus a compounding fee that is subject to change by Envolve Pharmacy Solutions.

PAYMENT GUIDELINES

Claim Payment

Clean claims are paid within 30 calendar days of the receipt of the claim for most plans, unless otherwise specified by law.

Electronic Funds Transfer (EFT)

Providers have the option to receive Electronic Funds Transfer (EFT). To participate, provider must complete the “Pharmacy EFT Payment Request Form” containing banking information. Please allow 14 calendar days for your enrollment to be processed. The form is located on the Envolve Pharmacy Solutions website at <https://pharmacy.envolvehealth.com/pharmacists/forms-for-download.html> and should be returned to the email or fax number listed on the form upon completion.

Claims Payment/Remittance Advice

Envolve Pharmacy Solutions pays the provider according to the agreed upon rates subject to the terms and conditions of the Participating Pharmacy Agreement, Envolve Pharmacy Solutions provides a report showing the record of all claims submitted, processed, and paid in each processing cycle. The reports are distributed by mail, or posted on the Envolve Pharmacy Solutions SFTP site.

If the provider is receiving pharmacy remittance electronically, the provider must adhere to HIPAA regulations which mandate ASCX-12N 835 and updates as required. Envolve Pharmacy Solutions will not provide any other electronic formats. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Envolve Pharmacy Solutions by either fax to (559) 244-3793 or mail to the following address:

Envolve Pharmacy Solutions, Inc.
Attn: Provider Network Services
5 River Park Place East, Suite 210
Fresno, CA 93720

Disputed Claims

Providers are obligated to review remittance advices when received to verify their accuracy. To dispute a claim payment or adjustment, the provider must notify Envolve Pharmacy Solutions’ Accounts Payable department at (800) 413-7721 within the time frame specified in the Participating Pharmacy Agreement, or if not specified, within thirty (30) calendar days.

- > Providers must explain in sufficient detail the basis for its disputed claim payment or adjustment. Providers may submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration, of additional reimbursement.

Applicable only to an underpayment by Envolve Pharmacy Solutions to Provider, any claim payment not disputed after thirty (30) days of Provider's receipt of its remittance advice is deemed to be confirmed as accurate by the Provider.

Envolve Pharmacy Solutions is responsible for investigating any remittance advice dispute or adjustment only if properly notified in the manner and time frame specified above.

MAC Pricing Issues

If you experience negative reimbursement for a drug on our MAC list, please complete and fax a Pharmacy Pricing Inquiry Form for our review. The current form is located on the Envolve Pharmacy Solutions website at:

<https://www.envolverx.com/Media/Default/docs/USS MAC Pricing Inquiry Form.pdf>

Submissions must meet the following conditions or the inquiry will be denied:

- > Submission received from Envolve Pharmacy Solutions contracted entity
- > Member was not inconvenienced and member's plan was not contacted
- > Submitted within 60 days of claim fill date
- > Inquiry submitted for a claim in paid status (no reversed claims are reviewed)
- > Accurate completion of information on the current Pharmacy Pricing Inquiry Form
- > Invoice provided clearly identifying wholesaler, purchase date, NDC, and full package price
- > NDC on form and invoice matches claim information in Envolve Pharmacy Solutions systems
- >

Please note that Envolve Pharmacy Solutions does not guarantee that all claims produce a positive margin. Envolve Pharmacy Solutions will evaluate information provided, however Envolve Pharmacy Solutions is not obligated to adjust any claim or make changes to the pharmacy reimbursement or the MAC list.

Pricing Changes

Envolve Pharmacy Solutions may change the applicable AWP discount and dispensing fee and/or service fee by giving the provider written notice of such amendment thirty (30) calendar days prior. The provider may reject such amendment by providing written notice to Envolve Pharmacy Solutions. Such notice must be received by Envolve Pharmacy Solutions prior to the effective date of the amendment. Envolve Pharmacy Solutions has the right to immediately terminate the Agreement or provider participation from a particular network in the event any such amendment is rejected by provider.

Pricing Benchmark

Envolve Pharmacy Solutions (at its sole discretion) upon thirty (30) calendar days written notice to provider, may utilize different pricing benchmarks (i.e., WAC instead of AWP) for all or some of the pricing of Claims; provided, however, the change to the new pricing benchmark(s) maintains comparable pricing as existed prior to such change.

Rebates

Envolve Pharmacy Solutions and/or Plans shall have and retain the right to submit all Claims for Covered Medications dispensed to Members to pharmaceutical companies in connection with rebate or other similar programs. Pharmacy shall not submit any Claims for Covered Medications dispensed to Members to any pharmaceutical company for the purpose of receiving any rebates or discounts, or the like.

Provider Information Updates

Providers must notify Envolve Pharmacy Solutions in writing of any changes in name, address, telephone number, services, and/or ownership. This information must be sent by either: fax to (559) 244-3793 or mail to the following address:

Envolve Pharmacy Solutions, Inc.
Attn: Provider Network Services
5 River Park Place East, Suite 210
Fresno, CA 93720

Directories

The provider must allow Envolve Pharmacy Solutions and plan sponsors to list the provider in applicable directories and databases for distribution and use by eligible plan members, plan sponsors and others as determined by Envolve Pharmacy Solutions and/or plan sponsors. Moreover, Envolve Pharmacy Solutions may list the providers that participate in performance initiatives foremost in paper and web-based directories and in plan sponsor reporting.

Performance Initiatives

The provider must support Envolve Pharmacy Solutions performance initiatives such as, but not limited to, performance drug program, Drug Utilization Review, formulary adherence, prior authorization, managed drug limitations, dose optimization, and prerequisite step therapy.

Educational Materials

Envolve Pharmacy Solutions may educate the provider about products, programs and services as well as distribute plan sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on the Envolve Pharmacy Solutions website and/or affiliate plan sponsor website.

Generic Drug Standards

Whenever permitted, the provider is required to dispense a generic drug in accordance with applicable laws. Additionally, the provider is required to use reasonable efforts to fulfill Envolve Pharmacy Solutions and plan sponsor mandatory generic programs. The provider is required to stock a sufficient amount of drugs under their generic name coinciding with the practice of local prescribers, the Envolve Pharmacy Solutions and/or local plan sponsor formulary(s) or their preferred drug lists.

The provider is required to contact the prescriber to encourage a change to a generic substitute when the prescription contains a “dispense as written” (DAW) signature for a multisource brand drug. When a multisource brand drug is dispensed, provider must submit the correct DAW code as set forth in the section of this Manual entitled DAW Codes and Descriptions.

DAW Codes and Descriptions

0 – No Product Selection Indicated: This is the field default value appropriately used for prescriptions where selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

1 – Substitution Not Allowed by Prescriber: This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

2 – Substitution Allowed – Patient Requested Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

3 – Substitution Allowed – Pharmacist Selected Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

4 – Substitution Allowed – Generic Drug Not In Stock: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

5 – Substitution Allowed – Brand Drug Dispensed As Generic: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, and the pharmacist is utilizing the brand product as the generic entity.

6 – Override: This value is used by various claims processors in very specific instances, as defined by the claims processors and/or its client(s).

7 – Substitution Not Allowed – Brand Drug Mandated By Law: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

8 – Substitution Allowed – Generic Drug Not Available in Marketplace: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable.

9 – Other: This value is reversed and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this.

Drug Utilization Review

Inappropriate drug therapy can cause member injury and lead to additional health care costs. In an effort to reduce the number of situations where an eligible plan member may receive inappropriate drug therapy, Envolve Pharmacy Solutions provides a concurrent Drug Utilization Review (DUR) program that detects a potential therapeutic problem or drug interaction at the point of service.

The functions of the DUR program are to:

- > Analyze prescriptions submitted through Envolve Pharmacy Solutions
- > Screen prescriptions for several types of therapeutic or drug interaction problems
- > Serve as a clinical information service

Envolve Pharmacy Solutions' claims processing system electronically alerts the dispensing pharmacy of therapeutic or drug interaction problems via the following standard NCPDP point of service (POS) alerts:

- > "DA" drug allergy
- > "DC" inferred drug-disease precaution
- > "DD" drug-drug interaction
- > "DF" drug-food interaction
- > "ER" overuse precaution
- > "HD" high dose alert
- > "ID" ingredient duplication
- > "LD" low dose alert
- > "LR" underuse precaution
- > "MC" actual drug-disease precaution
- > "MN" insufficient duration alert
- > "MX" excessive duration alert
- > "OH" drug-alcohol interaction
- > "PA" pediatric
- > "PG" pregnancy
- > "PR" prior adverse reaction
- > "TD" duplicate therapy
- > Clinical Significance
- > Other Pharmacy Indicator
- > Previous Fill Date
- > Previous Fill Quantity
- > Database Indicator
- > Other Prescriber Indicator

Point-of-sale (POS) messaging is also used to alert pharmacists in the event that a prescription claim is not in compliance with Preferred Drug Lists or Formularies. These alerts, known as the Therapeutic Interchange Program – provide POS messaging regarding preferred, cost-effective drug alternatives for our clients' members.

Additionally, clinical drug restrictions, included as a component of the benefit design, are programmed into our claim processing system to prevent unsafe and inappropriate use of medications. These restrictions cannot be overturned at the pharmacy and include duration of treatment edits related to maximum dosing, quantity limits, and early refills. They require further review by the prescriber and coordination of care with managed care specialists (i.e. prior authorization pharmacist, health plan medical directors, etc.).

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional

judgment of the provider or prescriber. The provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims processing system and for performing provider services in each jurisdiction consistent with the scope of their respective licenses. Drug use inconsistent with the Envolve Pharmacy Solutions criteria may be appropriate in certain clinical settings.

Formularies

Formulary management is an integrated patient care process which enables physicians, pharmacists and other health care professionals to work together to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes. The medications and related products listed on a formulary are determined by the Pharmacy and Therapeutics (P&T) Committee.

All medications and related products subject to clinical review are assigned to a formulary “tier.” The tier represents the level of coverage the health plan will provide. The preferred tier(s) are referred to as “formulary” and non-preferred tier(s) as “non-formulary.”

Envolve Pharmacy Solutions develops and assists plan sponsors in developing formularies that achieve desirable clinical outcomes and help control overall health care costs. Formularies are provided as a reference for drug therapy selections. The final choice of specific drug selection for an eligible plan member rests solely with the prescriber.

The provider must support all formulary initiatives and inform an eligible plan member when a non-formulary drug has been prescribed, and as stated in the foregoing, use best efforts to contact the prescriber to encourage formulary compliance. When a claim is submitted for a non-formulary drug and the plan has a drug formulary, it rejects with CODE 75: PRIOR AUTHORIZATION REQUIRED. In many cases, the member copayment is higher for a non-formulary drug.

Prior Authorization

For some health plans, certain medications will require a Prior Authorization (PA). In these situations, the prescriber is required to supply additional documentation to Envolve Pharmacy Solutions and/or the health plan sponsor to determine whether certain criteria are met for the drug to be covered under the health plan.

The PA process allows prescribers to work in conjunction with licensed clinicians to determine the most appropriate regimen for our members. Often, PA review targets high-risk and/or high-cost medications that require additional attention when prescribing.

If a medication is designated for prior authorization, the claim can reject with the following messages:

“NOT ON PDL”

“PRIOR AUTHORIZATION REQUIRED”

In most cases, the claims system response also provides the correct contact information in the

subsequent message. If the prescriber feels the drug is medically necessary, he or she needs to call the number listed in the POS messaging to initiate coverage.

The provider must support all clinical programs and services and inform eligible persons when a drug designated for prior authorization has been prescribed. The provider must use its best efforts to contact and inform the prescriber when prior authorization messaging occurs.

Drug PA decisions will be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria will be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norm when justified on a case-by-case basis. Denials will be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity or to determine the experimental or investigational nature of health care services as required by state regulations.

If the eligible plan member is unhappy with a prior authorization decision or the terms of his or her benefit plan, he or she has to file an appeal. Decisions about benefit coverage are made by the health plan sponsor. The eligible plan member should refer to his or her health plan member handbook to learn how to file for an appeal with the plan.

If a plan member contacts the Provider Services Call Center to register a complaint, the call center staff refers the plan member to the health plan sponsor.

Drug Alert and Recall

The FDA provides notification of mandatory or voluntary drug alerts, recalls and market withdrawals through the FDA MedWatch Safety Alert E-mail program. Envolve Pharmacy Solutions will designate key individuals within the organization to receive these notices.

Envolve Pharmacy Solutions will identify member(s), prescribing practitioner(s), and contracted dispensing network pharmacy(s) affected by the FDA notice of recall or market withdrawal for safety reasons, which includes voluntary withdrawals by the manufacturer or those under FDA requirement, and coordinate an appropriate response with Envolve Pharmacy Solutions' internal and external clients and/or the client's designee.

MEMBER RIGHTS AND RESPONSIBILITIES

At Envolve Pharmacy Solutions we take responsibility for providing the very best services and benefits possible to our third party payer members; their responsibility is to know how to use them. Members are encouraged to read and understand their benefits.

Member has the right to...

- > Know the terms of your pharmacy benefit.
- > Receive information about Envolve Pharmacy Solutions, our services, and your rights and responsibilities.
- > Be treated with respect, dignity, and the right to privacy.
- > Contact Envolve Pharmacy Solutions or your plan sponsor with a grievance, appeal or complaint.
- > Be an active participant in conversations with your health care professional in making decisions about your health care.
- > Have a candid discussion with your health care professional on the appropriate or medically necessary treatment opinions for your condition regardless of cost or benefit coverage.
- > Access your PHI maintained by Envolve Pharmacy Solutions.
- > Have information about your personal drug use protected. This right does not prevent the use of your information for healthcare purposes. Healthcare purposes include quality improvement, peer review, disease management, reporting, claims adjudication, and compliance programs.
- > Make recommendations about the Envolve Pharmacy Solutions Member Rights and Responsibilities policy.
- > Access prescription services regardless of sex, age, sexual orientation, ethnicity, national origin, religion, genetic information, disability, or source of payment.

Member has the Responsibility to...

- > Read the member handbook located on the Envolve Pharmacy Solutions website at <https://pharmacy.envolvehealth.com/members/forms.html> to become familiar with your prescription benefit and Envolve Pharmacy Solutions' services.
- > Review and understand your formulary. You should provide it to your health care professional so safe, cost-effective medication choices can be made.
- > Understand your health problems and be proactive in your own treatment. If you do not understand your illness or treatment, discuss it with your health care professional.
- > Learn about your drug therapy, including the limitations and risks.
- > Tell Envolve Pharmacy Solutions and the pharmacist if you have additional insurance coverage. This helps us process claims and work with other payers.
- > Inform your plan sponsor of your status changes (such as marriage) that could affect your eligibility for coverage.
- > Consider the results of not following your health care professional's advice.

- > Give your health care professional the details necessary to choose the right drug therapy for you. Important information includes health status, lifestyle, and current and past medications.
- > Adopt lifestyle habits that complement safe and effective use of drug therapy. Examples include following drug therapy and observing recommended limitations on smoking, diet and alcohol use.
- > Comply with financial obligations, administrative, and operational procedures of your pharmacy benefit.
- > Report wrongdoing and fraud to Envolve Pharmacy Solutions and your plan sponsor.
- > Confirm with your health care professional that the quantity, days' supply, and directions on your prescription are correct before giving it to your pharmacist.
- > Know the limits and rules of your benefit plan.

