MedCare® Pharmacy Networks Policies and Procedures Manual
(Also known as the Pharmacy Provider Manual)

The contents of this MedCare® Pharmacy Network Policies and Procedures Manual ("Manual") are confidential and proprietary to MedImpact Healthcare Systems, Inc. ("MedImpact") and may not be reproduced, transmitted, published, or disclosed to others without MedImpact’s prior written authorization. This Manual must be surrendered to MedImpact upon termination of Member Pharmacy’s MedCare® Pharmacy Network Agreement (the "Agreement") (into which this Manual is incorporated) for whatever reason. If any of the following provisions are prohibited, restricted, or limited by Law, such provision will be limited or non-enforceable to the extent necessary to comply with such Law.

1. CONTACT INFORMATION
2. PHARMACY CHANGE NOTIFICATION
3. CREDENTIALING AND QUALITY ASSURANCE
4. PHARMACY SERVICES AND OPERATIONS
   - Verification of Eligible Persons
   - Signature Log
   - DUR Messaging
   - Formularies
   - Generic Dispensing
   - Clinical Programs
   - Rebate Programs
   - Refills
   - Nondiscrimination
   - Eligible Person Grievances, Complaints, and Appeals
   - Professional Judgment and Conduct
   - Documentation
   - Third Party Vendor
5. CLAIMS SUBMISSION
   - BIN Number
   - DAW
   - Rejected Claims
   - Claim Reversals
   - Compounds
   - Taxes
   - Prior Authorizations
   - Format Submission Requirements
   - E-Prescribing
6. CLAIMS PAYMENT
7. PRICING CHANGES

8. AUDIT

9. ADVERTISING AND PROMOTION

10. CONFIDENTIALITY AND PROPRIETARY RIGHTS

11. COURT ORDERS, SUBPOENAS, OR GOVERNMENTAL REQUESTS

12. MEMBER PHARMACY TERMINATION

13. MISCELLANEOUS
   Assignment
   Notices to Member Pharmacy
   Waiver
   Applicable Law
   Force Majeure

14. DEFINED TERMS
   Average Wholesale Price or AWP
   Eligible Persons
   Laws
   MAC or Maximum Allowable Cost
   Member Pharmacy
   Online Claim System
   Payor
   Plan
   Policies and Procedures
   Prescription Drug Benefit
   Usual and Customary or U&C

15. COMPLAINT AND GRIEVANCE PROCESS

16. REGULATORY COMPLIANCE
   Medicare Part D
   Deficit Reduction Act of 2005 / False Claims Acts
   Florida Medicaid / Hernandez Settlement Agreement
   State Regulatory Addenda
1. CONTACT INFORMATION
Inquiries regarding this Manual should be directed to:

MedImpact HealthCare Systems, Inc.
P.O. Box 320425
Alexandria, VA 22320
(800) 788-2949
(866) 524-2629 Fax

2. PHARMACY CHANGE NOTIFICATION
Member Pharmacy must immediately notify MedImpact in writing of any change in the information provided in the Agreement, the Pharmacy Network Participation Acceptance Form, or any information or documentation provided to MedImpact in connection with any credentialing or quality assurance initiatives. Any changes in such documentation must be reported to:

MedImpact HealthCare Systems, Inc.
P.O. Box 320425
Alexandria, VA 22320
(800) 788-2949
(866) 524-2629 Fax

In the event of a conflict or missing information from Member Pharmacy and the information on file with NCPDP regarding Member Pharmacy, MedImpact may rely on the information on file with NCPDP regarding Member Pharmacy, including for purposes of directories and payments hereunder.

3. CREDENTIALING AND QUALITY ASSURANCE
Member Pharmacy must comply with the credentialing and quality assurance initiatives required by MedImpact, including any special quality management requirements and programs established by MedImpact or Payors.

Member Pharmacy must meet all standards of operation as required by Law. Member Pharmacy must maintain an internal quality assurance program and, upon request, report on such program to MedImpact, along with remedial action plans.

4. PHARMACY SERVICES AND OPERATIONS
Member Pharmacy shall provide Prescription Drug Benefits to Eligible Persons in accordance with the terms of the Agreement (including these Policies and Procedures), the prescriber's directions, the applicable Plan, applicable Law, and Member Pharmacy's professional judgment. Member Pharmacy may refuse to provide Pharmacy Services to an Eligible Member based on that professional judgment, which must be documented. Member Pharmacy shall use its best efforts to maintain an adequate supply of medications.

Verification of Eligible Persons
Eligibility of persons is verified through the Online Claim System. If you have any questions regarding eligibility, please contact 1-800-788-2949. MedImpact is not obligated to reimburse any claim for a Prescription Drug Benefit provided to a person whose eligibility was not properly verified.
**Signature Log**

Unless otherwise agreed to in writing by MedImpact, when providing Prescription Drug Benefits to Eligible Persons, Member Pharmacy must obtain the signature of the Eligible person, or his or her authorized representative, on a third party signature log to confirm that he or she has received the Prescription Drug Benefit provided. The third party signature log must be in accordance with industry standards and contain all information required by MedImpact. As permitted by Law, in lieu of a third party signature log, Member Pharmacy may maintain an electronic tracking system to record and confirm the receipt of Prescription Drug Benefits and such system must be in accordance with industry standards and contain all information required by MedImpact.

**DUR Messaging**

MedImpact's Online Claim System may provide messaging related to drug utilization review and other clinical programs and services. Member Pharmacy must review all DUR and other messages transmitted by MedImpact and exercise its professional judgment in acting on such messages. DUR messages are not intended to replace the sound professional knowledge and judgment of the Member Pharmacy or prescribing physician. Drug use inconsistent with the DUR criteria may be appropriate in certain situations.

The information contained in DUR messages is derived from third party sources and is not independently developed by MedImpact. MedImpact utilizes industry materials and the advice and resources of outside vendors and healthcare professionals to provide DUR messages. The usefulness of DUR messages is necessarily limited by the amount of patient input into the Online Claim System, the amount of information provided by Payers, and the thoroughness and accuracy of industry information and information provided by third parties. DUR messages are intended as an aid to, and not a substitute for, the knowledge, expertise, skill and judgment of prescribers, Member Pharmacy, or other healthcare professionals. Member Pharmacy, prescribers, other healthcare professionals, and Payers are individually responsible for acting or not acting upon information generated and transmitted by MedImpact including without limitation upon DUR messages. MedImpact does not control the healthcare decisions made or actions taken by Member Pharmacy, prescribers, other healthcare professionals, Payers, or members. The DUR messages do not contain all currently available information on healthcare or pharmaceutical practices. MedImpact is not responsible for failing to include information in a DUR message, for the actions or omissions of contributors of information, or for misstatements or inaccuracies in industry materials utilized by MedImpact. All warranty disclaimers and exclusions made by contributors of information or data to MedImpact shall apply to Member Pharmacy with respect to the DUR messages provided hereunder.

**Formularies**

Member Pharmacy must support all formulary initiatives and inform Eligible Persons when a non-formulary drug has been prescribed and use its best efforts to contact the prescribing physician to encourage formulary compliance. The final choice of specific drug selection for an Eligible Person rests solely with the prescribing physician.

**Generic Dispensing**

Member Pharmacy must dispense a generic drug whenever permitted and in accordance with applicable Laws. Member Pharmacy must use its best efforts to carry out MedImpact and/or Payer generic programs.
Clinical Programs
Subject to applicable Law, Member Pharmacy must provide to MedImpact any and all reasonably available information that MedImpact needs to perform clinical programs and services and conduct drug utilization review. Member Pharmacy must support all such clinical programs and services.

Rebate Programs
MedImpact has the right to submit all prescriptions relating to the Agreement to pharmaceutical companies in connection with rebate and any similar programs. Member Pharmacy shall not submit any of the prescriptions relating to the Agreement to any pharmaceutical company for the purpose of receiving any rebate or discount, except as authorized by MedImpact in writing.

Refills
Member Pharmacy shall not process an automatic refill for a Prescription Drug Benefit for an Eligible Person unless and until such refill has been authorized by the Eligible Person.

Nondiscrimination
Member Pharmacy must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, religion, disability, medical condition, political convictions, age, sexual orientation, and marital or family status. Unless professional judgment dictates otherwise, Member Pharmacy must provide Prescription Drug Benefits and related services to all Eligible Persons.

Eligible Person Grievances, Complaints, and Appeals
Member Pharmacy agrees to cooperate fully with MedImpact or the Payor in the investigation and resolution of Eligible Person complaints, grievances, and appeals (in accordance with applicable procedures related thereto) concerning Member Pharmacy and/or Prescription Drug Benefits provided under the Agreement, including providing MedImpact with requested documentation related thereto.