PROVIDER COMPLAINT AND GRIEVANCE PROCESS

Envolve Pharmacy Solutions' Provider Services Call Center offers targeted support to providers with additional questions. The following provider complaint process details the steps needed for review and follow-up of a formal oral or written complaint to the Pharmacy Relations and Provider Help Desk.

Provider Complaint and Grievance Process

A complaint is an expression of dissatisfaction by a complainant in writing to Envolve Pharmacy Solutions or, if orally, then reduced to writing, about any matter related to Envolve Pharmacy Solutions other than a determination of medical necessity for a service. A complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding with, or providing accurate information to, the complainant. A grievance is an expression or dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

When a provider contacts the call center and presents a formal oral or written complaint about our service(s), the Customer Service Representative must document and forward the complaint/grievance by emailing myaccountmgr@envolvehealth.com. If the provider would prefer to fill out a Complaint Form, the associate may mail the *Compliment, Complaint and Appeal Form* or direct the provider to the Envolve Pharmacy Solutions website at

https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/formsfordownload/Appeal%20to%20Complaint_07212016.pdf to obtain a copy. The complaint must include the following information:

- > Provider Information: Provider Name, address, phone number, Insured Member's ID#, Group # and plan sponsor
- > Complainant information: Date and time of submission, name, title and phone number
- > Nature of complaint

The Operations Department staff will send an acknowledgement letter to the complainant within 24 hours of receipt. The acknowledgement letter will include the identification number of the issue, the person to whom the issue has been assigned, and the estimated date of completion (within 30 calendar days), that the complainant may appoint a representative to act on their behalf and that the complainant or complainant's representative may review information related to the complaint/grievance upon request and/or submit additional information to be considered.

Envolve Pharmacy Solutions has 30 calendar days to research and resolve the complaint/grievance. The resolution letter will include the steps taken to resolve the complaint/grievance and a description of the appeal process if applicable. A grievance is not entitled to an appeal.

If the provider chooses to appeal a complaint resolution, the provider may submit a written appeal request to the Compliment, Complaint and Appeal Processing Department within 180 calendar days from the date on the notice of complaint resolution letter. The written request should be mailed to:

Compliment, Complaint and Appeal Processing
Envolve Pharmacy Solutions, Inc.
5 River Park Place East, Suite 210
Fresno, CA 93720
Fax: (559) 244-3793

A letter acknowledging the appeal request will be sent to the provider within 10 business days. The appeal will be researched and resolved by an Envolve Pharmacy Solutions objective Director and a written decision will be issued within 30 calendar days of receipt.

If the provider chooses to further appeal the original appeal decision, a written request must be filed within 30 calendar days from the date on the notice of first appeal resolution letter. The appeal will be researched and resolved by the Senior Vice President Operations (Pharmacy) and a written decision will be issued within 30 calendar days of receipt as "Final Resolution."

Eligible Plan Member Complaint and Grievance Process

Envolve Pharmacy Solutions strives to provide exceptional service. If an eligible plan member is unhappy with anything about Envolve Pharmacy Solutions or its pharmacy network, or is unhappy with a service we have provided or encounters a problem with a pharmacy in our network, they should review the Explanation of Benefits or Description of Coverage provided by their plan sponsor to learn how to file a complaint. They can also contact Envolve Pharmacy Solutions directly so we can improve the situation and better assist them. Filing a formal complaint in regards to benefits or services is referred to as a complaint. Any interpersonal issues are referred to as a grievance.

To submit a complaint/grievance to Envolve Pharmacy Solutions, they can:

1. Contact Envolve Pharmacy Solutions' Customer Service Center at (800) 413-7721.
2. Fill out a Compliment, Complaint And Appeal Form.
 - a. A Customer Service Representative may mail the form upon request
 - b. The form is located on the Envolve Pharmacy Solutions website at https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/formsfordownload/Appeal%20to%20Complaint_07212016.pdf and should be returned to the address listed on the form upon completion.
3. Write to us outlining their concern with the following information:
 - a. Provider Information: Provider Name, address, date of birth and phone number.
 - b. Pharmacy Information: Insured Member's ID#, Group # and plan sponsor.
 - c. Complainant information: Date and time of submission, name, title and phone number.
 - d. Nature of complaint.

This written request should be mailed to:

Compliment, Complaint and Appeal Processing
Envolve Pharmacy Solutions, Inc.
5 River Park Place East, Suite 210
Fresno, CA 93720
Fax: (559) 244-3793

Envolve Pharmacy Solutions has 30 calendar days to research and resolve the complaint/grievance after a formal or written complaint/grievance is received. Should they disagree with the written decision, the member has the right to appeal the decision, if applicable.

PHARMACY AUDIT STANDARDS

Inspections Rights

Envolve Pharmacy Solutions reserves the right to audit compliance with the provider during the term of the Participating Pharmacy Agreement and for three (3) years (or such longer or shorter period required by Law) following termination of the Agreement for any reason. Envolve Pharmacy Solutions reserves the right to inspect all provider records relating to the Agreement. Envolve Pharmacy Solutions has engaged an “audit designee” to perform all audits of the pharmacy provider network.

Audit Types

Audits may be conducted in the form of a desktop, on-site or claim check audit to monitor compliance with state and federal regulations, Envolve Pharmacy Solutions Participating Pharmacy Agreements and this Manual.

Pharmacy Identification for Audit

Pharmacies are identified for an audit based on one or more of the components listed below:

- > Apparent aberrant utilization and billing patterns, as identified by the “audit designee” data mining logic.
- > Modeling and error matrix algorithms.
- > Risk indexing based on known fraudulent practices.
- > Profiling reports generated by “audit designee’s” internal Fraud Waste and Abuse department.
- > Findings from other auditing work, e.g. concurrent audit review.
- > Input from the State the pharmacy is located in.
- > Referrals provided by the Fraud Waste and Abuse department.
- > Referrals from MEDIC’s (Medicare Drug Integrity Contractor) and regional fraud conferences.
- > Fraud prevention and detection advisory opinions, alerts, bulletins, etc., distributed by the United States Department of Health and Human Services, OIG.
- > Other factors agreed upon by the Fraud Waste and Abuse department and the “audit designee.”

Common Claim Errors Resulting in Audits

Some of the most common claim errors cited in pharmacy audits are:

- > Quantity dispensed and paid for exceeds quantity written on prescription.
- > Patient signatures are missing from the pharmacy signature logs.
- > No signature logs kept at pharmacy.
- > Physician indicates that generic may be dispensed, pharmacy dispenses and bills for branded drug.

- > Pharmacy refilled prescription without proper authorization.
- > Prescriptions refilled too early (Incorrect day supply submitted).
- > Prescriptions are not on file.
- > Missing refill records (no refill records on prescription hard copy or computer).
- > Incorrect NDC number billed, forcing a claim to be paid.
- > Prescription billed to incorrect patient.
- > Pharmacy dispensed generic drug and billed for brand.
- > No quantity on prescription.
- > No directions on prescription.
- > Compounded prescriptions submitted and paid incorrectly.
- > Incorrect and/or fraudulent submission of DAW codes.
- > Incorrect physician information submitted.
- > Excluded providers.

Desktop Audits

Notification of Audit - the pharmacy is sent a preliminary letter asking for copies of specific prescriptions and signature logs. Pharmacies are given 30 calendar days to respond with the information.

Final Review – if additional documentation is sent in to mitigate a discrepancy or the 30 day period has elapsed; the auditor reviews the final results of the audit and a final letter is processed. The Final Letter lists any remaining discrepancies and provides the pharmacy 30 calendar days to send in appeal documentation before considering the audit complete. This appeal period may vary depending on state guidelines/regulations and/or client requirements.

Appeal Period – if appeal documentation is sent in to further challenge previously contested discrepancies; the documentation is reviewed by the auditor and an Appeal Letter is sent to the pharmacy outlining any remaining discrepancies. **If no further documentation is sent in by the pharmacy, the audit is considered closed after 30 calendar days from the Final Letter date.**

On-site Audits

Notification of Audit - the pharmacy is notified of a scheduled **Audit & Compliance Solutions** audit. The Auditor calls and verifies the audit date with the pharmacy manager and supplies pertinent information regarding the audit materials requested.

Audit Conducted - the Auditor is equipped with a laptop computer and a portable scanner. The auditor arrives the day of the scheduled audit and conducts an informal entrance interview. The auditor presents the pharmacy manager with a list of prescriptions that are included in the audit and a list of pre-selected signature logs. The On-site® Audit application (AuditTrak) displays a snapshot of the prescription claim along with all associated refills covered in the audit date range. The Auditor compares the information from the original hard copy of the prescription with the information submitted for payment. Inconsistencies and other informational discrepancies are noted on the computer screen. The program requests a scan of the prescription for any identified potential discrepancy. For audits where

scans are not available or are prohibited by statute, the Auditor may request additional documentation. Notes, questions, and free form observations are captured through the use of drop down menus. Independent contracted pharmacists and pharmacy technicians use these remarks to complete the review. Each individual prescription is reviewed and checked for completion before the auditor can sign off and move to the next prescription. Auditors use their pharmacy background to provide observations on pharmacy appearance, type of inventory and standards of pharmacy practice. HIPAA, CMS, and credentialing documentation may be requested. A field report is left the day of the audit which contains general discrepancy types and other pharmacy specific information. The pharmacist must sign this report.

First Review - The preliminary audit is reviewed and the “audit designee” review staff applies appropriate plan rules and regulations to the audit. **After the *first* review, a preliminary report is sent out to the pharmacy electronically or via UPS. The pharmacy has approximately 30 calendar days to submit any post audit documentation that might mitigate the noted discrepancies (Refer to Appendix B – Discrepancy List).**

Final Review – if post audit documentation is sent in or the 30 day period has elapsed, the Auditor reviews the audit and processes a final letter. **The Final Letter lists any remaining discrepancies and provides the pharmacy 15 calendar days to send in appeal documentation before considering the audit as closed and final.**

Appeal Period – if additional appeal documentation is sent in to further challenge previously contested discrepancies, the documentation is reviewed by the auditor and an Appeal Letter is sent to the pharmacy listing any remaining discrepancies. **If no further documentation is sent in by the pharmacy, the audit is considered closed and final after 15 calendar days from the Final Letter date.**

Claim Check Audits

Single claims submitted incorrectly by pharmacies are reviewed during this audit. “Audit designee” will contact the pharmacy providers and request a copy of the Rx and the Signature log. Once received, “audit designee” compares the information submitted on the client’s claims file with the copies of the Rx and Signature Log.

Notification - Pharmacies are contacted **either via mail or facsimile (fax)**. The notification requests claim information (copy of prescription and signature log).

Preliminary Review – copies of prescriptions and signature logs are reviewed against billing data to determine errors – **pharmacies are allowed 14 calendar days to submit additional documentation regarding potential errors.**

Final Review – pharmacies are notified of any remaining errors

Documents and Records Access

The pharmacy must provide Envolve Pharmacy Solutions plan sponsors, governmental agencies, and departments and/or their representatives or agents access to examine, audit, and copy any and all records deemed by Envolve Pharmacy Solutions as necessary to determine compliance with the terms of the agreement.

The provider must make available to the auditor a clutter free work area, located away from the busiest area of the pharmacy, but with ease of access to the documents and records required for the audit. The provider must maintain proper staffing on the scheduled audit date to ensure the provider is reasonably available for questions and the retrieval of information.

The provider authorizes the release of information deemed necessary to determine the provider's compliance with the provider agreement to appropriate agencies and parties including, but not limited to, governmental authorities, third party payers, wholesalers, professional review organizations, and other such parties as requested by the aforementioned agencies and parties, or by Envolve Pharmacy Solutions.

Envolve Pharmacy Solutions tries to minimize the burden on the provider while requesting the necessary information to perform an audit. However, if an Envolve Pharmacy Solutions Auditor is denied access to the provider or if the provider fails to release all the requested documentation, 100 percent of the amount for the paid claims in question will immediately become due and owed and Envolve Pharmacy Solutions may offset such amounts against any amounts owed by Envolve Pharmacy Solutions to the provider.

Provider must promptly comply with all requests for documentation and records.

Prescription Requirements

Prescription hard copies means written prescriptions, refill authorizations, institutional orders, verbal or telephoned orders, facsimile orders, prescription transfers and electronic prescriptions relied on by the provider at the time of dispensing. To qualify as an electronic prescription, the electronic prescription must be noted prior to dispensing and have a system assigned user, date, and time stamp to take the place of hard copy documentation. Prescription hard copies must be renewed at least annually, or more frequently as required by applicable law.

All documentation related to the prescription record must be stored for at least three years or longer as required by law.

A prescription is considered valid when the original prescription contains the following information at the time of dispensing:

- > Patient's first and last name
- > Patient's current address
- > Patient's date of birth

- > Date of issuance
- > Prescriber's full name, NPI and telephone number and, if the prescription is for a controlled substance, the Prescriber's DEA number. If the Prescriber did not include their NPI/DEA number(s) on the prescription hard copy, then the pharmacy is responsible for acquiring the Prescriber ID either from the pharmacy's claim system or by contacting the Prescriber. The participating pharmacy must document the correct Prescriber ID on the prescription hard copy or on a prescription label, affixed to the back of the prescription hard copy.
- > Name, and strength of the drug prescribed
- > Quantity authorized by the prescriber
- > Specific dosage directions. Directions may be obtained through direct communication with the Prescriber or, if the prescriber is not available, the patient. Directions must be noted on the prescription hard copy. "As Directed" is not allowed.
- > Substitution instructions with appropriate documentation
- > Refill instructions
- > Prescription number
- > If the prescription is for a drug under a federally regulated program (e.g., iPledge), the Provider must document the authorization number obtained from the program on the prescription hard copy before dispensing.
- > Documentation noting reason for refilling a prescription early (e.g., lost medication)

During an audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Envolve Pharmacy Solutions recommends that providers document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the drug. A notation on the prescription may eliminate a question from the Auditor or help to resolve the discrepancy.

Signature Log

The provider must maintain a signature log (paper or electronic) for all claims in chronological order as prescriptions are received by the Member, including off-site delivery, with the following information: member name, prescription number, third party program, member (or legal representative) signature and date prescription is picked up.

Unless specific state or federal statutes or regulations or any plan sponsor(s) require a physical signature, in lieu of a signature log, the provider may maintain an electronic proof-of-service to establish that the covered drug was dispensed and received by the eligible member or the member's representative and shall reflect, at a minimum, the following: (i) Member name or Member ID; (ii) prescription number; (iii) date and time the covered drug was received by the member (or member's representative) [e.g. the POS computer receipt or such information electronically stored in the normal course of the Provider's business in the delivery of prescription drugs to its customers, including price paid by the Member (or Member's representative)].

The signature log, or proof of service, must be retained for seven years or longer in accordance with all applicable laws.

Eligible members who have prescriptions delivered or mailed must also sign a delivery log that must be tied back to the electronic proof of service document within the provider's POS system.

Wholesaler, Manufacturer and Distributor Purchase Records

Wholesaler, manufacturer and distributor purchase records must be maintained for a minimum of three years or as required by law to substantiate that the drugs dispensed were purchased from an authorized source. Envolve Pharmacy Solutions may request that the provider gives authorization to the wholesaler, manufacturer or distributor to release corresponding purchase records to Envolve Pharmacy Solutions to facilitate the purchase verification process. The provider must promptly comply with such requests. If the provider fails to promptly provide such authorization, Envolve Pharmacy Solutions has the right to charge back 100 percent of the amount for any paid claims in question.