Professional Judgment and Conduct
Member Pharmacy must comply with all applicable Laws and provide all services and products in a professional manner and in compliance with the highest industry standards, with care, skill, and diligence. Member Pharmacy must at all times exercise professional judgment in providing pharmacy services to an Eligible Person. Member Pharmacy is under no obligation to provide a Prescription Drug Benefit which, in his/her professional judgment, should not be dispensed.

Documentation
Member Pharmacy must maintain accurate, complete, up-to-date, and otherwise in conformance with generally accepted standards and good pharmacy practice, all documents and records related to the provision of Prescription Drug Benefits to Eligible Persons. Such documents and records include, but are not limited to:

- Original prescriptions
- Signature and/or electronic tracking logs
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/doctor orders
Member Pharmacy must maintain such documents and records in a readily obtainable location for a period of six (6) years from the date of service or such longer period as required by Law.

**Third Party Vendor**

MedImpact reserves the right to utilize qualified third party vendor(s), including but not limited to ChainDrugStore.net and Intellisoft. The third party vendor(s) will perform designated functions on behalf of MedImpact. Such functions may include but are not limited to: communications/messaging/notifications to Member Pharmacy, transmittal and receipt of documents (including but not limited to amendments, Authorization to Participate forms, certifications, and attestations), payment via electronic funds transfer (EFT), analytic tools, and credentialing. Such third party vendor(s) shall have executed agreement(s) with MedImpact containing non-disclosure/non-use/confidentiality provisions to protect the confidentiality of information including, but not limited to, information protected under the Health Insurance Portability and Accountability Act (HIPAA), intellectual property, and other confidential information of MedImpact and its third-party business partners.

**5. CLAIMS SUBMISSION**

Member Pharmacy must submit all claims for Prescription Drug Benefits provided to Eligible Persons to MedImpact, regardless of whether or not any additional amounts are owed to Member Pharmacy over the amount paid by the Eligible Person. All such claims must be submitted electronically at the point of sale. If unable to transmit claims electronically at the point of sale, Member Pharmacy must submit to MedImpact no less frequently than once every 7 calendar days, claim forms detailing the Prescription Drug Benefits provided to Eligible Persons following the procedures set by MedImpact. MedImpact will furnish claim forms and identify the information to be contained thereon. A reasonable handling fee of $5.00 per claim may apply in those situations in which Member Pharmacy submits claims non-electronically. Claims submitted more than 7 calendar days after the Prescription Drug Benefit was provided will not be paid.

**BIN Number**

When submitting claims electronically, Member Pharmacy must submit a Bank Identification Number (BIN) to route the claim properly to MedImpact.

**DAW**

Pharmacy must submit an accurate Dispense as Written (DAW) code, in accordance with the NCPDP specifications. DAW submissions may change the calculation of the claims adjudication depending on Payer specifications. Member Pharmacy will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW code.

- DAW 0—DAW Indicated
- DAW 1—Substitution Allowed—Dispensed As Written By Prescriber
- DAW 2—Substitution Allowed—Patient Requested Product Dispensed
- DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed
- DAW 4—Substitution Allowed—No Generic Available
- DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic
- DAW 6—Override
- DAW 7—Substitution Not Allowed—Brand Mandated By Law
- DAW 8—Generic not available in marketplace
DAW 9—Other

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

**Claim Reversals**
Member Pharmacy must submit a claim reversal when an Eligible Person fails to pick up a filled prescription within 14 calendar days. Such reversal must be submitted online through MedImpact’s Online Claim System within 3 business days following the 14 calendar day period.

**Compounds**
Prescription Drug Benefits which are compounded prescriptions for Eligible Persons must be submitted to MedImpact by using the NDC number of the most expensive Legend Drug. The compound must contain at least one ingredient that is a Legend Drug.

**Taxes**
If any taxes, assessments and/or similar fees ("taxes") are imposed on Member Pharmacy by a governmental authority based upon Member Pharmacy’s provision of Prescription Drug Benefits to Eligible Persons, Member Pharmacy may request reimbursement from Payer or Eligible Person for such taxes that are allowed and imposed by applicable Law. Member Pharmacy must transmit the applicable tax amount allowed by Law through the Online Claim System. In no event does this give Member Pharmacy any additional or different rights than those allowed by Law. In no event shall MedImpact be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments or similar fees. Member Pharmacy shall assume the responsibility of making and shall timely make payments to the appropriate taxing authorities of the amount of any taxes received.

**Prior Authorizations**
Certain Prescription Drug Benefits require prior approval before they will be covered by a Payer. Such approval is Plan specific. Follow the guidelines on the Plan Profile Sheet for directions on obtaining the requisite prior approval.

**Format Submission Requirements**
Member Pharmacy must transmit the required data for each claim in the then-current standard version of the NCPDP format. The telecommunications interface equipment shall be the responsibility of the Member Pharmacy and shall meet the minimum standards set by MedImpact from time to time. Member Pharmacy is responsible for any claims processing fees through claims switch processors.

Without limiting the generality of the foregoing, Member Pharmacy shall ensure that all claims include Member Pharmacy’s and the prescribers’ National Provider Identifier (“NPI”) (if the prescriber’s NPI is not available, another non-NPI identifier such as the prescriber’s DEA number or the prescriber’s state license number, as permitted by state Law, must be included).

Without limiting the generality of the foregoing, Member Pharmacy shall comply with *MedImpact’s most current Payer Sheet*. 

4/16/2014
**E-Prescribing**

Member Pharmacy shall support and comply with all electronic prescription standards, requirements, and guidance adopted by CMS, the federal Drug Enforcement Administration, and other federal and state government agencies as required by Law, when such final standards, requirements, and guidance are effective, and as such standards, requirements, and guidance may be revised from time to time, including but not limited to: (i) NCPDP SCRIPT Standard, Implementation Guide, Version 8 Release (8.1) or Version 10 Release 6 (10.6) for communications concerning prescriptions or prescription-related information between Member Pharmacy and prescribers; (ii) NCPDP SCRIPT 8.1 or 10.6 for communications concerning medication history between MedImpact, Member Pharmacy and prescribers and refill status between Member Pharmacy and prescribers; (iii) NCPDP Telecommunication Standard Specification, Version D, Release 0 (Version D.0) for communications concerning eligibility between MedImpact and Member Pharmacy; (iv) the prescriber’s NPI; and (v) additionally, for electronic prescriptions of controlled substances, The Department of Justice, Drug Enforcement Administration’s Electronic Prescriptions for Controlled Substances Final Rule, 75 FR 16236 (March 31, 2010). Without limiting the generality of the foregoing, in addition, Member Pharmacy shall ensure that all electronic prescription claims include Member Pharmacy’s and the prescribers’ NPIs (if the prescriber’s NPI is not available, another non-NPI identifier such as the prescriber’s DEA number or the prescriber’s state license number, as permitted by state Law, must be included). Also, Member Pharmacy shall use NCPDP Telecommunication Standard Version D.0 Field 419 DJ – Prescription Origin Code so that the source of origin for prescriptions filled can be identified and reported.

6. **CLAIMS PAYMENT**

MedImpact will reimburse Member Pharmacy according to the Agreement and will provide Member Pharmacy with a report showing the record of all claims submitted, processed, and paid in each processing cycle. If Member Pharmacy fails to advise MedImpact in writing of any alleged error, miscalculation, discrepancy or basis for questioning the correctness of any claim within 30 calendar days after the report is sent or available to Member Pharmacy, Member Pharmacy will be deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the report for that cycle. Thus, all claims will be final as to Member Pharmacy on the thirtieth (30th) calendar day following the date the report is sent to Member Pharmacy, and Member Pharmacy may not challenge any such claim or payment for such claim after the thirtieth (30th) day following the report. In no event will MedImpact have any liability above or beyond claim amounts paid to MedImpact by Payer for such thirty (30) calendar day period. This does not apply with respect to any overpayments made to Member Pharmacy. Any check not cashed by Member Pharmacy within 30 days of its issuance may be voided.

To request an adjustment to a claim, Member Pharmacy must timely submit to MedImpact sufficient documentation to evidence that the claim was paid incorrectly. Such adjustment requests must be mailed to:

**MedImpact HealthCare Systems, Inc.**
P.O. Box 320425
Alexandria, VA 22320
(800) 788-2949
(866) 524-2629 Fax
Unless otherwise agreed to in writing by an officer of MedImpact, after deducting applicable fees owed to MedImpact by Member Pharmacy and Eligible Member Copayment, claims will be paid at the lower of: (1) Member Pharmacy's Usual and Customary price; (2) the applicable AWP discount and dispensing fee; or (3) MAC plus the applicable dispensing fee. In no case shall reimbursement to Member Pharmacy exceed Member Pharmacy's Usual and Customary price.

Drug classification (e.g., legend vs. over-the-counter, brand vs. generic) will be as published by the First Data Bank Service in its Blue Book and AWP pricing will be the price as published by Medi-Span or such other nationally recognized classification and pricing source which MedImpact may select.

MedImpact is not obligated to reimburse Member Pharmacy for a claim if Member Pharmacy has breached any of the provisions or terms set forth in the Agreement with respect to that claim. Any overpayments made to Member Pharmacy may be deducted from amounts otherwise payable to Member Pharmacy. However, should Member Pharmacy owe MedImpact an overpayment amount that will not be reimbursed via offset to MedImpact within a reasonable time period (as determined solely by MedImpact), Member Pharmacy shall immediately remit payment to MedImpact in accordance with a written demand from MedImpact.

For the services MedImpact provides to Member Pharmacy under this Agreement, MedImpact charges Member Pharmacy a fee per transaction. These fees will be immediately due and owing by Member Pharmacy to MedImpact and MedImpact has the right to deduct such amounts from any amounts payable to Member Pharmacy. A transaction means each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication sent to MedImpact through the Online Claim System. Any modifications to this transaction fee requirement must be in writing and signed by an officer of MedImpact.

**Consumer Discount Card Programs**

As applicable and to the extent that Member Pharmacy is a participant in MedImpact’s Consumer Discount Card Network, MedImpact will communicate to Member Pharmacy via the online claims adjudication system the discounted amount to collect from the Eligible Member (“Member Discount”). The Member Discount may be more than the contracted rate owing to Member Pharmacy and may vary from the AWP discount, MAC, or dispensing fee owed to Member Pharmacy. Member Pharmacy agrees to collect from the Eligible Member at the point of sale the full Member Discount amount indicated by the online claims adjudication system. MedImpact may withhold from other payments due to Member Pharmacy under the Agreement or may invoice Member Pharmacy for the difference in the Member Pharmacy contracted rate hereunder and the Member Discount. Member Discount will not exceed Member Pharmacy’s Usual and Customary Charge. In no event will Member Pharmacy charge an Eligible Member more than the lower of the Member Pharmacy’s Usual and Customary Charge or the Member Discount.

The Consumer Discount Card Network applies to cash discount card programs. Eligible Persons of cash discount card programs may include individuals and groups with no insured prescription drug benefit or with a limited prescription drug benefit when the Eligible Person is paying 100% of the cost share. The discounts offered hereunder may be used for Eligible Persons, their dependents, and/or their pets and may be applicable to all products dispensed by prescription including but not limited to OTC products, compounds, supplements, or other medical products or devices.
Member pharmacy agrees to comply with all applicable federal, state, and local laws, rules, and regulations regarding consumer discount card programs.

7. PRICING CHANGES
MedImpact may change the applicable AWP discount and dispensing fee and/or service/transaction fee by giving Member Pharmacy thirty (30) days prior written notice of such amendment. Member Pharmacy may reject such amendment by providing written notice to MedImpact of its intent not to accept such amendment. Such notice must be received by MedImpact prior to the effective date of the amendment. MedImpact has the right to immediately terminate the Agreement or Member Pharmacy’s participation from a particular network in the event any such amendment is rejected by Member Pharmacy.

8. AUDIT
MedImpact and its authorized agents have the right to audit compliance with the Agreement during the term of the Agreement and for six (6) years after its expiration, or any longer period as required by applicable Law. Upon reasonable notice from MedImpact, during regular business hours, Member Pharmacy must provide auditors with or access to examine and/or copy any and all documents and records that MedImpact deems necessary to determine whether the Member Pharmacy is compliant with the Agreement. Member Pharmacy must promptly comply with all requests for documentation and records. If MedImpact is denied admission to the Member Pharmacy or if Member Pharmacy does not timely present requested documentation and records, Member Pharmacy may be assessed a $500 fee or MedImpact may deem 100% of the claims to be audited as noncompliant, with all such amounts previously paid to Member Pharmacy for such claims to be immediately due and owing to MedImpact and may be deducted from any amounts payable to Member Pharmacy.

In addition, where based on a sampling of audited claims, MedImpact determines that Member Pharmacy has engaged in fraud or abuse or has made common errors in the submission of claims, MedImpact has the right to extrapolate for purposes of determining the amount due and owing to MedImpact for noncompliant claims, which amount shall become immediately due and owing to MedImpact. Member Pharmacy shall have 30 days to provide documentation to MedImpact to dispute such findings.

If Member Pharmacy is deemed noncompliant, certain penalties may apply, including, but not limited to fees, interest, penalties, damages, or other charges imposed upon MedImpact by governmental entities, regulatory agencies, and/or Payers. If discrepancies are found, overpayments from discrepant claims and/or any other charges resulting from non-compliance become immediately due and owing by Member Pharmacy to MedImpact. MedImpact has the right to deduct any such amounts from any amounts payable to Member Pharmacy.

MedImpact may report its audit findings to Payers, appropriate governmental entities, and regulatory agencies.

9. ADVERTISING AND PROMOTION
Without the prior written consent of MedImpact, Member Pharmacy must not use words, symbols, trademarks or service marks which MedImpact uses, in advertising or promotional materials or otherwise, and Member Pharmacy must not advertise or publicly display that it is a Member Pharmacy without the prior written consent of
MedImpact. Member Pharmacy must immediately cease any and all such usage immediately upon request of MedImpact or upon termination of this Agreement.

When a Member Pharmacy advertisement is directed to Eligible Persons of a Payer, Member Pharmacy must include, in a form and content agreeable to Member Pharmacy and MedImpact, a reference that it is a MedImpact Member Pharmacy with the MedCare® Network.

MedImpact may list Member Pharmacy by name, address, and telephone number for each of its locations in applicable directories, brochures, or other publications for distribution and/or use by MedImpact, Payers, and Eligible Persons.

10. CONFIDENTIALITY AND PROPRIETARY RIGHTS
All Eligible Persons' information related to Prescription Drug Benefits and other records identifying Eligible Persons shall be treated by Member Pharmacy as confidential and proprietary. Member Pharmacy agrees never to use Eligible Persons' information for competitive purposes, nor to provide such information to others for Member Pharmacy'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 Payer or MedImpact in writing.

All materials relating to pricing, contracts, programs, services, business practices, and procedures of MedImpact are proprietary and confidential. Member Pharmacy must maintain the confidential nature of such materials and return them to MedImpact upon termination of the Agreement. All information contained in the claims system or that was obtained by or through the administration and processing of claims is the property of MedImpact.

Member Pharmacy must promptly notify MedImpact if it becomes aware of any use of confidential information or data that is not authorized by MedImpact.

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

11. COURT ORDERS, SUBPOENAS, OR GOVERNMENTAL REQUESTS
If MedImpact receives a court order, subpoena, or governmental request relating to Member Pharmacy, MedImpact may comply with such order, subpoena, or request, and Member Pharmacy must indemnify and hold harmless MedImpact for, from, and against any and all costs (including reasonable attorneys' fees and costs), losses, damages, or other expenses MedImpact may incur in connection with responding to such order, subpoena, or request.

12. MEMBER PHARMACY TERMINATION
The Agreement may be terminated as follows:

No Cause Termination
Either party may terminate the Agreement upon 30 calendar days' prior written notice to the other party, or such longer time as required by Law.
**Termination upon Insolvency**

Either party may terminate this Agreement with written notice to the other immediately upon the filing by or against the non-terminating party of any action under the Federal Bankruptcy Act, or any other Law or act regarding insolvency, reorganization, arrangement, or extension for the relief of debtors, including the assignment of assets for the benefit of creditors, and the appointment of a receiver or trustee for transfer or sale of a material portion of the non-terminating party's assets.

**Termination for Default**

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 upon ten (10) days' prior written notice, provided, however, that the defaulting party has not cured such default within ten (10) days prior to the end of such ten (10) day period. This paragraph shall not be construed to prevent either party from seeking injunctive relief, including specific performance, against the other prior to the expiration of the cure period.

**Immediate Termination**

MedImpact may terminate this Agreement immediately upon written notice to Member Pharmacy in the event of (i) Member Pharmacy's breach of any representations or warranties set forth in this Agreement; (ii) failure by Member Pharmacy to meet any licensing or credentialing requirements as defined by any state or federal agency or by any nationally recognized accreditation agency program standards or by MedImpact or any applicable Payer; (iii) the right to control the operation of the business of Member Pharmacy is transferred or given to a different person or entity; or (iv) Member Pharmacy's fraudulent submission of false claim information. Further, MedImpact may terminate Member Pharmacy from participating in any specific Payor's network without cause upon a 30-day written notice to Member Pharmacy (or such longer period as required by applicable Law).

**Rights and Remedies in the Event of Termination or Breach**

In the event of termination of this Agreement for any reason, in addition to all other rights and remedies MedImpact may have at Law, equity, or under this Agreement, MedImpact shall have the right to deduct from any amounts owing to Member Pharmacy any amounts which Member Pharmacy owes to MedImpact.