Audit Resolution

Any such amounts owed to Envolve Pharmacy Solutions for discrepant claims or other charges for noncompliance and audit-related costs will be offset against any amounts Envolve Pharmacy Solutions owes to the provider. Methods used to collect amounts due as a result of audit discrepancies may include, but are not limited to, a request for check, and will therein be offset against the provider's account payable. The provider may be suspended or terminated from participation in any Envolve Pharmacy Solutions Pharmacy Network if the provider fails to pay Envolve Pharmacy Solutions within 30 calendar days of the receipt of an invoice due to audit findings.

When Envolve Pharmacy Solutions collects from the provider amounts due as a result of audit discrepancies, the provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an eligible person or plan sponsor in relation to such adjustment or chargeback.

Envolve Pharmacy Solutions may report its audit findings to plan sponsors, appropriate governmental entities, regulatory agencies, professional review and audit organizations, and other such entities.

Medicare pharmacy claims

A member could have separate Medicare Part B and Part D prescription drug plans (PDP). In those instances, the pharmacist will receive a rejection for Part B-covered items and services from the health plan. To process the claim under the member's Part B plan, the pharmacist should resubmit the claim with the appropriate BIN/PCN combination.

All member information, such as the cardholder ID, remains the same. If there are problems, submitting and adjudicating the claim, the pharmacists need to call the Argus Pharmacy Help Desk for Medicare pharmacy claims at (877) 935-8021.

Medicare Part B vs. Part D billing

The Centers for Medicare & Medicaid Services (CMS) make a distinction between drugs covered under Medicare Part B and those covered under Medicare Part D to help pharmacists determine the appropriate insurance carrier to bill. In general, Envolve Pharmacy Solutions considers most drugs meeting the CMS definition of a Part D drug and dispensed at a retail pharmacy to be covered under Medicare Part D. Envolve Pharmacy Solutions also considers most drugs administered as part of a physician service to be covered under Medicare Part B. For members who have both a Part B plan and a Part D plan, the following guidelines apply.

Medicare Part B plans cover the following drugs (including, but not limited to):

- > Oral immunosuppressive drugs secondary to a Medicare-approved transplant
- > Oral antiemetic drugs for the first 48 hours after chemotherapy
- > Inhalation drugs delivered through a nebulizer with the service location being the patient's home
- > Diabetic testing supplies, such as blood glucose meters, test strips and lancets
- > Certain drugs administered in a home setting that require use of an infusion pump, such as certain antifungal or antiviral drugs and pain medications
- > Flu and pneumonia vaccines
- > Insulin used in a pump

Medicare Part D plans cover the following drugs (including, but limited to):

- > Most prescription drugs
- > Insulin (excluding insulin used in a pump)
- > Supplies used for the administration of insulin, such as syringes, needles, gauze, alcohol swabs and insulin pens
- > Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, Hepatitis B vaccines (when they meet the CMS coverage requirements for Part B coverage) and vaccines used for the treatment of an injury or illness (e.g., tetanus vaccine)

- > Prescription-based smoking cessation products
- > Injectable drugs that may be self-administered
- > Injectable or infusible drugs administered in a home setting and not covered by Medicare Part A or Part B
- > Infusion drugs not covered under Part B and administered in a home via intravenous (IV) drip or push injections. (e.g. intramuscular drugs, antibiotics, parenteral nutrition, immunoglobulin and other infused drugs)

For a drug to be included in the Part D benefit, the product must satisfy the definition of a Part D drug and not otherwise be excluded. A Part D drug must be regulated by the U.S. Food and Drug Administration (FDA) as a drug, biological or vaccine.

PDPs cover Part D drugs; MA plans cover Part B drugs; and MAPD plans cover both Part B and Part D drugs. A coverage determination for Part D requests are based upon the CMS coverage guidelines. **A drug claim will never be eligible for coverage under Part B and Part D simultaneously.**

Envolve Pharmacy Solutions follows the CMS coverage guidelines. To assist in making the appropriate determination for Part B or Part D coverage and payment, Envolve Pharmacy Solutions may require prior authorization. To request prior authorization when required, members, prescribers and appointed or authorized representatives should contact Envolve Pharmacy Solutions at (866) 399-0928. The caller should be prepared to answer questions related to the prescribed drug. These questions are used to help determine coverage and payment as either Part B or Part D. If insufficient or incomplete information is received and the determination of Part B or Part D coverage cannot be made, a fax form requesting more information may be sent to the prescriber.

Envolve Pharmacy Solutions Processing of Medicare Drug Exclusions

For Medicare members, Envolve Pharmacy Solutions will process claims in the following manner:

- > **Medicare Part B drugs**
- > **Medicare Part D drugs, including some over-the-counter drugs**

Medicare Vaccine Administration

The Medicare program covers administration associated with the injection of some vaccines. Pharmacists in Envolve Pharmacy Solutions-participating pharmacies may administer the vaccines if allowed by state law.

Drugs Covered under Part D for a Beneficiary Who Has Elected Hospice

For prescription drugs to be covered under Part D when the enrollee has elected hospice, the drug must be for treatment of a condition completely unrelated to the terminal illness or related conditions; (e.g. the drug is unrelated to the terminal prognosis of the individual).

Medicare Coverage Determinations

Medicare members, their appointed or authorized representatives, and prescribers have the right to request Envolve Pharmacy Solutions to make a decision regarding the coverage of a drug, reimbursement for a drug purchased out-of-pocket or reimbursement for a drug purchased at an out-of-network pharmacy.

Members, their appointed or authorized representatives, and prescribers can request an expedited (24 hour) coverage determination if the member's health would be placed in jeopardy by waiting the standard 72 hours for a decision. Requests for payment or reimbursement cannot be expedited.

Members, their appointed or authorized representatives, and prescribers may request a coverage determination or expedited coverage determination by faxing the request to (877) 941-0480. For questions, contact Envolve Pharmacy Solutions' Customer Service at (866) 399-0928.

Exceptions to plan coverage for Medicare members

Medicare members can ask Envolve Pharmacy Solutions to make an exception to its coverage rules; however, the member's prescriber must support the request in a written statement. Members may submit several types of exception requests, including the following:

- > Request for a drug to be covered, even if not on Envolve Pharmacy Solutions' drug list
- > Request that Envolve Pharmacy Solutions waive coverage restrictions or limits on a drug (e.g., prior authorization, step therapy, dispensing-limit restrictions)
- > Request for a higher level of coverage for a drug. For example, if a drug is considered a tier 4 non-preferred drug, the member may ask that it be covered as a tier 3 resulting in a lower copayment for the member
- >

A member may request an expedited exception if his or her health would be placed in jeopardy by waiting the standard 72 hours for a decision. Members, prescribers and their appointed or authorized representatives can request an exception or an expedited exception by faxing the request to Envolve Pharmacy Solutions at (877) 941-0480 which will be reviewed within 24 hours.

Envolve Pharmacy Solutions Pharmacy Compliance

CMS requires all entities that contract with Envolve Pharmacy Solutions or an Envolve Pharmacy Solutions subsidiary, including pharmacies, to meet Medicare compliance program training requirements. These requirements include review, and adherence to Envolve Pharmacy Solutions' compliance policies and procedures.

Envolve Pharmacy Solutions' general compliance and Fraud, Waste and Abuse (FWA) requirements for contracted pharmacy providers include, but are not limited to:

1. Monitoring and auditing the compliance of subcontractors that deliver services or support related to administrative or health care services provided to a member of an Envolve Pharmacy Solutions Medicare Advantage or Prescription Drug Plan.

2. Obtaining approval from Envolve Pharmacy Solutions for relationships with downstream entities. Envolve Pharmacy Solutions must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicare member protected health information (PHI) in oral, written or electronic form.
3. Having policies and procedures in place for preventing, detecting, correcting and reporting FWA, including, but not limited to:
 - a. Requiring employees and subcontractors to report suspected and/or detected FWA
 - b. Safeguarding Envolve Pharmacy Solutions' confidential and proprietary information
 - c. Providing accurate and timely information/data in the regular course of business
4. Cooperating fully with any investigation of alleged, suspected or detected violation of the manual, Envolve Pharmacy Solutions policies and procedures, applicable state or federal laws or regulations and/or remedial actions.
5. Publicizing disciplinary standards to employees and subcontractors.

Medicare Prescription Drug Coverage and Your Rights

Each Medicare Part D plan sponsor must arrange with its network pharmacies for the distribution of this notice to Part D enrollees when a prescription cannot be covered (“filled”) under the Medicare Part D benefit at the point of sale (POS). This notice must be provided to the enrollee when the pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D. The notice instructs the enrollee their right to contact their Part D plan and request a coverage determination, including an exception. This notice fulfills the requirements found in 42 CFR §423.562(a)(3) and §423.128(b)(7)(iii). OMB Approval No. 0938-0975.

Enrollee’s Name: (Optional)

Drug and Prescription Number: (Optional)

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an “exception”** if you believe:

- > you need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary;”
- > a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your appointed or authorized representatives, and prescribers may request a coverage determination or expedited coverage determination by faxing the request to (877) 941-0480. For questions, contact Envolve Pharmacy Solutions’ Customer Service at (866) 399-0928.

Be ready to provide the following information:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan’s notice will explain why coverage was denied and how to request an appeal if you disagree with the plan’s decision.

Refer to your plan materials or call 1-800-MEDICARE {1(800) 633-4227} for more information.

FREQUENTLY ASKED QUESTIONS BY PROVIDER

1. What eligibility information do you have on file for this plan member (e.g., member identification number, group identification number, date of birth, gender)?

When a provider submits a claim using a plan member's eligibility information which does not match the eligibility information for this member in the Envolve Pharmacy Solutions claims processing system, the claim will be rejected. When this occurs, the provider will receive a denial message due to non-matched eligibility data. Upon receipt of a denial message, the provider will verify eligibility information with the eligible plan member to ensure that the provider has the correct information. If correct, the provider is encouraged to contact a customer service representative at Envolve Pharmacy Solutions to clarify any discrepancies in eligibility information. Until the discrepancies are corrected, the plan member's claims will continue to reject. Moreover, the provider should advise the eligible plan member to contact and inform his/her health plan sponsor of the incorrect eligibility information and request that the information be corrected.

2. What is the plan member's co-payment for Brand medications and Generic medications?

The provider needs to submit the claim through the claims processing system to receive the adjudicated response, which will include the co-payment amount to collect as well as any relevant information about eligibility plan coverage, pricing and applicable clinical programs and services. The customer service representative at Envolve Pharmacy Solutions can help the provider by releasing information about the amount the eligible plan member must pay as per their plan design.

3. What is the prior authorization approval procedure for an eligible plan member?

Envolve Pharmacy Solutions only administers prior authorization (PA) services for some of its plan sponsors. A Medicaid provider needs to note the PA response, which generally includes the on-line retransmission instruction or appropriate contact information and telephone numbers. A commercial provider needs to contact the Envolve Pharmacy Solutions call center for prior authorization procedures. The representative at the call center will assist by providing information about the member's plan design, directing the provider to the appropriate plan administrator, or assisting at the point of service with the prior authorization number code.

4. What is the procedure for authorizing claims identified as "refill too soon," "cost exceeds maximum," "plan limitations exceeded," or "submit to primary carrier, Envolve Pharmacy Solutions to be billed as a secondary payer"?

Many plan sponsors allow eligible plan members to secure an early refill for a vacation supply. If the eligible plan member states that he/she is eligible for an early refill (e.g., vacation overrides, spilled or lost medications), the provider can submit the claim as usual. If the claim rejects as an early refill or exceeds plan limitations, the provider should contact Envolve Pharmacy Solutions' call center for coverage verification. If the plan sponsor allows for an early refill, the representative from the call center will issue the appropriate prior authorization so that the claim can be processed.

A claim for which Envolve Pharmacy Solutions is the secondary payer may trigger a "submit to primary carrier, Envolve Pharmacy Solutions to be billed as a secondary payer" message. This

message indicates that the member has dual coverage and that payment must be coordinated with the primary payer through coordination of benefits (COB). Many times the secondary claims are not accepted online and must be submitted on a paper claim. This will have to be verified on a case by case basis.

5. What are the annual benefits for the eligible plan member?

When the provider submits the claim, the adjudicated response will provide messaging to include plan coverage limits. The representatives at the call center will also provide plan limitation information, (e.g., co-pays, maximum benefit, plan guidelines).

6. What is your bank identification number (BIN) and processor control number (PCN)?

With the many different types of plans that we have, there can be more than one PCN for the same pharmacy chain depending on which type of plan the specific member is on. The BIN is often provided on the member's identification card. BINs/PCNs are listed on the Payer Sheets. Providers should refer to the member ID Card for the most accurate, recent processing information to adjudicate a claim. If the number is not provided, please call the Provider Services Call Center for the Envolve Pharmacy Solutions BIN or PCN.

APPENDIX A – REGULATORY ADDENDA

Pharmacy acknowledges that various federal and state mandates may apply with respect to the Participating Pharmacy Agreement and the services provided to Members of Plans. Such mandates are included in addenda to this Manual and may provide specific, different, and/or additional contractual provisions applicable to some of the services, Members, and/or Plans (Regulatory Addenda), all of which are incorporated herein by this reference. Pharmacy agrees that it has received the Regulatory Addenda, has read such Regulatory Addenda, and agrees to the terms and conditions set forth in such Regulatory Addenda, without requiring a separate signature thereon to be effective. The provisions in the Regulatory Addenda only apply if they are required and then only as those provisions relate to Members whose Plans are governed by the applicable provisions. In the event of a conflict between the Participating Pharmacy Agreement and an applicable Regulatory Addendum, the Regulatory Addendum shall control to the extent required by Law. Pharmacy represents and warrants that it is, and shall remain, in compliance with all applicable Laws, including but not limited to those Laws referenced in the Regulatory Addenda. Pharmacy acknowledges and agrees that the Regulatory Addenda may be amended and/or supplemented with additional addenda by Envolve Pharmacy Solutions from time to time upon written notice to Pharmacy. Regulatory Addenda shall be provided or made available to Pharmacy by Envolve Pharmacy Solutions in written or electronic format.

STATE OF ARIZONA MEDICAID REGULATORY REQUIREMENTS

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

This Addendum applies to the extent that Pharmacy provides prescription drug services to individuals who are recipients of benefits under the state Medicaid program (collectively and/or individually "Plan") under Arizona law. The parties agree that any provision not required by the Arizona Medicaid program or applicable laws or regulations, shall not be binding.

DEFINITIONS

Provider: Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

Providers who are denied payment of a claim have the right to formal claim disputes. Provider claim disputes and hearing requests should be sent in either writing or by fax to the following address:

CLAIM DISPUTES

Bridgeway Health Solutions
Attention: Provider Claim Disputes
1850 W. Rio Salado Parkway
Suite 201
Tempe, AZ 85281

The fax number for Bridgeway Claims Disputes is (866) 687-0518

All claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

If the Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claim (s) in a manner consistent with the Decision along with any applicable interest within 15 business days of the date of the Decision. If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

Provider shall report to Envolve Pharmacy Solutions and other proper authorities incident, accident and death (IAD) reports of abuse, neglect, injury, alleged human rights violation, exploitation Health Care Acquired Conditions and death in conformance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, Chapter 900. Reporting will include the following information: Provider shall report to Envolve Pharmacy Solutions and other proper authorities incident, accident and death (IAD) reports of abuse, neglect, injury, alleged human rights violation, exploitation, Healthcare Acquired Conditions (HCAC) and death in conformance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, Chapter 900. Reporting will include information including:

- Member Information
 - Name
 - Address
 - DOB
 - AHCCCS ID
 - CIS ID
 - Eligibility Status
 - COT Status
 - DDD
 - CMDP
 - Funding Source
 - Diagnosis
- Provider Information
 - Provider Name
 - Address
 - AHCCCS ID
 - Telephone Number
 - Clinical Director
 - E-mail Address
- Incident Details
 - Location of Incident
 - Date and Time of Incident
 - Date Reported to Provider
 - Incident Type/AHCCCS Allegation
- Description of the Incident
- Member Condition Before/After Incident
- Description of Any Medical Services Received
- Witnesses
- Actions Taken and/or Recommended by the Provider
- Notifications – Who was notified
- Clinical Director Review of the Incident

STATE OF CALIFORNIA MEDICAID REGULATORY REQUIREMENTS

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

This Addendum applies to the extent that Pharmacy provides prescription drug services to individuals who are recipients of benefits under the state Medicaid program (collectively and/or individually “Plan”) under California law. The parties agree that any provision not required by the California Medicaid program, DHCS, MCO, or applicable laws or regulations, shall not be binding.