In the event Member Pharmacy breaches any provision of the Agreement, in addition to all other termination rights, MedImpact shall have the right to (i) suspend any and all obligations of MedImpact under and in connection with this Agreement, (ii) impose reasonable investigation and handling fees, and/or (iii) offset against any amounts owed to Member Pharmacy under this Agreement or under any other agreement between MedImpact and Member Pharmacy, any amounts required to be paid by Member Pharmacy to MedImpact. These rights and remedies are in addition to any and all other rights and remedies that may be available to MedImpact under the Agreement or at Law or equity.

Termination of the Agreement for any reason shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.
Cooperation with Transition of Care upon Termination
In the event of termination of this Agreement or in the event of Member Pharmacy’s termination from a particular network, it is understood and agreed that Member Pharmacy shall cooperate in the orderly transfer of care of Eligible Persons including but not limited to, the transfer of prescriptions to another provider.

13. MISCELLANEOUS

Assignment
Member Pharmacy may not assign the Agreement to any other person or entity without the prior written approval of MedImpact, which approval or denial is in the sole discretion of MedImpact. Any attempted assignment by Member Pharmacy without the prior written approval of MedImpact will be void and of no force and effect. In the event Member Pharmacy makes a valid assignment to a successor with the prior written approval of MedImpact, any successor to ownership will be responsible for all liabilities and obligations of its predecessor under the Agreement.

Notices to Member Pharmacy
All notices by MedImpact to Member Pharmacy pursuant to the Agreement may be given via the claims system, by facsimile, e-mail, or mail at the facsimile number, e-mail address, or mailing address as set forth in the Member Pharmacy’s Pharmacy Network Participation Acceptance Form.

All notices will be deemed received when delivered in person, by e-mail, or by facsimile, or, if sent by mail, the notice will be deemed received on the third business day after the date such notice was mailed.

Waiver
Failure to exercise any of the rights under the Agreement for any one default will not be a waiver of the right to exercise any of the rights for subsequent defaults.

Applicable Law
The Agreement and all matters or disputes relating thereto will be governed by California Law without regard to choice of law provisions.

Force Majeure
Neither party will be deemed to have breached the terms set forth in the Agreement to the extent that either MedImpact or Member Pharmacy is prevented from performing hereunder, all or any part, as a result of causes that are beyond the party’s reasonable control, including, but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, or third party nonperformance.

14. DEFINED TERMS

Average Wholesale Price or AWP
Average Wholesale Price or AWP means the average wholesale price for a given pharmaceutical product as published by Medi-Span or other classification and pricing source which MedImpact may select. Aside from AWP pricing, MedImpact will utilize First Databank for all other drug attributes. The applicable AWP for prescriptions dispensed shall be based on the actual NDC submitted. If MedImpact determines the
need to utilize another recognized source for AWP pricing or drug attributes, or a benchmark other than AWP, MedImpact will provide such notification of its change.

**Copayment**
Co-payment means the deductible, copayment, coinsurance, or other required payment by an Eligible Person, as communicated by the Online Claim System or such other written method utilized by MedImpact.

**Eligible Persons**
Eligible Person means a person entitled to a Prescription Drug Benefit pursuant to a Plan.

**Law**
Law means any federal, state, local or other constitution, charter, act statute, law, ordinance, code, rule, regulation, order, specified standards or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America, or any state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

**MAC or Maximum Allowable Cost**
MAC or Maximum Allowable Cost means the upper limit price for certain multiple-source drugs dispensed without regard to the specific manufacturer whose drug is dispensed.

**Member Pharmacy**
Member Pharmacy means the entity doing business as a licensed professional pharmacy, which participates in MedImpact’s networks.

**Online Claim System**
The telecommunication system maintained by MedImpact and employed by Member Pharmacy and MedImpact to communicate Prescription Drug Benefits and claims information.

**Payer**
Payer means the entity that contracts with MedImpact for prescription benefit management services, including, but not limited to, trust funds, insurance companies, self-insured plans, health maintenance organizations, preferred provider organizations, or third party administrators.

**Plan**
Plan means that portion of a Payer's drug benefit plan that relates to a Prescription Drug Benefit with respect to Eligible Persons.

**Policies and Procedures**

**Prescription Drug Benefit**
Prescription Drug Benefit means any drug or device covered, in whole or in part, by a Plan for an Eligible Person.
Usual and Customary or U&C
Usual and Customary or U&C means the lowest price Member Pharmacy would charge to a cash paying customer at that location for an identical prescription on that day. This price must include any applicable discounts, promotions, or other offers to attract customers.

15. MEDIMPACT’S MEMBER PHARMACY GRIEVANCE RESOLUTION PROCESS

MedImpact values its relationships with Member Pharmacies and strives to address and resolve Member Pharmacy concerns efficiently, fairly and cost-effectively. Whenever possible, MedImpact resolves issues raised by Member Pharmacies at the time of the initial contact. However, if the issue cannot be resolved informally, MedImpact offers a process for Member Pharmacies to use to resolve their Grievances. A Grievance is any concern or issue raised by a Member Pharmacy that results from its relationship with MedImpact and may include, but is not limited to, a claim and other billing issue, a contract issue, or an operations issue. Grievances by Member Pharmacies are handled by MedImpact as: (1) Grievances and (2) Appeals. Member Pharmacy should note that the process and timeframes stated below generally apply to Member Pharmacy Grievances; however, when applicable state Laws or regulations and/or the MedCare Pharmacy Network Agreement (including documents incorporated by reference) requires different processes or timeframes, MedImpact will adjust the process accordingly.

Initial Grievance
Member Pharmacy may make an Initial Grievance by calling MedImpact’s Customer Service Center at: 1-800-788-2949, 24 hours per day, seven days per week. If a Customer Service Representative is unable to resolve the Initial Grievance, Member Pharmacy may choose to submit an Appeal to:

MedImpact HealthCare Systems, Inc.
P.O. Box 320425
Alexandria, VA 22320

Appeal
To initiate an Appeal, Member Pharmacy must submit its concern in writing within 30 calendar days from the date of MedImpact’s adverse decision or action to:

MedImpact HealthCare Systems, Inc.
P.O. Box 320425
Alexandria, VA 22320

In order to be complete, a Member Pharmacy Appeal must include at least the following information (as applicable): (i) Member Pharmacy name; (ii) Member Pharmacy tax identification number; (iii) Member Pharmacy contact information; (iv) Covered Individual name; (v) insurer’s identification information; (vi) dates of service; (vii) billed and paid amounts, if applicable; (viii) clear and concise explanation of the reason for the Grievance (i.e., underpayment; no authorization; claim bundling; benefit issue; contract issue); (ix) a copy of the original claim and explanation of payment or explanation of benefits, if applicable; (x) copies of all other applicable documentation.

MedImpact generally will resolve Appeals within thirty (30) business days of receipt of request for an Appeal.

4/16/2014
Incomplete Appeals will be returned to Member Pharmacy with a request for additional information. Returned Appeals may be resubmitted with the additional information within thirty (30) business days from the date the returned Appeal is mailed to Member Pharmacy. MedImpact generally will resolve Appeals within thirty (30) business days of receipt of the additional information.

**Conclusion of Grievance Process**

The resolution of an Appeal concludes MedImpact’s Member Pharmacy Grievance Resolution Process. If Member Pharmacy wishes to pursue an issue further, Member Pharmacy should consult its MedCare Pharmacy Network Agreement (including any incorporated documents) and applicable state Laws for any additional rights and obligations it may have (i.e., arbitration).

16. **REGULATORY COMPLIANCE**

**Medicare Part D**

Member Pharmacy must comply with all applicable Medicare Laws and regulations and instructions of Centers for Medicare and Medicaid Services (“CMS”) with respect to Medicare Part D (Prescription Drug Plans and Medicare Advantage plans).

If Member Pharmacy participates in a pharmacy network that furnishes Prescription Drug Benefits to Eligible Persons enrolled in Medicare Part D plans, the following requirements and provisions apply to Member Pharmacy:

**Medicare Rights Notice**

Member Pharmacy shall use CMS Form 10147 entitled “MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS” (the “Medicare Rights Notice”) to instruct Eligible Persons to contact their Part D plan to obtain a coverage determination or ask for a formulary or tiering exception if the Eligible Person disagrees with the information provided by a Member Pharmacy concerning a requested prescription. Member Pharmacy shall distribute this Medicare Rights Notice to Eligible Persons.

If Member Pharmacy is a long term care (“LTC”) pharmacy it must send, fax or otherwise deliver the Medicare Rights Notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Eligible Person (or the Eligible Person’s appointed representative) and the Eligible Person’s treating physician with the notice. A copy of the notice should be placed in the Eligible Person’s file at the LTC facility.