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

1. Pharmacy shall provide pharmaceutical services and prescription drugs in accordance with all applicable Federal and State laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22 CCR Sections 53214 and 53854 and Title 16, Sections 1707.1, 1707.2, and 1707.3.
2. Pharmacy will submit all claims to Envolve Pharmacy Solutions so as to enable Envolve Pharmacy Solutions to meet its requirements to MCO and DHCS.
3. Pharmacy certifies that it and the pharmacists providing services under this Addendum are licensed, certified, or registered and in good standing in the Medicare and Medicaid/Medi-Cal programs. Pharmacy also certifies it has a valid National Provider Identifier (NPI) number for all applicable locations.
4. Pharmacy agrees to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.
5. In accordance with the State Contract and DHCS requirements, Pharmacy shall cooperate and participate in Envolve Pharmacy Solutions and/or MCO training regarding the Medi-Cal Managed Care program to operate in full compliance with the State Contract and all applicable Federal and State statutes and regulations. Training shall relate to Medi-Cal Managed Care services, policies, procedures, and any modifications to existing services, policies, or procedures. Training shall include methods of sharing information between Envolve Pharmacy Solutions, Pharmacy, Members, and/or other health care professionals and information on Member rights. As deemed necessary by MCO or DHCS, Pharmacy shall cooperate and participate in any ongoing training.
6. Pharmacy shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Agreement to a Medi-Cal Member. Pharmacy shall not hold Members liable for MCO's debt if MCO becomes insolvent.
7. Envolve Pharmacy Solutions shall reimburse Indian Health Programs for services provided to Members who are qualified to receive services from an Indian Health Program as set forth in 42

USC Section 1396u-2(h)(2), Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009, and, insofar as they do not conflict with Federal law or regulations, the reimbursement options set forth in Title 22 CCR Section 55140(a).

8. Envolve Pharmacy Solutions shall describe any prior authorization requirements for pharmacy services in Envolve Pharmacy Solutions' pharmacy manual.
9. Pharmacy shall be open, at a minimum, during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
10. Reimbursement to pharmacies for psychotherapeutic drugs listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, Pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.
11. Reimbursement to pharmacies for drugs for the treatment of HIV/AIDS listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, Pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.
12. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. To the extent Pharmacy or any Contracted Pharmacy is unclear about its respective duties and obligations, Pharmacy shall request clarification from Envolve Pharmacy Solutions. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.
13. Pharmacy shall comply with all applicable provisions of the State Contract, federal, State and local laws and regulations, and all amendments thereto. Pharmacy understands and agrees that this Addendum and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State Contract.
14. Pharmacy agrees to comply with Envolve Pharmacy Solutions' Manual, which is defined as the Envolve Pharmacy Solutions pharmacy policy and procedure manual published by Envolve Pharmacy Solutions, as amended and/or supplemented by Envolve Pharmacy Solutions from time to time upon thirty (30) calendar days' notice to Pharmacy, which sets forth Envolve Pharmacy Solutions' policies and operational procedures required to be followed by Pharmacy in providing pharmacy services to Members under this Agreement. The Manual is provided or made available to Pharmacy by Envolve Pharmacy Solutions in hard copy or electronic format. The current Manual is available at www.Envolverx.com.

FLORIDA MEDICAID REGULATORY ADDENDUM TO PARTICIPATING PHARMACY AGREEMENT

Hernandez Settlement. Network Provider shall ensure that it complies with all applicable requirements of the Hernandez Settlement Agreement (HSA). An HSA situation arises when a Medicaid Enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of:

- (1) An unreasonable delay in filling the prescription;
- (2) A denial of the prescription;
- (3) The reduction of a prescribed good or service; and/or
- (4) The termination of a prescription.

If Network Provider desires, the Bureau of Managed Health Care will provide copies of all Hernandez related policies and procedures for review and written approval.

STATE OF LOUISIANA MEDICAID REGULATORY ADDENDUM

This Regulatory Addendum applies to the extent that Pharmacy provides prescription drug services to individuals who are recipients of benefits under the state Medicaid program (collectively and/or individually “Plan”) under Louisiana law. The parties agree that any provision not required by the Louisiana Medicaid program, CCN (as defined below), or applicable laws or regulations, shall not be binding.

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

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

1. Louisiana Healthcare Connections (CCN) has contracted with the Louisiana Department of Health and Hospitals (DHH) to arrange for the provision of medical services to Members under the Coordinated Care Network – Prepaid Program, as defined herein.
2. This Addendum is intended to supplement this Agreement by setting forth the parties’ rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the Coordinated Care Network – Prepaid Program.
3. Pharmacy agrees and understands that Covered Services shall be provided in accordance with the contract between DHH and CCN (Medicaid CCN Contract), the Pharmacy Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Pharmacy is unclear about Pharmacy’s duties and obligations, Pharmacy shall request clarification from CCN.
4. Definitions. The capitalized terms used in this Addendum shall have the meanings stated herein or in the Agreement.
 - A. **CCN-P Policy and Procedure Guide** means the policy and procedure guide for the Coordinated Care Network – Prepaid Program Pharmacies.
 - B. **Clean Claim** means (1) a bill for services, (2) a line item of service or (3) all services for one recipient within a bill. Clean Claim means one that can be processed without obtaining additional information from Pharmacy or from a third party. It includes a Claim with errors originating in a State’s claims system. It does not include a Claim from a Pharmacy who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.
 - C. **CommunityCARE** means the Louisiana Medicaid Primary Care Case Management program which links Medicaid/CHIP eligibles to a PCP as their medical home.
 - D. **Coordinated Care Network – Prepaid Program (CCN-P)** means any prepaid entity that participates in the State Medicaid Program and is regulated by the State Department of Insurance with respect to licensure and financial solvency pursuant to Title 22 of the Louisiana Revised Statutes, but shall solely with respect to its products and services offered pursuant to the State Medicaid program be regulated by the DHH.

- E. **Covered Person** means an individual enrollee of CCN's Coordinated Care Network – Prepaid plan.
 - F. **Covered Services** means Medically Necessary health care services to which a Covered Person is entitled under the Louisiana Medicaid State Plan.
 - G. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual, (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.
 - H. **Emergency Services** means covered inpatient and outpatient services that are furnished by a Pharmacy that is qualified to furnish these services under 42 C.F.R. §§ 438.114(a) and 1032(b)(2), and needed to screen, evaluate and stabilize an Emergency Medical Condition.
 - I. **Medically Necessary or Medical Necessity** means health care services that: (1) are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care; (2) are deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunctions; (3) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; and (4) must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and are deemed not Medically Necessary.
 - J. **RFP** means the Louisiana Department of Health and Hospitals Request for Proposal #305PUR-DHHRFP-CCN-P-MVA.
 - K. **State** means the state of Louisiana.
 - L. **State Plan** or **Louisiana Medicaid State Plan** means the binding written agreement between the DHH and the federal Centers for Medicare and Medicaid Services, which describes how the Medicaid program is administered.
 - M. **Unreasonable Delay** shall have the meaning set forth in the CCN-P Policy and Procedure Guide.
5. Coordinated Care Network – Prepaid Program Requirements
- A. This Addendum and the Agreement contains all the terms and conditions agreed upon by the parties with respect to the Coordinated Care Network – Prepaid Program. The parties shall make no alteration, variation, modification, waiver, or extension of this Agreement's termination date or early termination of this Agreement unless such change is reduced to writing, duly signed, and attached to this Agreement; however, CCN may, with prior notice to DHH, provide amendments to Pharmacy by written notification through CCN bulletins, if mutually agreed to in terms of the Agreement. Pharmacy shall not assign any of its duties or responsibilities under this Agreement, or enter into any subcontracts or otherwise delegate

services provided thereunder, without CCN's and Envolve Pharmacy Solutions' prior written approval. The parties agree that they shall, pursuant to this Section, amend this Addendum as necessary to comply with the State Plan, RFP, and other requirements of DHH.

- B. Covered Services shall be provided in accordance with the State Plan. Pharmacy shall provide Covered Services to Covered Persons through the last day that this Agreement is in effect. Pharmacy acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.
- C. Pharmacy shall not refuse to provide Medically Necessary or preventative Covered Services to Covered Persons for non-medical reasons (except services allowable under federal law for religious or moral objections).
- D. Pharmacy shall be currently licensed and/or certified under applicable State and federal statutes and regulations and shall maintain throughout the term of this Addendum all necessary licenses, certifications, registrations and permits as are required to provide the services under the Agreement and this Addendum.
- E. Pharmacy shall permit DHH, U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services, Office of Inspector General, State Comptroller, State Auditor's Office, and the Louisiana Attorney General's Office to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of Covered Services and the timeliness and accuracy of encounter data submitted to the CCN. CCN shall cooperate with these evaluations and inspections and, upon request, assist with such reviews.
- F. Pharmacy shall participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by CCN and/or DHH or its designee, whether announced or unannounced.
- G. Pharmacy shall monitor and report the quality of Covered Services delivered under this Addendum and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Pharmacy practices and/or the standards established by DHH or its designee.
- H. Pharmacy shall comply with any plan of corrective action initiated by Envolve Pharmacy Solutions, CCN and/or required by DHH.
- I. Pharmacy shall submit all reports and clinical information required by the CCN, including but not limited to, as applicable, HEDIS, AHRQ (the Agency for Healthcare Research & Quality), and EPSDT.
- J. Pharmacy shall safeguard Covered Person information in accordance with applicable State and federal laws and regulations and the standards set forth below:
 - i. Be at least as restrictive as those imposed upon the DHH by 42 C.F.R. Part 431, Subpart F (2005, as amended) and La R.S. 45:56;
 - ii. Identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
 - iii. Require the written authorization of the Covered Person or potential Covered Person before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 C.F.R. § 164.508;
 - iv. Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

v. Subject violators to appropriate personnel sanctions.

Pharmacy further acknowledges that all material and information, in particular information relating to Covered Persons or potential Covered Persons, which is provided to or obtained by or through Pharmacy's performance under this Agreement, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws. Pharmacy shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement. All information as to personal facts and circumstances concerning Covered Persons or potential Covered Persons obtained by the Pharmacy shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the Covered Person/potential Covered Person except as otherwise permitted or required by applicable State or federal law or regulations, provided that nothing stated herein shall not prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Covered Persons/potential Covered Persons shall be limited to purposes directly connected with the administration of this Agreement.

- K. Pharmacy acknowledges and agrees that this Agreement makes full disclosure of the method and amount of compensation or other consideration to be received from CCN.***
- L. Pharmacy shall provide the name and address of the official payee to whom payment shall be made and shall also promptly submit to Envolve Pharmacy Solutions all information, which shall be complete and accurate, needed for Envolve Pharmacy Solutions to facilitate payment to Pharmacy for Covered Services provided to Covered Persons hereunder.
- M. Envolve Pharmacy Solutions shall pay ninety percent (90%) of all Clean Claims within fifteen (15) days of the date of receipt. Envolve Pharmacy Solutions shall pay ninety-nine percent (99%) of all Clean Claims within thirty (30) days of the date of receipt. The date of receipt shall be considered the date Envolve Pharmacy Solutions receives the Clean Claim, as indicated by the date stamp on the Clean Claim. The date of payment shall be considered is the date of the check or other form of payment.
- N. Pharmacy shall submit all claims for payment no later than twelve (12) months from the date of service.
- O. Pharmacy shall accept payment made by Envolve Pharmacy Solutions on behalf of CCN as payment-in-full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Covered Person. For purposes of this section, the term "Covered Person" shall include the patient, and, if applicable, the patient's parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Covered Person.
- P. At all times during the term of this Agreement, Pharmacy shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Agreement, unless the Pharmacy is a state agency. Specifically, for all Pharmacies that are not state agencies, Pharmacy shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:
 - i. Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for Pharmacy in connection with the performance of this Agreement;

- ii. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Pharmacy, its officers, employees, or subcontractors in the performance of this Agreement;
 - iii. Any claims for damages or losses resulting to any person or firm injured or damaged by Pharmacy, its agents, its officers, employees, or contractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under this Agreement in a manner not authorized by this Agreement or by federal or State regulations or statutes;
 - iv. Any failure of the Pharmacy, its officers, employees, or subcontractors to observe the federal or State laws, including, but not limited to, labor laws and minimum wage laws;
 - v. Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
 - vi. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of the Pharmacy, its agents, officers, employees or subcontractors.
- Q. Pharmacy recognizes and shall abide by all State and federal laws, rules and regulations and guidelines applicable to the provision of Covered Services under the Coordinated Care Network – Prepaid Program.
- R. The parties recognize that in the event of termination of the Medicaid CCN Contract, CCN shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the parties’ activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH.
- S. Pharmacy shall adhere to the quality assurance and utilization review requirements as outlined in the CCN-P Policy and Procedure Guide, which are incorporated herein by reference.
- T. Pharmacy shall give Envolve Pharmacy Solutions immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Pharmacy’s ability to perform under this Agreement.
- U. Neither Envolve Pharmacy Solutions nor CCN shall prohibit or otherwise restrict Pharmacy from advising or advocating on behalf of a Covered Person who is Pharmacy’s patient (i) for the health status, medical care or treatment options for the Covered Person, including any alternative treatment that may be self-administered; (ii) for any information that the Covered Person needs in order to decide among all relevant treatment options; (iii) for the risks, benefits and consequences of treatment or non-treatment; and (iv) for the Covered Person’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, provided Pharmacy is acting within the lawful scope of practice.
- V. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended),

Pharmacy shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the Covered Services provided under this Agreement.