This is a standard notice. Member Pharmacy shall not deviate from the content of the Medicare Rights Notice. Please note that the Office of Management and Budget (OMB) control number must be displayed in the upper right corner of the Medicare Rights Notice. Member Pharmacy may elect to place their logo in the space above “Medicare Prescription Drug Coverage and Your Rights”.

**AWP Pricing Updates**

MedImpact shall update the AWP pricing in MedImpact’s Online Claim System no less frequently than once every seven (7) days (beginning with an initial update on January 1 of each year) with data received from MedImpact’s third party pricing source, Medi-Span.
Extended Day Supplies
In accordance with Chapter 5 of the Prescription Drug Benefits Manual, for Member Pharmacies that have contracted to provide a ninety (90) day supply of Prescription Drug Benefits, Member Pharmacy agrees to accept the lesser of the contracted amount the Member Pharmacy would receive for dispensing a ninety (90) day supply or the amount Member Pharmacy would receive had the Eligible Person received three (3) thirty (30) day supplies of the Prescription Drug Benefit.

On-Line Submission and Negotiated Price to Members
42 CFR 423.505(b)(17) requires Member Pharmacy to submit claims in real time by means of point of service claims adjudication systems and 42 CFR 423.104(g)(1) requires Member Pharmacy to provide the negotiated prices to Eligible Persons. Accordingly, it is important that all Part D Claims be submitted in real time at the point of sale so that the Eligible Person can obtain the benefit of the negotiated price. In the event a Part D Claim is not submitted online at the point of sale and an Eligible Person submits a paper claim for a Prescription Drug Benefit filled by Member Pharmacy, MedImpact may deduct from Member Pharmacy the difference in the amount paid to Member Pharmacy by the Eligible Person and the negotiated price Member Pharmacy is entitled to under the Agreement.

Best Available Evidence Policy- LICS Subsidy
The following provides information on how CMS’ Best Available Evidence Policy applies with respect to MedImpact and the Part D sponsors that contract with MedImpact.

CMS’ Best Available Evidence Policy is available at:
http://www.cms.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp

Under Medicare Part D, certain Part D members are entitled to a cost-sharing subsidy, which is extra financial assistance for Part D members who have limited income and resources. CMS determines which individuals qualify for the cost-sharing subsidy. In making this determination, CMS currently relies on files from the states and Social Security Administration. The eligibility status of the member is then updated in the CMS system and provided to Part D plan sponsors.

When submitting a claim to MedImpact, if the on-line system does not reflect that a member is qualified for a cost-sharing subsidy at the point of sale, it is because the CMS system has not identified that individual as eligible for a cost-sharing subsidy. If your pharmacy or a Part D member at your pharmacy believes that the member is eligible for a cost-sharing subsidy that is not reflected in the on-line system, unless MedImpact has informed you otherwise in writing for a specific plan sponsor, you should contact the applicable Part D plan sponsor (at the telephone number on the member’s identification card) for information on where to submit Best Available Evidence so that the member’s eligibility information can be updated in the system by the Part D plan sponsor. If your pharmacy and/or the Part D member does not have Best Available Evidence (as defined by CMS) available, the Part D member may contact his/her Part D plan sponsor for assistance.

Documents that qualify for Best Available Evidence as required by CMS are described in CMS’ Best Available Evidence Policy dated August 4, 2008, as follows:

To establish the subsidy status of a full benefit dual eligible beneficiary--

1. A copy of the beneficiary’s Medicaid card that includes the beneficiary’s name and an eligibility date during a month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
3. A print out from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
4. A screen print from the State’s Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
5. Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year; or,
6. For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter.

To establish that a beneficiary is institutionalized and qualifies for zero cost-sharing--

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
3. A screen print from the State’s Medicaid systems showing that individual’s institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

The following is a uniform form developed by NCPDP to be used by pharmacies to communicate documentation of eligibility for LICS to Part D plans on behalf of Medicare beneficiaries. All forms of documentation being submitted and/or used for certification of eligibility should be identified on the cover sheet by checking the appropriate document description and maintained as required by law and contract.

Pharmacy name

<table>
<thead>
<tr>
<th>Pharmacy name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>Address</th>
<th>City, State, Zip</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part D plan name

<table>
<thead>
<tr>
<th>Part D plan name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Group#

<table>
<thead>
<tr>
<th>Group#</th>
<th>BIN#</th>
<th>PCN#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Member name

<table>
<thead>
<tr>
<th>Member name</th>
<th>Date of birth</th>
<th>Member ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Pharmacy provider has attached/included a copy of the documentation as indicated on this coversheet.

4/16/2014
Pharmacy provider has obtained and is maintaining a copy of the documentation per contract requirements; as indicated below.

**Dual Eligible Member – At the high or low LICS cost-sharing level**

- 1. Copy of member’s Medicaid card which includes the member’s name and eligibility date.
- 2. Report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status.
- 3. Copy of a state document that confirms active Medicaid status.
- 4. A print out from the State electronic enrollment file showing Medicaid status.
- 5. A screen print from the State’s Medicaid systems showing Medicaid status.
- 6. Other documentation provided by the State showing Medicaid status.

**Dual Eligible Member – Institutionalized Care, zero LICS cost-sharing level**

- 7. A remittance from the facility showing Medicaid payment for a full calendar month for the member.
- 8. A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the member.
- 9. A screen print from the State’s Medicaid systems showing the member’s institutional status based on at least a full calendar month stay for Medicaid payment purposes.

**SSA Award Letter**

- 10. Full subsidy.
- 11. Partial subsidy.

<table>
<thead>
<tr>
<th>Certified by (Signature, or indicate “Signature on file”)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed name</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Medication Errors**

Member Pharmacy shall track medication errors, take corrective action with respect to such errors, and provide a report of such to MedImpact or to the applicable Medicare Part D plan sponsor with respect to Eligible Persons.

**Medicare Part A and Medicare Part B Services**

To the extent Member Pharmacy provides Medicare Part A and/or Part B services, Member Pharmacy shall not hold Eligible Persons who are eligible for both Medicare and Medicaid financially responsible for Medicare Part A and Part B copayments, coinsurance or deductibles when Medicaid is responsible for payment of such amounts. In addition, as applicable to such claims for such Part D Eligible Persons, Member Pharmacy shall accept Payer’s payment for services as payment in full, or to bill the appropriate state source. This requirement shall not prohibit Member Pharmacy from collecting the cost-sharing amount, from an Eligible Person, for a non-Part D covered drug delivered on a fee-for-service basis to any Part D Eligible Person, which payment has not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits.
**Medicare Part A vs. Medicare Part D**

When dispensing prescriptions to Eligible Persons during inpatient stays at skilled nursing facilities, Member Pharmacy shall bill and seek reimbursement under Medicare Part A and shall ensure that the Eligible Persons’ coverage under Medicare Part A has been exhausted before billing and seeking reimbursement from Medicare Part D plan sponsors. Member Pharmacy shall not bill claims for reimbursement under Part D if such claims are covered by Part A. Member Pharmacy shall retrospectively review Eligible Persons’ Part A eligibility with their contracted LTC facilities and shall reverse ineligible Part D claims and shall refund Eligible Persons that inappropriately paid Part D cost-sharing. Member Pharmacy understands and agrees that if MedImpact becomes aware that Member Pharmacy billed prescription claims for reimbursement under Medicare Part D that should have been billed under Medicare Part A, MedImpact shall reverse such claims on behalf of Payers who are Part D plan sponsors, shall withhold any amounts due from such reversed claims and shall require Member Pharmacy to refund Eligible Persons that inappropriately paid Part D cost-sharing. Member Pharmacy further understands that MedImpact may incorporate provisions into its retrospective utilization review and pharmacy audit strategies to target potential ineligible Part D payments for drugs covered by Medicare Part A.

**Deficit Reduction Act of 2005 / False Claims Acts**

Under the Deficit Reduction Act of 2005, certain entities are required by law to establish policies and provide information regarding the federal False Claims Act and similar state laws, an employee’s right to be protected as a whistleblower, and policies and procedures for detecting and preventing fraud, waste, and abuse in state and federal health care programs (“DRA Policies”). Any contractor, subcontractor, agent, and other person which or who furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by these entities are required to adopt their DRA Policies, as may be amended from time to time. MedImpact will provide or make available to Member Pharmacy, the DRA Policies. To the extent Member Pharmacy or any of its employees furnish or otherwise authorize the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by these MedImpact or Payers, Member Pharmacy shall comply with the DRA Policies and shall require its employees and subcontractors (as approved by MedImpact) to comply with the DRA Policies.

**Florida Medicaid / Hernandez Settlement Agreement**

Member Pharmacy understands that the Florida Agency for Health Care Administration entered into a settlement agreement (the Hernandez Settlement Agreement) relating to the type of notification a pharmacy must give a Medicaid recipient when the pharmacy refuses or is unable to fill a prescription (i.e., an unreasonable delay in filling the prescription; a denial of the prescription; the reduction of a prescribed good or service; and/or termination of a prescription).

Under the Hernandez Settlement Agreement, Member Pharmacy must comply with the following when serving Florida Medicaid recipients:

1. Member Pharmacy must post signs advising Medicaid recipients that if reimbursement for their prescription drug(s) is initially rejected, they will be given written information by the Member Pharmacy, including a
pamphlet, that will tell them the reason their drug claim reimbursement was rejected and what they can do about it.

2. Member Pharmacy must provide notice to recipients whose claim reimbursement for a prescription drug is rejected by way of either a printed copy of the computer screen stating the reason(s) for rejection or by writing the reason(s) for claim reimbursement rejection and the date of the rejection on the pamphlet which must be given to the recipient.

3. For those recipients not physically present in the pharmacy when claim reimbursement is rejected for the recipient’s claim, such as recipients who have a relative pick up medicines for them, Member Pharmacy must deliver the pamphlet (and copy of computer screen, where appropriate), containing the reason(s) for rejection to the recipient via the same means by which the prescription medication would have delivered (e.g., mail, personal delivery).

4. The required written notice can either be provided to the recipient or to a person acting on behalf of a recipient as specified in HIPAA, and such notice must be made in accordance with applicable law and HIPAA procedures.

5. Member Pharmacy must provide all recipients whose prescription drug claim reimbursement has been rejected with a copy of the applicable pamphlet issued by the Agency for Health Care Administration of the State of Florida, which pamphlet is available from the Agency for Health Care Administration of the State of Florida.

**State Regulatory Addenda**

Member Pharmacy acknowledges that various state mandates may apply with respect to this Agreement and the services provided to Eligible Persons. Member Pharmacy represents and warrants that it is, and shall remain, in compliance with all applicable Laws, including the regulatory addendums which, from time to time, may be attached hereto and incorporated herein by this reference.

The following state regulatory addenda are to the MedCare Pharmacy Network Agreement ("Agreement") entered into between Member Pharmacy and MedImpact and incorporate the following provisions set forth in each state regulatory addenda attached hereto. Member Pharmacy agrees that by executing the Agreement, Member Pharmacy is executing the applicable state addenda and shall not require a separate signature in order to be effective.

In conformance with the Agreement, in the event of a conflict between any of the documents comprising the Agreement, the terms of any applicable state-specific addendums shall control first.
ALABAMA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, managed care organizations, insurers, or carriers under Alabama law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Alabama law, Member Pharmacy agrees:

   a. That in no event, including but not limited to, non-payment, MedImpact’s or Payor’s insolvency, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons, or persons other than MedImpact or Payor acting on behalf of Eligible Persons for services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles, and coinsurances on MedImpact’s or Payor’s behalf made in accordance with the terms of the Plan between Payor and Eligible Persons. Ala. Code § 27-21A-3; Ala. Admin. Code r. 482-1-080-.05(2)(c); 420-5-6.10(2)(q)(1).

   Member Pharmacy further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Eligible Person, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons, or persons on their behalf. Ala. Admin. Code r. 420-5-6.10(2)(q)(1).

   b. Member Pharmacy may not change, amend, or waive any provision of this Agreement without prior written consent of MedImpact. Any attempts to change, amend, or waive the Agreement are void. Ala. Admin. Code r. 420-5-6.10(2)(q)(1).

2. This Agreement shall not establish reimbursement rates or procedures that result in reimbursement rates for services rendered to Eligible Persons covered by Payor which are less than the usual and customary rates paid by consumers not covered by a third party plan for the same or similar services. Ala. Code § 34-23-115.

3. Member Pharmacy shall be compensated at the rate and frequency set forth in the Agreement and any related attachments. Ala. Code § 34-23-112.
4. Member Pharmacy agrees to resolve all disputes, controversies and claims in the manner set forth in the Agreement and any related attachments. Ala. Code § 34-23-112.


7. Member Pharmacy shall provide MedImpact and the Alabama Department of Insurance with written verification that Member Pharmacy is registered with the Alabama State Board of Pharmacy in accordance with Ala. Code § 27-45-20.
ALASKA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of medical service corporations, managed care insurance plans, health maintenance organizations, and insurers under Alaska law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health care insurer, Member Pharmacy agrees:


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

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

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

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

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

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

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

4/16/2014
e. Member Pharmacy shall not be penalized or Member Pharmacy’s contract terminated by MedImpact because Member Pharmacy acts as an advocate for an Eligible Person in seeking appropriate, medically necessary health care services. Alaska Stat. § 21.07.010(a)(5).

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

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

h. Nothing in the Agreement shall be construed as creating a direct financial incentive to Member Pharmacy for withholding covered health care services that are medically necessary. Alaska Stat. § 21.07.010(b)(1).

i. Nothing in the Agreement or this Addendum shall have the effect of requiring Member Pharmacy to contract for all products that are currently offered or that may be offered in the future by Payor. Alaska Stat. § 21.07.010(b)(2).

j. Nothing in the Agreement or this Addendum shall be construed as requiring Member Pharmacy to provide Prescription Drug Benefits at the same rate as Member Pharmacy has contracted with other managed care entities. Alaska Stat. § 21.07.010(b)(3).

k. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be required to indemnify or hold harmless MedImpact or Payor for their own acts or conduct. Alaska Stat. § 21.07.010(c).

l. In the event the Agreement is terminated and an Eligible Person is pregnant or being actively treated by Member Pharmacy on the date of termination, Member Pharmacy agrees to continue treating Eligible Person upon request and the Agreement shall remain in force with respect to that continuing treatment for the longest of the following periods: (a) until the end of the current policy of plan year; (b) through completion of postpartum care, if Eligible Person was pregnant on the date of termination; (c) 90 days after the termination date if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or (d) until the end of medically necessary treatment for Eligible Person’s condition, disease, illness, or injury if Eligible Person has a terminal condition, disease, illness, or injury. For purposes of this paragraph, “terminal” means a life expectancy of less than one year. Alaska Stat. § 21.07.030(f).

2. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a medical service corporation under Alaska law, Member Pharmacy agrees:
a. That Member Pharmacy shall provide Prescription Drug Benefits to Eligible Persons and that the obligation to furnish these services shall be a direct obligation of the Member Pharmacy to the Eligible Persons as well as to MedImpact and Payor;

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

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

d. That if Member Pharmacy withdraws from the Agreement, the withdrawal may not be effective as to an Eligible Person’s contract in force on the date of the withdrawal until the termination of the Eligible Person’s contract or the next anniversary of the Eligible Person’s contract, whichever date is earlier; and

e. That the Agreement is subject to review and prior approval of the Alaska Director of Insurance. Alaska Stat. §21.87.140.

3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization operating under Alaska law, Member Pharmacy agrees that:

a. Nothing in the Agreement shall limit Member Pharmacy from expressing criticism of health care services provided by MedImpact and/or Payor.

b. Nothing in the Agreement shall limit Member Pharmacy from communicating orally or in writing with an Eligible Person regarding health care services.

c. The Agreement with Member Pharmacy shall not be terminated unless Member Pharmacy receives advance written notice of the cause for the termination.

d. Nothing in the Agreement shall be construed as creating a financial incentive for Member Pharmacy to deny or delay health care services. Alaska Stat. §21.86.150.
ARIZONA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health care services organization, hospital and medical service corporation, insurers, or carriers under Arizona law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. MedImpact shall not restrict or prohibit Member Pharmacy’s good faith communication with its patients concerning the patients’ health care or medical needs, treatment options, health care risks or benefits. Ariz. Rev. Stat. §§ 20-118(A), 29-827(A), 20-1061(B)(1).

2. MedImpact shall not terminate the Agreement or refuse to renew the Agreement with Member Pharmacy solely because Member Pharmacy in good faith does any of the following:
   a. Advocates in private or in public on behalf of a patient.
   b. Assists a patient in seeking reconsideration of a decision made by MedImpact and/or Payor to deny coverage for Prescription Drug Benefits.

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

4. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health care services organization under Arizona law, Member Pharmacy agrees:
   a. In the event that MedImpact or Payor fails to pay for covered services as set forth in the Eligible Person’s evidence of coverage or contract, the Eligible Person shall not be liable to Member Pharmacy for any amounts owed by MedImpact and/or Payor, and Member Pharmacy shall not bill or otherwise attempt to collect from the Eligible Person any amount owed by MedImpact and/or Payor. Ariz. Rev. Stat. § 20-1072(A).
b. Member Pharmacy, and any agent, trustee, or assignee of Member Pharmacy shall not maintain an action at law against an Eligible Person to collect any amounts owed by MedImpact and/or Payor for which the Eligible Person is not liable to Member Pharmacy under the preceding subparagraph. Ariz. Rev. Stat. § 20-1072(C).