- W. Pharmacy acknowledges that no provision contained in this Agreement provides incentives, monetary or otherwise, for the withholding of Medically Necessary services.
- X. In accordance with 43 C.F.R. §438.210(e), compensation to Envolve Pharmacy Solutions, CCN or individuals that conduct utilization management activities shall not be structured as to provide incentives for the individual or Envolve Pharmacy Solutions or CCN to deny, limit, or discontinue Medically Necessary services to any Covered Person.
- Y. The Pharmacy may only contract with Envolve Pharmacy Solutions if such conflict of interest safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place per State Medicaid Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option. Pharmacy represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Pharmacy further covenants that, in the performance of this Addendum, no person having any such known interests shall be employed.
- Z. In addition to any requirements contained in this Addendum relating to record maintenance and retention, Pharmacy shall maintain and retain records as follows: Pharmacy shall maintain an adequate record system for recording services, service Pharmacies, charges, dates and all other commonly accepted information elements for Covered Services rendered to Covered Persons pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement). Pharmacy shall give Covered Persons and their representatives access to and copies of the Covered Persons' medical records, to the extent and in the manner provided by La. R. S. § 40:1299.96 and 45 C.F.R. § 164.524, as amended, and subject to reasonable charges.
- AA. Pharmacy shall retain any and all Covered Person records, including but not limited to financial and medical records, for at least six (6) years following the date of final payment for Covered Services provided by Pharmacy to a Covered Person, and for a longer period of time if the records are under review, audit or related to any matter in litigation until the review, audit or litigation is complete. Records retained pursuant to this subsection shall be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of any authorized representative of DHH. Pharmacy shall retain all records originated or prepared in connection with Pharmacy's performance of its obligations under this Addendum. Pharmacy further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Covered Persons relating to the delivery of care or service under this Addendum, and as further required by DHH, for a period of six (6) years from the expiration date of the Agreement, including any extensions. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of such period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of such period, whichever is later. If Pharmacy stores records on microfilm or microfiche, Pharmacy must agree to produce, at its expense, legible hard

- copy records upon the request of State or federal authorities, within twenty-one (21) calendar days of the request.
- BB. Pharmacy acknowledges and agrees that this Agreement specifies the amount, duration and scope of services to be provided by Pharmacy and informs Pharmacy of Covered Services under the State Plan, including all specific Pharmacy requirements outlined in the Medicaid CCN Contract and/or CCN-P Policy and Procedure Guide.
 - CC. Pharmacy shall adhere to all requirements for CCN's Participating Health Care Pharmacies set forth in the RFP, the Medicaid CCN Contract and CCN-P Policy & Procedure Guide, which terms are incorporated herein by this reference. CCN shall furnish these documents to Pharmacy upon request.
 - DD. At the direction of DHH and CCN, Envolve Pharmacy Solutions shall impose financial penalties on Pharmacy in the event Pharmacy fails or refuses to respond to CCN's request for prescription record information.
 - EE. In the event CCN or Envolve Pharmacy Solutions fails to pay for Covered Services as set forth in the evidence of coverage, the Covered Person will not be liable to Pharmacy for any sums owed by CCN.
 - FF. Pharmacy acknowledges and agrees to the procedure for processing and resolving grievances and the location and telephone number where grievances may be submitted is set forth in the Pharmacy Manual in accordance with La. R. S. § 22:263.
 - GG. Pharmacy shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under this Agreement without the prior approval of CCN.
 - HH. The parties acknowledge and agree that the defined term "Covered Person" identifies the population covered by this Agreement.
 - II. Notwithstanding anything else in this Addendum, Pharmacy shall not be required to accept or continue treatment of a patient with whom Pharmacy feels he or she cannot establish and/or maintain a professional relationship.
 - JJ. Pharmacy is not permitted to encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by DHH.
 - KK. Pharmacy shall comply and submit to CCN or Envolve Pharmacy Solutions disclosure of information in accordance with the requirement specified in 42 C.F.R. § 455, Subpart B.
 - LL. If any requirement in this Agreement is determined by DHH to conflict with the Medicaid CCN Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.
 - MM. Pharmacy shall coordinate emergency services without the requirement of prior authorization of any kind.
 - NN. If Pharmacy performs laboratory services, the Pharmacy must meet all applicable state requirements, 42 CFR 493.1 and 493.3, and any other federal requirements.
 - OO. Pharmacy is permitted to subcontract with another Prepaid Health Plan or other managed care entity.

MICHIGAN MEDICAID REGULATORY REQUIREMENTS

Attachment A: Medicaid

SCHEDULE A

GOVERNMENTAL CONTRACT REGULATORY REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the Michigan Medicaid Product under a Governmental Contract.

1. Definitions. As used in this Schedule A to Attachment A, the following terms shall be defined as set forth below.

1.1. "Clean Claim" has the meaning set forth at Mich. Comp. Laws § 400.111i, which as of the Effective Date means a claim that does at a minimum all of the following: (a) identifies the health professional or health facility that provided treatment or service, including a matching identifying number; (b) identifies the patient and plan; (c) lists the date and place of service; (d) is for Covered Services; (e) is certified pursuant to Mich. Comp. Laws § 400.111b(17) and has the identifying information required under Mich. Comp. Laws § 400.111b(21); (f) if necessary, substantiates the medical necessity and appropriateness of the care or service provided; (g) if prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate; and (h) includes additional documentation based upon services rendered as reasonably required by the Payor.

1.2. "Covered Services" means the services provided under Medicaid, and provided, or arranged to be provided by Health Plan to Covered Persons pursuant to the State Contract.

1.3. "DCH" means the Michigan Department of Community Health.

1.4. "PCP" means a Participating Provider who is any of the following, as applicable: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, or pediatric physician when appropriate for a Covered Person, other physician specialists when appropriate for a Covered Person's health condition, nurse practitioners, and physician assistants.

1.5. "State" means the State of Michigan.

1.6. "State Contract" means the then effective contract with the Michigan Department of Community Health (or any successor thereto) for the Comprehensive Health Care Program.

2. Compliance with Applicable Authorities. Provider shall comply with all applicable state, federal and local laws and ordinances, state and federal statutes, regulations and administrative procedures in connection with its performance under this Agreement. Provider acknowledges and agrees that this Agreement is subject to and governed by, and that Provider shall not interfere with nor shall this Agreement be construed in a manner that impairs Health Plan's ability to operate consistent with, such applicable laws, regulations and administrative procedures, including but not limited to Section 1903(m) of the Social Security Act and 42 CFR Part 434, as well as all applicable Medicaid provider manuals and publications for coverages and limitations.

3. Nondiscrimination. Provider shall provide Covered Services to Covered Persons without regard to Covered Persons' race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. Provider shall not deny a Covered Service or availability of

a facility or provider identified in the State Contract. Provider shall not intentionally segregate Covered Persons in any way from other persons receiving health care services.

4. Public Health Reporting. Provider shall comply with all State-specified reporting requirements for communicable disease and other health indicators.

5. Prohibited Affiliations with Individuals Debarred by Federal Agencies. Provider acknowledges and agrees that reimbursement for any services ordered, prescribed, or rendered by Provider or Provider's employees ("Provider's employees" shall include directors, offices, partners, agents, all employees and persons with beneficial ownership of more than 5% of Provider's equity) who is currently suspended or terminated from direct and indirect participation in the Medicaid Program or federal Medicare program.

6. Prohibition from Collecting Payments from Covered Persons. Provider is prohibited from seeking payment from Covered Persons for Covered Services rendered to Covered Persons under the Agreement and shall look solely to the Health Plan for compensations for Covered Services rendered. No cost sharing or deductibles, or patient-pay amounts can be collected from Covered Persons unless authorized by DCH. Provider shall not bill Covered Persons for the difference between the Provider's charge and the Health Plan's payment for Covered Services. Provider shall not seek nor accept additional or supplemental payment from a Covered Person, his/her family, or representative, in addition to the amount paid by Health Plan, regardless of an agreement signed by the Covered Person to do so. If a Covered Service requires a co-payment, Provider is prohibited from denying Covered Services to a Covered Person due to Covered Person's inability to pay such co-payment. A Covered Person must not be held liable for any of the following provisions, consistent with 42 CFR 438.106 and 42 CFR 438.116: (a) Health Plan's debts, in case of insolvency; (b) Covered Services under this Agreement provided to the Covered Person for which DCH did not pay Health Plan; (c) Covered Services provided to the Covered Person for which DCH or Health Plan did not pay Provider due to contractual, referral or other arrangement; and/or (d) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if Health Plan provided the services directly. Provider acknowledges that Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to providers in the case of services provided to Covered Person who charge at a rate in excess of the rate permitted under this Agreement. Provider acknowledges that the Medicaid Program is the payor of last resort.

7. Transfer of Covered Persons. Provider acknowledges and agrees that in the event the health or safety of a Covered Person is in jeopardy, such Covered Person shall be immediately transferred to another Health Plan primary care provider, if and as medically appropriate.

8. Treatment Decisions. Provider is not prohibited from discussing treatment options with Covered Persons that may not reflect the Health Plan's position or may not be covered by the Health Plan. Provider, acting within the lawful scope of practice, is not prohibited, or otherwise restricted, from advising or advocating on behalf of a Covered Person who is his or her patient for (i) the Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Covered Person needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment;

and (iv) the Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9. Compliance with Medicaid Accessibility Standards. Provider shall comply with the Medicaid accessibility standards as provided under the State Contract.

10. Quality Improvement and Utilization Review Activities. Provider will cooperate with Health Plan's quality improvement and utilization review activities, including but not limited to complying with Health Plan's clinically appropriate practice parameters and protocols/guidelines, participating in discussions with Health Plan personnel regarding performance feedback and clinical standards, taking appropriate action to correct deficiencies, and implementing appropriate corrective action.

11. Continuity of Care. Provider shall provide for continuity of treatment in the event Provider's participation terminates during the course of a Covered Person's treatment by Provider.

12. Payments for Retroactive Eligibility. Provider acknowledges and agrees that with the exception of newborns, Health Plan is not responsible for any payments owed to Provider for services rendered prior to a Covered Person's enrollment with the Health Plan.

13. Electronic Billing Capacity. Provider shall comply with the HIPPA and DCH guidelines regarding electronic billing capacity. Provider must be able to submit bills to Health Plan using the same format and coding instructions as required for the Medicaid fee-for-service program. Health Plan may require additional documentation, such as medical records, to justify the level of care provided. In addition, Health Plan may require prior authorization for services for which the Medicaid fee-for-service program does not require prior authorization.

14. Marketing Materials. Provider acknowledges and agrees that all written and oral marketing materials and health promotion incentive materials must be approved by DCH prior to use. Provider is prohibited from marketing in Provider's office, including but not limited to distributing written materials in the providers' office. Provider shall not engage in prohibited marketing practices or use marketing materials that have not been approved in writing by DCH.

15. Medical Records. Provider shall maintain medical records of all medical services received by the Covered Person from that Provider. Such medical records shall include, at a minimum, a record of outpatient and emergency care, specialist referrals, ancillary care, diagnostic test findings including all laboratory and radiology, prescriptions for medications, inpatient discharge summaries, histories and physicals, immunization records, and other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided. Provider's medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment. Medical records must be signed and dated. All medical records must be retained for at least seven (7) years. Provider must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information and shall afford DCH and/or CMS prompt access to all Covered Person's medical records. Neither CMS nor DCH are required to obtain written approval from a Covered Person before requesting such Covered Person's medical record. When a Covered Person changes PCP, the former PCP must forward his or her medical records or copies of

medical records to the new PCP within ten (10) working days from receipt of a written request. If Provider is a hospital, Provider shall comply with all medical record requirements contained within 42 CFR Sections 456.101 through 456.145.

16. Covered Persons Rights. Provider will comply with all requirements concerning Covered Persons' rights, including but not limited to all enrollee rights specified in 42 CFR 438.100 (a)(1), 42 CFR 438.100(c), and 42 CFR 438 102(a), as well as the right to i) confidentiality; ii) participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about treatment options; iii) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; iv) request and receive a copy of his or her medical records, and request that they be amended or corrected; v) be furnished healthcare services consistent with this Agreement and State and Federal regulations; vi) be free to exercise his or her rights without adversely affecting the way Health Plan, providers or the State treats the Covered Person; and vii) be free from other discrimination prohibited by State and federal regulations.

17. Family Planning Providers. If Provider is a family planning provider, Provider is encouraged to communicate with PCPs once any form of medical treatment is undertaken.

18. PCP Requirements. If Provider is a PCP, Provider will, as applicable, provide the Well Child/EPSTD services as delineated in the EPSTD section of the Practitioner Chapter in the Medicaid Provider Manual, and shall use vaccines available free under the Vaccine for Children (VFC) program for children 18 years old and younger available at no cost. In such event, Provider is encouraged to participate with the Michigan Care Improvement Registry (MCIR). In the event Provider is a PCP, Provider is responsible for supervising, coordinating, and providing all primary care to each assigned Covered Person. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each Covered Person's health care, and maintaining the Covered Person's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services.

19. CSHCS Provider Requirements. If Provider is a PCP who serves Covered Persons enrolled in Children's Special Health Care Services, Provider must regularly serve children or youth with complex chronic health conditions and, whenever possible, be appropriate for youth and adults who are transitioning to Adulthood. In addition, such Provider's practice must i) have a mechanism to identify children/youth with chronic health conditions; ii) provide expanded appointments when the child/youth has complex needs and requires more time; iii) have experience coordinating care for children/youth who see multiple professionals (pediatric subspecialists, physical therapists, mental health professionals, etc.); iv) have a designated professional responsible for care coordination for children/youth who see multiple professionals; and v) indicate willingness to accept new patients (children/youth) with complex chronic health conditions.

20. DCH Lab Requirements. If Provider is the State of Michigan Department of Community Health Laboratory ("DCH Lab"), the DCH Lab is responsible for providing all beneficiary-level data related to the tests listed in Attachment C of the State Contract performed by the DCH Lab. For all tests performed after May 1, 2012, the DCH Lab must provide this data to Health Plan within ninety (90) days of performing the test.

21. Medicare/Medicaid Suspension or Termination. Provider acknowledges that Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. Provider further acknowledges that Health Plan is prohibited from having a contractual, employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to Health Plan's contractual obligation with the State. Provider represents and warrants that Provider is not currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program.

22. Provider Disclosures. Provider shall provide to Health Plan and DCH all disclosures required under law and/or the State Contract, including but not limited to the following:

22.1. Criminal Convictions. Before entering into or renewing this Agreement, or at any time upon written request by DCH, Provider and any of Provider's directors, officers, partners, agents, employees, and persons with beneficial ownership of more than five percent (5%) of Provider's equity, must disclose to Health Plan any criminal convictions related to Federal healthcare programs.

22.2. Disclosures for Ownership and Control. Provider (or its fiscal agent or disclosing entity on behalf of Provider) shall provide the following Disclosures for Ownership and Control at the following times: i) submission of an application for credentialing; ii) execution of this Agreement; iii) request of DCH or CMS; iv) during re-credentialing/re-enrollment; and v) within thirty-five (35) days of a change in ownership of Health Plan:

a. Provider's name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address);

b. Provider's date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in Provider's entity;

c. Provider's tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by Provider in which Provider has a five percent (5%) or more interest;

d. The name, address, date of birth, the Social Security Number of the agent or managing employee of Provider's entity;

e. Information regarding relationships to others with ownership or control interest (Provider must report if the person (individual or corporation) with an ownership or control interest in Provider's entity is related to another person with ownership or control interest in Provider's entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling); and

f. Information regarding related organizations (Provider must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which Provider has an ownership or control interest).

Provider acknowledges that Provider's failure to provide the above-listed required information to Health Plan may lead to sanctions against Health Plan, including but not limited to the withholding of capitation payment from DCH.

22.3 Business Transactions. In addition to the above, within thirty-five (35) days of a request by DCH or CMS, Provider (or fiscal agent or disclosing entity on behalf of Provider) must provide information related to specific business transactions which include the following:

a. The ownership of any subcontractor as defined in Subsection 2.070 of the State Contract with whom Provider has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request; and

b. Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, as defined in Subsection 2.070 of the State Contract, during the five (5) year period ending on the date of the request.

Attachment A: Medicaid

SCHEDULE B

STATE MANDATED REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule B, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable. The phrase "Michigan Insurance Code" means the Michigan Compiled Statutes Section 500.3501 – 500.3580.

MI-1 Notification of Change in Status. Provider and each Contracted provider shall notify the Payor of any changes in the status of any items listed in Michigan Compiled Statutes Section 500.3528(5). (MICH.COMP. LAWS § 500.3528(5))

MI-2 No Payment From Covered Persons. Provider and each Contracted Provider shall not seek payment from any Covered Person for services provided pursuant to a Coverage Agreement, except for applicable copayments, coinsurances, and deductibles which may be collected directly from Covered Persons. (MICH. COMP. LAWS § 500.3529(3))

MI-3 Provider Assurances. Provider and each Contracted Provider shall ensure that they meet applicable licensure or certification requirements and shall cooperate with the Payor's quality assurance activities. Provider and each Contracted Provider acknowledge that there is appropriate access to records or reports concerning services provided to Covered Persons (MICH. COMP. LAWS § 500.3529(4); MICH. ADMIN. CODE R 325.6345)

MI-4 No Discouragement. Provider and each Contracted Provider acknowledge that they have not been discouraged from advocating on behalf of a Covered Person for appropriate medical treatment options pursuant to any grievance procedure or the patient's right to independent review, or from discussing with a Covered Person or any provider any of items in Michigan Compiled Statutes Section 500.3541. (MICH. COMP. LAWS § 500.3541; MICH. ADMIN. CODE R 325.6335)

MI-5 No Inducement for Services. The parties agree that there has not been any use of financial incentives or payments to Provider, any Contracted Provider, or any other health professional acting directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services. (MICH. COMP. LAWS § 500.3542(1))

MI-6 Records Available. Provider and each Contracted Provider agree that the Commissioner shall have access to all information of the Payor relating to the delivery of health services, including, but not limited to books, papers, computer databases, and documents, in a manner that preserves the confidentiality of the health records of individual Covered Persons, and that such access may require the submission of information regarding this Agreement or any agreement between Provider and a Contracted Provider, as the Commissioner considers necessary to ensure that this Agreement or any proposed agreement is in compliance with the Michigan Insurance Code. (MICH. COMP. LAWS § 500.3547(2))

MI-7 Continuation of Services. In the event of the Payor's insolvency, Provider and each Contracted Provider shall continue to provide Covered Services to Covered Persons for the duration of the period for which premiums have been paid and continue to provide Covered Services to any Covered Person who is an inpatient on the date of insolvency until his or her discharge. (MICH. COMP. LAWS § 500.3547(2))

MI-8 Assumption of Financial Risk. If, under this Agreement, Provider or Contracted Provider is assuming financial risk, then the following apply: (a) the Payor shall pay Provider and each Contracted Provider directly or through a licensed third party administrator for Covered Services provided to the Payor's Covered Persons, or (b) the Payor keeps all pooled funds and withholds amounts and accounts for them on its financial books and records and reconcile them at year end in accordance with this Agreement. (MICH. COMP. LAWS § 500.3569(2))

MISSISSIPPI MEDICAID REGULATORY ADDENDUM TO PARTICIPATING PHARMACY AGREEMENT

This Regulatory Addendum (“Addendum”) applies to the extent that Pharmacy provides prescription drug services to individuals who are recipients of benefits under the state Medicaid program (collectively and/or individually “Plan”) under Mississippi law. The parties agree that any provision not required by the Mississippi Medicaid program, Magnolia (as defined below), or applicable laws or regulations, shall not be binding.

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

Magnolia Health Plan, Inc. (“Magnolia”) has contracted with the State of Mississippi Medicaid Program via the Mississippi Division of Medicaid, Office of the Governor (“DOM”) to arrange for the provision of prescription services to Covered Persons of the MississippiCAN Program, as defined herein.

Magnolia has contracted with Envolve Pharmacy Solutions to provide certain pharmacy benefit management services to Magnolia in support of the MississippiCAN Program, including the contracting and administration of a pharmacy network. Pharmacy desires to participate in such network.

This Addendum is intended to supplement the Agreement by setting for the parties’ rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the MississippiCAN Program.

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

SECTION 1

APPLICABILITY

See above.

SECTION 2

DEFINITIONS

Unless otherwise defined in this Addendum, all capitalized terms shall be as defined in the Agreement. For purposes of this Addendum, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Addendum or the Agreement is inconsistent with any definitions under the applicable Mississippi Medicaid Program, the definitions shall have the meaning set forth under the applicable Mississippi Medicaid Program.

2.1 **CMS:** Center for Medicare and Medicaid Services is an agency within the US Department of Health & Human Services responsible for administration of several key federal health care programs.

- 2.2 **Covered Person:** An individual who is currently enrolled with Magnolia for the provision of services under the MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member, or Patient-Beneficiary under the Agreement.
- 2.3 **Covered Services:** A health care service or product for which a Covered Person is enrolled with Magnolia to receive coverage under the MississippiCAN Program Contract.
- 2.4 **DOM:** The Mississippi Division of Medicaid, Office of the Governor.
- 2.5 **MississippiCAN Program:** The Mississippi Medicaid coordinated care program for select Medicaid Beneficiaries.
- 2.6 **State:** The State of Mississippi or its designated regulatory agencies.
- 2.7 **MississippiCAN Program Contract:** Magnolia's contract with DOM, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

SECTION 3 REQUIRED TERMS

3.1 **Revoking Delegation.** In addition to its termination rights under the Agreement, Magnolia and Envolve Pharmacy Solutions shall have the right to revoke any functions, assignment authority, or activities delegated to Pharmacy under the Agreement and this Addendum or impose other sanctions if in Magnolia's or Envolve Pharmacy Solutions' reasonable judgment Pharmacy's performance under the Agreement and this Addendum is inadequate or untimely.

3.2 **Records.** Pharmacy shall maintain a record keeping system of current, detailed, organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the services rendered under the Agreement and this Addendum. Such records shall be maintained for a period of not less than ten (10) years from the close of the MississippiCAN Program Contract, or such other period as required by law. If records are under review or audit or are the subject of litigation, they must be retained until the review, audit, or litigation is complete. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Pharmacy and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.3 **Privacy.** Pharmacy shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Pharmacy agrees that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards. If required, Magnolia or

Involve Pharmacy Solutions will execute DOM's Business Associate Agreement (BAA) with Pharmacy upon implementation of this Addendum.

3.4 Ownership and Control Information. If applicable, Pharmacy shall cooperate with Magnolia in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with §1128 of the Social Security Act, 42 USC §1320a-7 and 42 C.F.R. §§455.104 – 106, and 455.436 as amended.

3.5 Certification on Relationship to State, DOM and CMS. Pharmacy certifies that no officer, director, employee, subcontractor or agent of Pharmacy, or person with an ownership or control interest in Pharmacy, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.6 Excluded Individuals and Entities. Pharmacy certifies that neither Pharmacy nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Involve Pharmacy Solutions will immediately terminate the Agreement and this Addendum upon becoming aware or receiving notice from DOM, whichever is earlier, that Pharmacy is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.7 Compliance with Laws. Pharmacy shall comply with all applicable federal, State and local statutes and regulations as set forth in the MississippiCAN Program Contract, including but not limited to the following, to the extent applicable to Pharmacy in Pharmacy's performance of the Agreement:

- (a) Title XIX of the Social Security Act;
- (b) Title VI of the Civil Rights Act of 1964;
- (c) The Age Discrimination Act of 1975;
- (d) The Rehabilitation Act of 1973;
- (e) The Genetic Information Non-Discrimination Act of 2008;
- (f) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Pharmacy performs pursuant to the Agreement, including but not limited to:
- (i) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of violating Facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

- (ii) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy and Conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy and Conservation Act.

- (g) Equal Opportunity in Employment (EEO) provisions, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor;"

- (h) The American with Disabilities Act (ADA). Pharmacy shall make reasonable accommodation for Covered Persons with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Covered Persons with disabilities from obtaining Covered Services;

- (i) Section 1128B (d) (1) of the Balanced Budget Act of 1997; and

- (j) Any other requirements associated with the receipt of federal funds.

- (k) Compliance with Mississippi Employment Protection Act, Section 71-11-1 et seq. of the Mississippi Code Annotated (Supp. 2008) and will register and participate in the status verification system for all newly hired employees.

3.8 **Approval of Marketing Materials.** Any marketing materials developed and distributed by Pharmacy as related to the performance of the Agreement and this Addendum must be submitted to Envolve Pharmacy Solutions to submit to Magnolia to submit to DOM for prior approval.

3.9 **Federal and State Funds Liability.** Pharmacy acknowledges and agrees that payments made to Pharmacy for services provided under the Agreement and this Addendum are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Pharmacy shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both Magnolia and DOM in the event of non-performance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCAN Program Contract. Pharmacy recognizes that payments made to the Pharmacy are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.10 **Fraud and Abuse.** Pharmacy shall cooperate fully with Magnolia's and Envolve Pharmacy Solutions' procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under the MississippiCAN Program Contract. Pharmacy and Magnolia are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Covered Persons, when detected.

3.11 Government Audit and Inspection. Pharmacy agrees that the State or any of its duly authorized representatives, DOM, CMS, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their agents prior approved by the DOM, at any time during the term of the Agreement and this Addendum, shall, at all reasonable times and within regular business hours, with or without notice, have the right to monitor and inspect the operations of Pharmacy for compliance with the provisions of the MississippiCAN Program Contract and all applicable federal and State law and regulations. This shall include, but not be limited to, the right to enter onto Pharmacy's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Pharmacy related to Pharmacy's performance under the Agreement and this Addendum. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCAN Program Contract or the Agreement and this Addendum; reviewing management systems and procedures developed under the MississippiCAN Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCAN Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Pharmacy. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Pharmacy must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCAN Program Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. Pharmacy must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.12 Independent Contractor Relationship. Pharmacy expressly agrees that Pharmacy is acting in an independent capacity in the performance of the Agreement and this Addendum and not as an officer, agent or employee of DOM, CMS or the State. Pharmacy further expressly agrees that the Agreement and this Addendum shall not be construed as a partnership or joint venture between Pharmacy and DOM, CMS or the State. Nothing in the Agreement and this Addendum shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.13 Indemnification. Pharmacy shall indemnify, defend, protect, save and hold harmless DOM and Covered Persons from and against all claims, suits, demands, actions, recovery, judgments and costs including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by any negligent act or omission by Pharmacy and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform the Agreement and this Addendum. Pharmacy shall further indemnify, defend, protect, save and hold harmless DOM and

Covered Persons from and against all claims, suits, demands, actions, recovery, judgments and costs including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of the death, bodily injury or damage to property or any agent, employee, business invitee or business visitor of Pharmacy.

3.14 **Insurance.** Pharmacy shall maintain during the term of the Agreement and this Addendum as applicable, general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by Magnolia or Envolve Pharmacy Solutions pursuant to the Agreement or as required under the MississippiCAN Program Contract.

3.15 **Notice of Legal Action.** Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Pharmacy shall provide to Envolve Pharmacy Solutions and Magnolia written notice of such legal action or notice, and, upon request by Envolve Pharmacy Solutions or Magnolia, a complete copy of all filings and other documents generated in connection with any such legal action:

- (a) Any action, suit or counterclaim filed against Pharmacy;
- (b) Any regulatory action, or proposed action, respecting Pharmacy's business or operations;
- (c) Any notice by Contractor from the Department Of Insurance or the State Health Officer;
- (d) The filing of a petition in bankruptcy by or against Pharmacy, or the insolvency of Pharmacy;
- (e) The conviction of any person who has an ownership or control interest in Pharmacy, or who is an agent or managing employee of Pharmacy, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act.

3.16 **Hold Harmless.** Pharmacy shall look solely to Magnolia for payment of services under the Agreement and this Addendum. Pharmacy shall hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Magnolia cannot or will not pay for such services. This provision shall survive any termination of the Agreement and this Addendum, including breach of the Agreement due to insolvency.

SECTION 4 OTHER REQUIREMENTS

4.1 **Compliance with MississippiCAN Program Contract.** All tasks performed under the Agreement and this Addendum shall be performed in accordance with the requirements of the MississippiCAN Program Contract, as applicable and as set forth in this Addendum and applicable

manuals, protocols, policies and procedures that Magnolia has provided or delivered to Pharmacy. The applicable provisions of the MississippiCAN Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Addendum relieves Magnolia of its responsibility under the MississippiCAN Program Contract. If any provision of the Agreement and this Addendum is in conflict with provisions of the MississippiCAN Program Contract, the terms of the MississippiCAN Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCAN Program Contract will be considered waived.

4.2 **Monitoring.** Magnolia and/or Envolve Pharmacy Solutions shall perform monitoring of Pharmacy on an on-going basis, and shall perform periodic formal reviews of Pharmacy consistent with the requirements of State and federal law and the MississippiCAN Program Contract, as applicable. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to Section 3.11 above, Magnolia shall identify to Pharmacy any deficiencies or areas for improvement mandated under the MississippiCAN Program Contract, and Pharmacy shall take appropriate corrective action within the relevant timeframe permitted, as applicable.

4.3 **Rights of DOM.** DOM shall have the right to invoke against Pharmacy any remedy set forth in the MississippiCAN Program Contract, including the right to require the termination of the Agreement and this Addendum, for each and every reason for which it may invoke such a remedy against Magnolia or require termination of the MississippiCAN Program Contract. Suspected fraud and abuse by Pharmacy will be investigated by DOM.

STATE OF OHIO MEDICAID REGULATORY REQUIREMENTS

Pharmacy Addendum to Envolve Pharmacy Solutions Pharmacy Participation Agreement

This Addendum is limited to the terms and conditions governing the provision of and payment for services provided to or on behalf of Buckeye Community Health Plan (BCHP) in the fulfillment of BCHP's contractual responsibilities to the Ohio Department of Job and Family Services (ODJFS) in the provision of health care services to Medicaid members who are covered under BCHP Medicaid benefit program.

ADDENDUM DEFINITIONS

The following defines the population groups identified in this addendum:

Aged Blind and Disabled (ABD) means a federal and state financed grant-in-aid program administered by the state providing medical coverage to the individuals age 65 and over (aged), or legally blind, or permanently and totally disabled, who may or may not receive Supplemental Security Income (SSI) population who meet the eligibility criteria of Chapter 5101:3-39 of the OAC.

Covered Families and Children (CFC) Medicaid (including Healthy Start, Healthy Families) means a federal and state financed grant-in-aid program administered by the state providing medical coverage to low-income families, children and pregnant women who meet the eligibility criteria of Chapter 5101:1-39 and 5101:1-40 of the OAC.

Healthy Families is Ohio's name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services to families who meet certain income limits.

Healthy Start is Ohio's name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services for pregnant women, infants, and children up to specified ages and income limits.

MCP means managed care plan. (Buckeye Community Health Plan-BCHP)

Medicaid means medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

OAC means the Ohio Administrative Code.

ODJFS means the Ohio Department of Job and Family Services.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Agreement.