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

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

   i. The duration of the contract period under the Eligible Person’s Plan or for sixty (60) days from the date of insolvency is declared, whichever is longer;
   ii. If the Eligible Person is confined on the date of insolvency in an inpatient facility until his or her discharge;
   iii. A notification from the receiver pursuant to Ariz. Rev. Stat. 20-1069(F) or a determination by the court that Payor cannot provide adequate assurance it will be able to pay Member Pharmacy’s claims for covered services that were rendered after the Payor is declared insolvent;
   iv. A determination by the court that the insolvent Payor is unable to pay Member Pharmacy’s claims for covered services that were rendered after the Payor is declared insolvent;
   v. A determination by the court that continuation of services would constitute undue hardship to Member Pharmacy;
   vi. A determination by the court that Payor has satisfied its obligations to all Eligible Persons under its Plans.


5. Notwithstanding anything to the contrary in the Agreement, where the Agreement provides for a defined length of time to adjust or request adjustment of the payment of a claim, Member Pharmacy and MedImpact and Payor shall each have the same length of time to adjust or request adjustment of the payment of a claim. Ariz. Rev. Stat. § 20-3102(I).
ARKANSAS ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organization, hospital or medical service corporation, insurers, or carriers under Arkansas law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Nothing in the Agreement shall be construed as permitting MedImpact to interfere with Member Pharmacy’s exercise of professional responsibilities to a patient. Ark. Code Ann. § 17-92-113(b).


3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Arkansas law, Member Pharmacy agrees:

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

   b. In the event of the insolvency of MedImpact or Payor, Member Pharmacy shall continue to provide Prescription Drug Benefits for the duration of the period after the insolvency for which premium payment has been made or until Eligible Person’s discharge from an inpatient facility, whichever is longer. Ark. Code Ann. § 23-76-118(c)(2).

4. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an insurer under a minimum basic benefit policy, Member Pharmacy agrees that Eligible Persons shall have no obligation to make payment for any medical service rendered by Member Pharmacy that is determined not to be medically necessary. Ark. Code Ann. § 23-98-109(a)(3)(C).
5. Member Pharmacy shall, without restriction or penalty, be free to disclose to Eligible Persons any health care information that Member Pharmacy deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by MedImpact and/or Payor. Ark. Code Ann. § 23-99-407.

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

7. Beginning August 15, 2013, to the extent applicable and required by Arkansas Code 17-92-507, the following shall apply with respect to MedImpact’s Maximum Allowable Cost Lists (as used in this Section 7, “Maximum Allowable Cost Lists” shall have the meaning set forth in Ark. Code 17-92-507):

   a. Before MedImpact places or continues a particular drug on MedImpact Maximum Allowable Cost Lists, the drug: (i) shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or has an NR or NA rating by Medispan or a similar rating by a nationally recognized reference; (ii) shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Arkansas; and (iii) shall not be obsolete.

   b. MedImpact’s Maximum Allowable Cost Lists are available to Arkansas Member Pharmacies subject to such Maximum Allowable Cost Lists. Arkansas Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s Maximum Allowable Cost Lists.

   c. Pricing on MedImpact’s Maximum Allowable Cost Lists may be updated daily, but in all cases within seven (7) calendar days from a change in the change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology. Because MedImpact’s Maximum Allowable Cost Lists may be updated daily, MedImpact hereby provides notice that the most current MedImpact Maximum Allowable Costs Lists are available to Arkansas Member Pharmacies online 24/7, 365 days a year (except for scheduled maintenance) through the Pharmacy Verification Network (PVN) at www.pharmacyverification.com (as noted above, Arkansas Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s Maximum Allowable Cost Lists through PVN).

   d. Arkansas Member Pharmacies subject to the Maximum Allowable Cost Lists may challenge a maximum allowable cost for a specific drug or
drugs on MedImpact’s Maximum Allowable Cost Lists as (i) not meeting the requirements of Ark. Code 17-92-507 or (ii) being below the cost at which the Member Pharmacy may obtain the drug. Arkansas Member Pharmacies can initiate an appeal within three (3) business days after the applicable fill date by submitting an email to mac@medimpact.com, detailing the challenge to the MedImpact maximum allowable cost, along with supporting information and/or documentation. MedImpact will respond to any such appeal within seven (7) business days after receipt of the appeal by either upholding or denying the appeal and (within such seven (7) business days after receipt of the appeal):

(i) If the appeal is upheld, MedImpact will make the change in the maximum allowable cost and Member Pharmacy can then reverse and rebill the claim in question (in which case, MedImpact will make the change effective for similarly situated pharmacies as defined by the payor that are subject to the Maximum Allowable Cost List); or

(ii) If the appeal is denied, provide the challenging Member Pharmacy or Pharmacist the National Drug Code number from national or regional wholesalers operating in Arkansas.

e. This Section 7: (i) applies only with respect to MAC lists owned and/or controlled by MedImpact; and (ii) does not apply to maximum allowable cost lists maintained by the Arkansas Medicaid program.

8. MedImpact’s Maximum Allowable Cost Lists are CONFIDENTIAL AND PROPRIETARY to MedImpact and contain material MedImpact may consider Trade Secrets. By providing Arkansas Member Pharmacies access to the MedImpact Maximum Allowable Cost Lists hereunder, they are being provided for specified use by the Arkansas Member Pharmacy and may not otherwise be used, reproduced, transmitted, published, or disclosed to others without prior written authorization from MedImpact. MedImpact maintains the sole and exclusive ownership, right, title, and interest in and to its Maximum Allowable Cost Lists. Without limiting the generality of the foregoing, Arkansas Member Pharmacies shall not attempt to replicate the information contained in the MedImpact Maximum Allowable Cost Lists and shall not use the information contained therein in a manner that places MedImpact at a commercial disadvantage. Arkansas Member Pharmacies shall allow only designated individuals who agree to the confidentiality protections herein to have access to the information in the MedImpact Maximum Allowable Cost Lists.
CALIFORNIA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health care service plans, health maintenance organizations, and insurers under California law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:


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

3. In the event MedImpact sells, leases, or transfers MedImpact’s network, the rights and obligations of Member Pharmacy shall be governed by the Agreement between MedImpact and Member Pharmacy. Cal. Bus. And Prof. Code § 511.3; Cal. Health & Safety Code § 1375.7(c).
4. Member Pharmacy acknowledges that MedImpact has disclosed in an electronic or paper format: (a) information regarding claims processes including directions for the electronic transmission, physical delivery and mailing of claims, all claim submission requirements, instructions for confirming MedImpact’s receipt of claims; and a phone number for claims inquiries and filing information; and (b) information regarding provider dispute processes including the identity of the office responsible for receipt and resolution of disputes, directions for the electronic transmission, physical delivery, and mailing of disputes, all claim dispute requirements, the timeframe for acknowledgment of receipt of a dispute, the phone number for dispute inquiries and filing information, and directions for filing substantially similar multiple claim disputes and other disputes.

Member Pharmacy acknowledges it has received in electronic form: (a) information as to the amount of payment Member Pharmacy shall receive for each service provided under the Agreement, including any fee schedules or other factors or units used in determining the fees for each service and (b) detailed payment policies and rules and nonstandard coding methodologies, if applicable, used to adjudicate claims. Member Pharmacy shall hereafter be provided information regarding fee schedules and reimbursement information annually on or before the Agreement’s anniversary date and upon written request.

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

5. To the extent required by law, MedImpact or Payor, as applicable, will disclose to Member Pharmacy the processes that MedImpact or Payor, as applicable, uses in providing utilization review or utilization management functions to authorize, modify, or deny health services under Prescription Drug Benefits provided by Payors. Cal. Health & Safety Code §§ 1363.5, 1367.01(b).

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

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

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

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

10. MedImpact values its relationships with Member Pharmacies and strives to address and resolve Member Pharmacy concerns efficiently, fairly and cost-effectively. Whenever possible, MedImpact resolves issues raised by Member Pharmacies at the time of the initial contact. However, if the issue cannot be resolved informally, MedImpact offers a process for Member Pharmacies to use to resolve their grievances. A description of MedImpact’s pharmacy grievance process is contained in Section 15 of the Manual. Cal. Health & Safety Code § 1367(h)(1); Cal. Ins. Code § 1023.137. The pharmacy grievance process shall allow for a submission deadline of at least 365 days to the extent required by 28 Cal. Code Reg. § 1300.71.38(d).

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

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

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

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

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

For purposes of this provision, an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Member Pharmacy shall continue to provide Prescription Drug Benefits for the duration of the acute condition.