Participating Pharmacy agrees to abide by all of the following specific terms:

1. Pharmacy agrees to release to the MCP and ODJFS any information necessary for the MCP to perform any of its obligations under the ODJFS provider agreement, including but not limited to compliance with reporting and quality assurance requirements.
2. Pharmacy agrees that their applicable facilities and records will be open to inspection by the MCP, ODJFS or its designee, or other entities as specified in OAC rule 5101:3-26-06.
3. Pharmacy agrees to allow the MCP access to all member medical records for a period of not less than six (6) years from the date of service and allow access to all record keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in OAC rule 5101:3-26-06(B).
4. The terms of the Agreement, which must be outlined, relating to the beginning date and expiration date or automatic renewal clause, as well as applicable methods of extension, renegotiation and termination apply to this Addendum.
5. Notwithstanding Item 4 of this Addendum, Envolve Pharmacy Solutions must give at least sixty (60) days prior notice for the nonrenewal or termination of the Agreement except in cases where an adverse finding by a regulatory agency or quality of care concerns dictate that the contract be terminated sooner. If Envolve Pharmacy Solutions issues a notice to nonrenewal or terminate this Agreement sooner than sixty days, the MCP must notify ODJFS within one working day of issuing the notice.
6. Notwithstanding item 4 of this addendum, the Pharmacy may nonrenew or terminate the Agreement if:
 - (A) The Pharmacy gives Envolve Pharmacy Solutions, Inc. at least sixty (60) days prior notice for the nonrenewal or termination of the agreement and the effective date for the nonrenewal or termination must be the last day of the month; or
 - (B) ODJFS has proposed action in accordance with OAC rule 5101:3-26-10 (G), regardless of whether the action is appealed, or if a quality of care concern dictates that the agreement be terminated sooner than sixty (60) days, the Pharmacy's nonrenewal or termination notice must be received by Envolve Pharmacy Solutions within fifteen (15) working days prior to the end of the month in which the Pharmacy is proposing nonrenewal or termination. If the notice is not received by this date, the Pharmacy must extend the nonrenewal or termination date to the last day of the subsequent month.
7. If Envolve Pharmacy Solutions receives the Pharmacy's notice to nonrenew or terminate this Agreement sooner than sixty (60) days, the MCP agrees to notify ODJFS within one (1) working day of the receipt of the Pharmacy's notice.
8. Pharmacy agrees to provide services through the last day the Agreement is in effect.
9. The procedures to be employed upon the ending, nonrenewal, or termination of this Agreement, apply to this Addendum including the Pharmacy's agreement to promptly supply any

- documentation necessary for the settlement of any reporting requirements or outstanding claims.
10. Pharmacy agrees that if the Agreement provides for assignment to another entity, no assignment, in whole or in part, shall take effect without sixty (60) days prior notice to Envolve Pharmacy Solutions, the MCP and ODJFS.
 11. Pharmacy agrees that this Agreement and Addendum contain the same terms that are applicable to the contracted service, is governed by, and is construed in accordance with all laws, regulations, and contractual obligations of the MCP.
 - (A) ODJFS will notify the MCP, the MCP shall notify Envolve Pharmacy Solutions and Envolve Pharmacy Solutions shall notify the Pharmacy of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.
 - (B) This addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.
 12. Pharmacy shall not discriminate in the delivery of services based on a member's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.
 13. Pharmacy shall be bound by the same standards of confidentiality which apply to the ODJFS and the state of Ohio as described in OAC rule 5101:1-1-03, including unauthorized uses or disclosures of protected health information.
 14. Pharmacy agrees to comply with the provisions for record keeping and auditing in Accordance with OAC rule 5101:3-26.
 15. Pharmacy agrees that Envolve Pharmacy Solutions' payment constitutes payment in full for any covered service and will not charge the member or ODJFS any copayment, cost sharing, down-payment, or similar charge, refundable or otherwise.
 16. Pharmacy agrees to hold harmless both ODJFS and the member in the event that Envolve Pharmacy Solutions cannot or will not pay for covered services performed by the pharmacy pursuant to the Agreement with the exception that the Pharmacy may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:
 - (A) The member was notified by the Pharmacy of the financial liability in advance of service delivery;
 - (B) The notification by the Pharmacy was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose;
 - (C) The notification is dated and signed by the member.
 17. Pharmacy is duly licensed or certified under applicable state and federal statutes and regulations to provide the services that are the subject of the Agreement.

18. Pharmacy agrees in providing health care services to members to identify and where indicated arrange for the following at no cost to the member:
 - (A) Sign language services
 - (B) Oral interpretation and oral translation services.
19. Pharmacy agrees to immediately forward any information regarding a member appeal or grievance (complaint) as defined in OAC rule 5101:3-26-01 to the MCP for processing.
20. MCP agrees to provide Envolve Pharmacy Solutions with copies of all relevant information received from ODJFS. Envolve Pharmacy Solutions will forward copies to the pharmacy as necessary.
21. If the Pharmacy is currently a Medicaid provider, Pharmacy must meet the qualifications specified in OAC rule 5101:3-26-05(C).
22. Pharmacy agrees to make available for transfer to new providers the medical records of members at no cost to the member.
23. Pharmacy agrees to comply with the MCP's quality assessment and performance improvement program.
24. Pharmacy agrees to comply with the ODJFS annual external quality review as described in OAC rule 5101:3-26-07.
25. MCP and Envolve Pharmacy Solutions agree not to prohibit, or otherwise restrict a Pharmacy acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
 - (A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (B) Any information the member needs in order to decide among all relevant treatment options.
 - (C) The risks, benefits, and consequences of treatment versus non-treatment.
 - (D) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
26. Pharmacy agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.
27. Pharmacy shall not discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates by reason of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry in the performance of the subcontract or in the hiring of any employees for the performance of services under the subcontract.

28. Pharmacy shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.
29. Pharmacy agrees to provide services to MCP's Medicaid members residing in all Ohio regions, and will provide services to CFC and ABD Medicaid eligibility categories.

TEXAS MEDICAID PROGRAM REGULATORY REQUIREMENTS

APPENDIX FOR THE TEXAS STAR, STAR+PLUS AND STAR KIDS PROGRAMS

THIS TEXAS MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this “Appendix”) supplements and is made a part of the subcontract (the “Subcontract”) between Superior Health Plan (“Superior”) and the subcontractor named in the Subcontract (“Subcontractor”).

SECTION 1 APPLICABILITY

This Appendix applies to the provision of subcontracted administrative services provided by Subcontractor under the State of Texas Medicaid Program (as further defined below) as governed by the Texas Health and Human Services Commission (HHSC) designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Superior is required to amend or supplement this Appendix as required or requested by the State, Subcontractor agrees that Superior shall be permitted to unilaterally initiate such additions, deletions or modifications. All subcontracts must be in writing and must include all specific activities and report responsibilities delegated to the Subcontractor by Superior.

SECTION 2 DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the applicable Texas Medicaid Program, the definitions shall have the meaning set forth under the applicable Texas Medicaid Program.

2.1 **CMS:** Center for Medicare and Medicaid Services is an agency within the US Department of Health & Human Services responsible for administration of several key federal health care programs.

2.2 **Covered Person:** An individual who is currently enrolled with Superior for the provision of services under the Texas CAN Program. A Covered Person may also be referred to as an Enrollee, Member under the Subcontract.

2.3 **Covered Services:** A health care service or product for which a Covered Person is enrolled with Superior to receive coverage under the Texas Star, Star+Plus and Star Kids Program Contract.

2.4 **HHSC:** The Texas Health and Human Services Commission.

2.5 **Texas STAR, STAR+PLUS and STAR Kids:** The Texas Medicaid coordinated care program for select Medicaid Beneficiaries.

2.6 **State:** The State of Texas or its designated regulatory agencies.

2.7 **Texas STAR, STAR+PLUS AND STAR Kids Contract:** Superior's contract with HHSC, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the Texas STAR, STAR+PLUS or STAR Kids.

SECTION 3

REQUIRED TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

3.1 **Revoking Delegation.** In addition to its termination rights under the Subcontract, Superior shall have the right to revoke any functions, assignment authority, or activities Superior delegates to Subcontractor under the Subcontract or impose other sanctions if in Superior's reasonable judgment Subcontractor's performance under the Subcontract is inadequate or untimely.

3.2 **Records.** Subcontractor shall maintain a record keeping system of current, detailed, organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the services rendered under the Subcontract. Such records shall be maintained for a period of not less than ten (10) years from the close of the STAR, STAR+PLUS or STAR Kids Program Contract, or such other period as required by law. If records are under review or audit or are the subject of litigation, they must be retained until the review, audit, or litigation is complete. HHSC requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Subcontractor and those copies of requested documents/records will be provided to HHSC or its designee free of charge.

3.3 **Privacy.** Subcontractor shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Subcontractor agrees that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of HHSC or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards. Superior will execute HHSC's Business Associate Agreement (BAA) with Subcontractor upon implementation of subcontract.

3.4 **Ownership and Control Information.** If applicable, Subcontractor shall cooperate with Superior in obtaining and providing information to HHSC related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with §1128 of the Social Security Act, 42 USC §1320a-7 and 42 C.F.R. §§455.104 - 106, and 455.436 as amended.

3.5 **Certification on Relationship to State, HHSC and CMS.** Subcontractor certifies that no officer, director, employee, subcontractor or agent of Subcontractor, or person with an ownership or control interest in Subcontractor, is also employed by, or is a public official of, the State of Texas or any of its agencies, HHSC or CMS.

3.6 Excluded Individuals and Entities. Subcontractor certifies that neither Subcontractor nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Superior will immediately terminate the Subcontract upon becoming aware or receiving notice from HHSC, whichever is earlier, that Subcontractor is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.7 Compliance with Laws. Subcontractor shall comply with all applicable federal, State and local statutes and regulations as set forth in the STAR, STAR+PLUS or STAR Kids Program Contract, including but not limited to the following, to the extent applicable to Subcontractor in Subcontractor's performance of the Subcontract:

- (a) Title XIX of the Social Security Act;
- (b) Title VI of the Civil Rights Act of 1964;
- (c) The Age Discrimination Act of 1975;
- (d) The Rehabilitation Act of 1973;
- (e) The Genetic Information Non-Discrimination Act of 2008;
- (f) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Subcontractor performs pursuant to the Subcontract, including but not limited to:
 - (i) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of violating Facilities. Any violations must be reported to DSHS, DHHS, and the EPA;
 - (ii) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy and Conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy and Conservation Act.
- (g) Equal Opportunity in Employment (EEO) provisions, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor;"

- (h) The American with Disabilities Act (ADA). Subcontractor shall make reasonable accommodation for Covered Persons with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Covered Persons with disabilities from obtaining Covered Services;
- (i) Section 1128B (d) (1) of the Balanced Budget Act of 1997; and
- (j) Any other requirements associated with the receipt of federal funds.
- (k) Compliance with Texas Labor Code, Section 2.051 and will register and participate in the status verification system for all newly hired employees.

3.8 **Approval of Marketing Materials.** Any marketing materials developed and distributed by Subcontractor as related to the performance of the Subcontract must be submitted to Superior to submit to HHSC for prior approval.

3.9 **Federal and State Funds Liability.** Subcontractor acknowledges and agrees that payments made to Subcontractor for services provided under the Subcontract are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Subcontractor shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both Superior and HHSC in the event of non-performance, misrepresentation, fraud, or abuse related to services provided pursuant to the STAR, STAR+PLUS or STAR Kids Program Contract. The Subcontractor recognizes that payments made to the Subcontractor are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.10 **Fraud and Abuse.** Subcontractor shall cooperate fully with Superior's procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under the STAR, STAR+PLUS or STAR Kids Program Contract. Subcontractor and Superior are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Covered Persons, when detected.

3.11 **Government Audit and Inspection.** Subcontractor agrees that the State or any of its duly authorized representatives, HHSC, CMS, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their agents prior approved by the HHSC, at any time during the term of the Subcontract, shall, at all reasonable times and within regular business hours, with or without notice, have the right to monitor and inspect the operations of Subcontractor for compliance with the provisions of the STAR, STAR+PLUS or STAR Kids Program Contract and all applicable federal and State law and regulations. This shall include, but not be limited to, the right to enter onto Subcontractor's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Subcontractor related to Subcontractor's performance under the Subcontract. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the STAR, STAR+PLUS or STAR Kids Program Contract or the Subcontract; reviewing management systems and

procedures developed under the STAR, STAR+PLUS or STAR Kids Program Contract or the Subcontract; and review of any other areas of materials relevant or pertaining to the STAR, STAR+PLUS or STAR Kids Program Contract or the Subcontract. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Subcontractor. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Subcontractor must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by HHSC, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the STAR, STAR+PLUS or STAR Kids Program Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. The Subcontractor must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.12 Independent Contractor Relationship. Subcontractor expressly agrees that Subcontractor is acting in an independent capacity in the performance of the Subcontract and not as an officer, agent or employee of HHSC, CMS or the State. Subcontractor further expressly agrees that the Subcontract shall not be construed as a partnership or joint venture between Subcontractor and HHSC, CMS or the State. Nothing in the Subcontract shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.13 Indemnification. Subcontractor shall indemnify, defend, protect, save and hold harmless HHSC and Covered Persons from and against all claims, suits, demands, actions, recovery, judgments and costs including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by any negligent act or omission by Subcontractor and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform the Subcontract. Subcontractor shall further indemnify, defend, protect, save and hold harmless HHSC and Covered Persons from and against all claims, suits, demands, actions, recovery, judgments and costs including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of the death, bodily injury or damage to property or any agent, employee, business invitee or business visitor of Subcontractor.

3.14 Insurance. Subcontractor shall maintain during the term of the Subcontract as applicable, general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Subcontract. Such workers compensation insurance shall comply with Texas Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by Superior pursuant to the Subcontract or as required under the STAR, STAR+PLUS or STAR Kids Program Contract.

3.15 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Subcontractor shall provide to Superior written notice of such legal action or notice, and, upon request by Superior, a complete copy of all filings and other documents generated in connection with any such legal action:

- (a) Any action, suit or counterclaim filed against Subcontractor;
- (b) Any regulatory action, or proposed action, respecting Subcontractor's business or operations;
- (c) Any notice by Contractor from the Department Of Insurance or the State Health Officer;
- (d) The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor;
- (e) The conviction of any person who has an ownership or control interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act.

3.16 Hold Harmless. Subcontractor shall look solely to Superior for payment of services under the Subcontract. Subcontractor shall hold the State, HHSC, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Superior cannot or will not pay for such services. This provision shall survive any termination of the Subcontract, including breach of the Subcontract due to insolvency.

SECTION 4 OTHER REQUIREMENTS

4.1 Compliance with STAR, STAR+PLUS or STAR Kids Program Contract. All tasks performed under the Subcontract shall be performed in accordance with the requirements of the STAR, STAR+PLUS or STAR Kids Program Contract, as applicable and as set forth in this Appendix and applicable manuals, protocols, policies and procedures that Superior has provided or delivered to Subcontractor. The applicable provisions of the STAR, STAR+PLUS or STAR Kids Program Contract are incorporated into the Subcontract by reference. Nothing in the Subcontract or this Appendix relieves Superior of its responsibility under the STAR, STAR+PLUS or STAR Kids Program Contract. If any provision of the Subcontract is in conflict with provisions of the STAR, STAR+PLUS or STAR Kids Program Contract, the terms of the STAR, STAR+PLUS or STAR Kids Program Contract shall control and the terms of the Subcontract in conflict with those of the STAR, STAR+PLUS or STAR Kids Program Contract will be considered waived.

4.2 Monitoring. Superior shall perform monitoring of Subcontractor on an on-going basis, and shall perform periodic formal reviews of Subcontractor consistent with the requirements of State and federal law and the STAR, STAR+PLUS or STAR Kids Program Contract, as applicable. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of HHSC or other authorities pursuant to Section 3.11 above, Superior shall identify to Subcontractor any deficiencies or areas for improvement mandated under the STAR, STAR+PLUS or STAR Kids Program Contract, and Subcontractor shall take appropriate corrective action within the relevant timeframe permitted, as applicable.

4.3 **Rights of HHSC.** HHSC shall have the right to invoke against Subcontractor any remedy set forth in the STAR, STAR+PLUS or STAR Kids Program Contract, including the right to require the termination of the Subcontract, for each and every reason for which it may invoke such a remedy against Superior or require termination of the STAR, STAR+PLUS or STAR Kids Program Contract. Suspected fraud and abuse by Subcontractor will be investigated by HHSC.

4.4. **Texas Maximum Allowable Price.** Superior and Subcontractor shall both comply with Texas Government Code section 533.05 (the use maximum allowable cost list).

SECTION 5 HHSC SPECIFIC REQUIREMENTS

5.1 **Provider Enrollment and Participation in the Vendor Drug Program.** A pharmacy must contract with the Texas Vendor Drug Program. Please contact the Texas Vendor Drug Program for information regarding contracting with the VDP and VDP specific requirements for participation.

5.2 **Eligible Plan Member Fees.** Medicaid Members will not be charged for medications filled in accordance to the Texas Vendor Drug Program formulary rules and requirements.

5.3 **Payer of Last Resort.** Envolve Pharmacy Solutions will follow UCM section 2.2 for the payment of claims and coordination of benefit per HHSC guidance.

5.4 **Submitting Compounds.** For Medicaid Members please refer to the Texas Vendor Drug Program formulary for a list of covered medications. Please note, the VDP generally does not cover bulk powders.

5.5 **Claim Payment.** Clean claims that are submitted electronically are paid within 18 calendar days of adjudication of the claim, and no later than 21 days after adjudication if the claim is not submitted electronically.

5.6 **Rebates.** Managed Care Organizations in Texas representing Medicaid Members are restricted from collecting rebates. Health and Human Services will collect any rebates in lieu of a health plan.

5.7 **Generic Drug Standards.** Dispense as written is not required when the brand is preferred and the generic equivalent is non-preferred. The Texas Vendor Drug Program lists both brand and generic formulary options and prescriptions are filled in accordance to VDP rules and requirements.

5.8 **DAW Codes and Descriptions.1 – Substitution Not Allowed by Prescriber:** This code is generally used to indicate substitution not allowed by the Prescriber. However, in Texas Medicaid a DAW = 1 is not required when the brand is preferred and the generic equivalent is non-preferred. For non-Medicaid prescriptions this value is used when the prescriber indicates the product should be dispensed as written.

5.9 **Formularies.** Superior Health Plan and Envolve Pharmacy Solutions strictly follow the Texas Vendor Drug Program formulary for all Medicaid Members. This formulary is available online at the Texas Vendor Drug Program website. Please reference at: <http://www.txvendordrug.com/>. Updates to

the Texas Vendor Drug Program are discussed in health plan Pharmacy and Therapeutics (P&T) Committee meetings.

5.10 **Prior Authorization.** For Medicaid Members the Texas Vendor Drug Program PAXpress and Clinical Prior Authorization criteria will be followed. Texas Medicaid Members may also request a fair hearing.

5.11 **Member Rights and Responsibilities.** Contact Superior directly with Member questions. Superior Health Plan is the primary point of contact for Member concerns. Envolve PeopleCare's call-in nurse triage assists with questions after hours.

5.12 **Medicare Pharmacy Claims.** All coordination of benefits for Medicaid eligible Members will follow HHSC guidance outlined in UMCM 2.2. This HHSC guidance will be followed to ensure the proper payment of claims. Appropriate point of sale messages will direct the local pharmacy to bill in accordance to this guidance. For Medicare Advantage or Medicare Medicaid Plan Members in the Superior Network claims process via the Argus platform.

Provider Complaint and Grievance Process. The provider complaint and grievance process in the Envolve Pharmacy Solutions Pharmacy Manual shall not apply with respect to Provider complaints and appeals related to the Superior HealthPlan. For Provider complaints and appeals related to the Superior HealthPlan, after Envolve Pharmacy Solutions' internal appeals process, Provider, as its exclusive remedy, may appeal to Superior HealthPlan in either writing or by fax to the following address:

Superior HealthPlan
Complaints Department
2100 S. IH35, Suite 202,
Austin, Texas 78704

The fax number for Superior HealthPlan Complaints is 1-866-683-5369.

**WASHINGTON MEDICAID REGULATORY ADDENDUM TO PARTICIPATING
PHARMACY AGREEMENT**

1. Pharmacy shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto. Pharmacy understands and agrees that this Product Attachment and/or this Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State Contract.
2. Pharmacy shall comply with all applicable State and federal laws and regulations regarding the collection, use and disclosure of i) Personal Information, as defined in Governor Locke’s Executive Order 00-03, and ii) Protected Health Information (“PHI”), as defined in 45 CFR. 160.103. Personal Information or PHI collected, used, or acquired in connection with this Agreement shall be used solely for the purposes of this Agreement. Pharmacy shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Agreement or as permitted or required by State or federal law or regulation. Pharmacy shall implement appropriate physical, electronic, and managerial safeguards to prevent unauthorized access to Personal Information and PHI. Pharmacy shall fully cooperate with HCA’s efforts to implement all requirements under the Health Insurance and Portability and Accountability Act.
3. Pharmacy shall cooperate with audits performed by duly authorized representatives of the State of Washington, the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget. Upon thirty (30) calendar days, Pharmacy shall provide access to its facilities and the records pertinent to this Agreement to monitor and evaluate Pharmacy’s compliance with this Agreement and MCO’s compliance with the State Contract, including, but not limited to, the quality, cost, use, health and safety and timeliness of services, and assessment of MCO’s capacity to bear the potential financial losses. Pharmacy shall provide immediate access to facilities and records pertinent to the Agreement for Medicaid fraud investigators pursuant to 42 CFR 438.6(g).
4. Pharmacy shall maintain financial, medical and other records pertinent to this Agreement. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Pharmacy related to this Agreement. All records and reports relating to the Agreement shall be retained by Pharmacy for a minimum of six (6) years after final payment is made under the Agreement. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.
5. Pharmacy hours of operation for Covered Persons shall be no less than the hours of operation offered to any other of Provider’s patients.

6. Pharmacy acknowledges and agrees that this Agreement Pharmacy agrees to release to MCO any information necessary to perform any of MCO's obligations under the State Contract.

Pharmacy shall have and maintain insurance appropriate to the services to be performed under this Agreement. Provider shall make copies of Certificates of Insurance available to HCA upon request

APPENDIX B – DISCREPANCY LIST

Please review the accompanying Discrepancy report. This is a preliminary report and post audit documentation may be accepted as described below. A time frame for post review documentation is shown in the accompanying letter. Consultations between Envolve Pharmacy Solutions and “audit designee” Audit & Compliance representatives will determine the final outcome.

In most cases, the “audit designee” will accept photocopies for documentation. Acceptable documentation that may mitigate potential discrepancies is described in the information below.

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
BMN <i>(Dispense as Written)</i>	Brand medication billed, but patient or prescriber’s “brand-only” order is not documented. DAW 1 or 2 to circumvent Program edits.	Partial Recovery	DAW 1 - Prescriber Statement* which validates that the substitution of brand product was authorized. Otherwise, No Post Audit Documentation Accepted.
CPW/CPD <i>(Compound Incorrectly Billed)</i>	A compounded prescription is incorrectly billed resulting in an overpayment.	Re-price RX	Compound Worksheet with Ingredients Listed (NDC, Qty & AWP Cost)
CPW/CPDD <i>(Billed for non-covered Part D drug)</i>	Rx is submitted for a compound containing a non-covered Part D drug	Full Charge Back	No Post Audit Documentation Accepted
CPW/CPDI <i>(Billed without indicator or using Push #)</i>	Rx is submitted without a compound indicator or push NDC # is used.	Part D - Full Charge Back Comm. - Reprice	Part D - No Post Audit Documentation Accepted Comm. - Compound Worksheet with NDCs, Quantities and Pricing
DDB <i>(Wrong Drug Billed) (Brand Submitted/Generic Dispensed)</i>	Pharmacy billed for a different medication than the one ordered by the prescriber with no documentation on RX or Patient Profile. Must have Pharmacist Notes on RX. Brand Drug was billed but Generic was dispensed.	Full Charge Back	If discrepant due to therapeutic exchange, Prescriber Statement* is accepted, otherwise No Post Audit Documentation Accepted.
DEA <i>(No DEA)</i>	The hard copy prescription does not contain a DEA number on the script or sticker (CII-CV drugs only).	Full Charge Back for CII-CV	State/Federal Mandate No Post Audit Documentation Accepted

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
DID <i>(Wrong Prescriber)</i>	The claim submitted contains an ID number; however it is not the ID number of the physician who authorized the prescription. Pharmacy submits an ID or Physician identifier different from the number printed on the prescription blank.	Full Charge Back	Prescriber Statement* from a non-sanctioned prescriber which shows the prescriber billed is a member of the same practice as correct prescriber. CII-CV, No Post Audit Documentation Accepted.
DN-1 <i>(Wrong Patient Billed)</i>	The patient identified on a hard-copy prescription is not the correct patient. Wrong suffix codes.	Full Charge Back	No Post Audit Documentation Accepted
DUP <i>(Duplicate Claim)</i>	Multiple claims for the same prescription fill were paid.	Full Charge Back	No Post Audit Documentation Accepted
EQB <i>(Exceeds QTY Limits)</i> <i>(Overfilled QTY)</i>	Quantity billed exceeds the quantity authorized by the prescriber/plan. No Documentation	Partial Recovery	No Post Audit Documentation Accepted
EQB <i>(Exceeds QTY Limits)</i> <i>(Overfilled QTY)</i>	Quantity billed exceeds the quantity authorized by the prescriber/plan. No Documentation	Partial Recovery	No Post Audit Documentation Accepted
EQBR <i>(Total Over Billed Quantity)</i>	Total units billed (with refills) exceed the total units authorized by prescriber	Partial Recovery	No Post Audit Documentation Accepted
EXP <i>(Exceeds Time Limit)</i>	The prescription is filled or refilled for a time period longer than that allowed by the Plan or applicable regulations.	Full Charge Back	State/Federal Mandate No Post Audit Documentation Accepted

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
FBW <i>(Filled before Written)</i>	Filled before written: Rx was filled before date written.	Full Charge Back	Prescriber Statement* which validates that the prescriber indicated the incorrect date. For CII's, No Post Audit Documentation Accepted.
ICS <i>(Wrong Pack Size)</i>	The package size submitted on the claim differs from the package size dispensed by the pharmacy. Pharmacy bills multiple of small size NDC when a stock larger size is available resulting in excess margins.	Difference in Payment	Documentation Showing Reason for Exchange
IDS <i>(Wrong or Incorrect Day Supply)</i>	The days supply value submitted by the pharmacy is not consistent with the quantity and directions.	Partial Recovery	No Post Audit Documentation Accepted
INV <i>(No Date of Service)</i>	CII-CV Drugs - hardcopy prescription contains no original date of service. Regular Rx - date on label is acceptable.	Full Charge Back for CII-CV	State Mandate Prescriber Statement*
INVA <i>(No Doctor Address or Patient Address)</i>	The hardcopy prescription does not include the Prescriber's or Patient's address.	Informational	Prescriber Statement*
INVD <i>(No Drug Name)</i>	The hard-copy prescription does not contain the name of the drug to be dispensed.	Full Charge Back	Prescriber Statement*
INVN <i>(No Patient Name)</i>	The hard-copy prescription contains no patient name.	Full Charge Back	Prescriber Statement*
INVS <i>(No Strength)</i>	The hard-copy prescription, for a drug available in more than one strength, fails to identify the strength to be dispensed.	Full Charge Back	Prescriber Statement*
IN VX <i>(No Doctor Signature)</i>	The hard copy prescription is not signed by the prescriber.	Full Charge Back	Prescriber Statement*
LTC <i>(Miscellaneous LTC Issues)</i>	Physician Order submitted does not cover date of service of claim requested.	Full Charge Back	Physician's Order, signed by prescriber, for current or most recent date of service with a validating Start Date or an

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
			Original Order with authorized refill documentation, both signed by the prescriber, for the charting period in question
MP-1 <i>(Can't Find Missing Prescription)</i>	Original hard-copy prescription cannot be found on file during the audit. Physician Order sheet not provided in LTC	Full Charge Back	Prescriber Statement*
MSL <i>(Signature Not Found/Missing Info)</i>	The signature log or delivery confirmation documenting receipt of pharmacy services cannot be found.	Full Charge Back	Member Statement** or acceptable Delivery Confirmation****
MSLC <i>(Cycle Filling or Post Consumption Billing)</i>	Cycle filling with no documentation. Fraudulent billing after medications are consumed by patient.	Full Charge Back	No Post Audit Documentation Accepted.
MSLD <i>(Not Dispensed)</i>	Prescription is billed but not dispensed to patient. Drugs are not returned to stock. Partial fills not picked up and not reversed	Full Charge Back / Partial Chargeback for partial fills not p/u	Original signed statement from the member verifying receipt of medication. Must contain member contact information** Drugs not returned to stock & Cycle Filling - no PAD allowed.
NCI <i>(Drug Not Covered)</i>	Pharmacy billed and was paid for a "non-covered" item.	Full Charge Back	May appeal if system was down.
NQY <i>(No Quantity)</i>	The hardcopy prescription does not indicate the quantity of the drug to be dispensed.	Full Charge Back / Partial	Prescriber Statement*
NSI <i>(No Directions For use)</i>	The hard-copy prescription does not indicate directions for use or dosage.	Full Charge Back	Prescriber Statement*
NVP <i>(No Doctor Name)</i>	The hard copy prescription does not identify the prescriber by printed name. No MD name CII-CV, Label with MD accepted for General Rx	Full Charge Back for CII-CV	Prescriber Statement*
OTH <i>(Miscellaneous Discrepancies)</i>	'Miscellaneous' is assessed when an issue has been cited that is not listed elsewhere on the Discrepancy Sheet. Note will be given with explanation.	To Be Decided	Depends upon Discrepancy - Refer to Pharmacy Report

Discrepancy Code	Description	Recovery Amounts	Post Audit Documentation
RXC <i>(Altered /Rx - Drug, Quantity, Date or Refills Altered)</i>	Drug, Quantity, Date or Refills altered with no documentation on RX.	Full Charge Back	Prescriber Statement*
RXCQ <i>(Cut Quantity)</i>	Quantity cut with no documentation on RX.	Additional Dispensing Fee/ unless Member Requested	Member Statement**
UAR <i>(Unauthorized Refill)</i>	Prescription is refilled more often than prescribed.	Full Charge Back	Prescriber Statement*
UAR2 <i>(Refill Too Soon - No documentation of Override Codes)</i>	Prescription is refilled sooner than appropriate with respect to quantity and directions for use.	Full Charge Back	No Post Audit Documentation Accepted.

*All physician statements must: (1) include the address and telephone number of the physician on the physician's own letterhead or be written on their preprinted prescription blanks, (2) clearly reference the patient's name, medication(s), date(s) of service, strength, directions, quantity ordered and refills (if applicable) and (3) include the physician's signature. 'Call in' prescriptions are not acceptable during the 'post-audit' or dispute phase.

**All patient statements must: (1) include their address and telephone number, (2) clearly reference the medication(s), date(s) of service, etc. and (3) include the patient's signature.

***Electronically documented refill information should be recorded in a static (i.e., information cannot be altered at a later date) electronic field.

****All Delivery Confirmations must include or make reference to additional, supporting documentation: (1) prescription number, (2) date of service of claim, (3) patient name/address, (4) receipt signature/proof of delivery.