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

A pregnancy refers to the three trimesters of pregnancy and the immediate postpartum period. Member Pharmacy shall continue to provide Prescription Drug Benefits for the duration of an Eligible Person’s pregnancy.

A terminal illness means an incurable or irreversible condition that has a high probability of causing death within one year or less. Member Pharmacy shall continue to provide Prescription Drug Benefits for the duration of an Eligible Person’s terminal illness, which may exceed 12 months from termination of the Agreement.

Member Pharmacy shall continue to provide Prescription Drug Benefits for the care of a newborn child between birth and age 36 months for a period not to exceed 12 months from the Agreement’s termination.

Member Pharmacy shall complete a procedure that is authorized by MedImpact or Payor as part of a documented course of treatment and has been recommended and documented by Member Pharmacy to occur with 180 days of the Agreement’s termination.

Member Pharmacy agrees that in rendering Prescription Drug Benefits during the continuation periods outlined above, Member Pharmacy shall be subject to the same contractual terms and conditions that were imposed upon Member Pharmacy prior to termination of the Agreement, including reimbursement rates.


16. Upon termination of the Agreement, Payor shall be liable under the same contractual terms and conditions in effect prior to termination for Prescription Drug Benefits.
Drug Benefits rendered by Member Pharmacy to an Eligible Person who retains eligibility under the Plan or by operation of law under the care of Member Pharmacy at the time of termination until the services being rendered to the Eligible Person by Member Pharmacy are completed, unless MedImpact or Payor makes reasonable and medically appropriate provision for the assumption of such services by a participating provider. 10 Cal. Code Reg. § 2240.2(d); 28 Cal. Code Reg. § 1300.67.4(10); 1300.67.8(e).

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

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

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


21. In the event of the insolvency of MedImpact or Payor, Member Pharmacy agrees to continue to provide Prescription Drug Benefits to Eligible Persons until the effective date of an Eligible Person’s coverage in a successor plan pursuant to either open enrollment or the allocation process but in no event longer than 45 days in the event of allocation or 30 days in the case of open enrollment, whichever is greater. Cal. Health & Safety Code §§1394.7(e), 1394.8

22. Nothing in the Agreement shall be construed to require Member Pharmacy to accept additional patients if, in Member Pharmacy’s reasonable professional judgment, accepting additional patient would endanger patients’ access to, or continuity of, care. Cal. Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(b).
23. Member Pharmacy shall be required to comply with any quality improvement or utilization management programs or procedures of MedImpact or Payor provided that such programs and procedures were disclosed to Member Pharmacy at least 15 days prior to Member Pharmacy’s execution of the Agreement. MedImpact and Payor may, however, make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, subject to the provisions of the paragraph immediately below. Cal. Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(b).

24. MedImpact may make material changes to the Agreement upon at least 45 business days’ prior notice of the change to Member Pharmacy. Member Pharmacy shall have the right to terminate the Agreement prior to implementation of the change. Cal Health & Safety Code § 1375.7(b); Cal. Ins. Code § 10133.65(c).

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

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

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

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

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

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

31. Member Pharmacy shall not collect surcharges for Prescription Drug Benefits. If MedImpact or Payor receives notice of any such surcharge, it shall take appropriate action as provided under the Agreement. 28 Cal. Code Reg. § 1300.67.8(d).

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

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

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

35. Member Pharmacy agrees that if its retail price for a prescription drug is less than an Eligible Person’s copayment, Member Pharmacy shall charge Eligible Person no more than the retail price. 28 Cal. Code Reg. § 1300.67.24(c)(1).

36. Member Pharmacy shall not make any additional charges for rendering services provided pursuant to the Agreement except as provided for in the Eligible Person’s agreement with the Payor. Cal. Admin. Code tit. 10, § 2240.4(a).


38. Member Pharmacy shall not discriminate against any Eligible Person on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such Eligible Person of any complaint, grievance, or legal action against Member Pharmacy. Cal. Admin. Code tit. 10, § 2240.4(a).
39. Immediately upon cancellation or amendment of the Agreement, Member Pharmacy shall send a notice of such cancellation or amendment, the text thereof, and the effective date thereof to Health Plan Registrar, Office of the Attorney General, 3580 Wilshire Boulevard, Los Angeles, California 90010, California Attorney General. 11 Cal. Code § 536.
COLORADO ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, carriers, health maintenance organizations, and managed care plans under Colorado law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Neither Member Pharmacy, Payor, nor MedImpact shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the other. Colo. Rev. Stat. § 10-16-121(1)(a); 3 Colo. Code of Reg. 702-4, Reg. 4-2-15(5)(A); 3 CO ADC 702-4:4-2-15.

2. Neither Payor nor MedImpact shall terminate the Agreement with Member Pharmacy because Member Pharmacy expresses disagreement with a decision by Payor or MedImpact to deny or limit benefits to an Eligible Person or because Member Pharmacy assists an Eligible Person to seek reconsideration of the decision or because Member Pharmacy discusses with a current, former, or prospective patient any aspect of the patient’s medical condition, any proposed treatments or treatment alternatives, whether covered by a Plan or not, policy provisions of a Plan, or Member Pharmacy’s recommendation regarding selection of a Plan based on Member Pharmacy’s knowledge of the health needs of such patients. Colo. Rev. Stat. § 10-16-121(1)(b); 3 Colo. Code of Reg. 702-4, Reg. 4-2-15(5)(A); 3 CO ADC 702-4:4-2-15.

3. Member Pharmacy shall not be subject to financial disincentives based on the number of referrals made to participating providers in the Plan for covered benefits so long as Member Pharmacy adheres to the utilization review policies and procedures of Payor and MedImpact. Colo. Rev. Stat. § 10-16-121(d).

4. Member Pharmacy shall hold Eligible Persons harmless for money owed to Member Pharmacy by Payor or MedImpact. In no circumstance shall Eligible Persons be liable to Member Pharmacy for money owed to Member Pharmacy by Payor or MedImpact. In no event, including but not limited to nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons or persons (other than Payor or MedImpact) acting on their behalf for services provided pursuant to the Agreement. This provision does not prohibit Member Pharmacy from collecting coinsurance, deductibles, copayments or fees for noncovered services delivered on a fee-for-service basis to Eligible Persons. Member Pharmacy agrees that this provision shall survive termination of the Agreement, for Prescription Drug Benefits rendered prior to termination of the Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of Eligible Persons.
This provision is not intended to apply to services provided after the Agreement has terminated. Member Pharmacy agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of the Agreement. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Colorado Commissioner of Insurance has received written notification of proposed changes. Colo. Rev. Stat. § 10-16-705(3); 3 Colo. Code of Reg. 702-4, Reg. 4-7-1 § 12.

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

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

7. Member Pharmacy agrees to provide Prescription Drug Benefits to Eligible Persons following termination of the Agreement in the following circumstances:

   a. Member Pharmacy agrees to continue to provide services in accordance with the terms of the Agreement to Eligible Persons for sixty (60) days after termination without cause if notice of Member Pharmacy’s termination was not provided to Eligible Persons as outlined in paragraph 6 above.

   b. Member Pharmacy agrees to continue to provide services for Eligible Persons being treated at an in-patient facility until discharged if Payor terminates coverage for any reason other than nonpayment of the premium, fraud or abuse. Colo. Rev. Stat. § 10-16-705(4).

8. Member Pharmacy shall not assign or delegate rights and responsibilities under the Agreement without prior written consent. Colo. Rev. Stat. § 10-16-705(8).
9. Member Pharmacy shall not discriminate, with respect to the provision of medically necessary Prescription Drug Benefits, against Eligible Persons that are participants in a publicly financed program. Colo. Rev. Stat. § 10-16-705(9).

10. Member Pharmacy agrees that the sole responsibility for obtaining any necessary preauthorization rests with Member Pharmacy or the participating provider that recommends or orders particular services, treatments, or procedures and not with Eligible Persons. Colo. Rev. Stat. § 10-16-705(14).

11. To the extent any definitions or provisions of the Agreement conflict with definitions or provisions contained in Plans or contained in Colorado Revised Statute, Title 10, Article 16, Part 7, the definitions or provisions of the Agreement shall not control. Colo. Rev. Stat. § 10-16-705(15).

12. Member Pharmacy agrees that Payor shall have the right to approve or disapprove Member Pharmacy’s participation status in Payor’s network. Colo. Rev. Stat. § 10-16-706(4).

13. Member Pharmacy agrees that in the event of MedImpact’s insolvency, Payor shall have the right to require the assignment to Payor of the provisions of the Agreement addressing Member Pharmacy’s obligation to furnish Prescription Drug Benefits. Colo. Rev. Stat. § 10-16-706(9).

14. In the event MedImpact makes a material change to the Agreement, as defined by Colorado Revised Statute, section 25-37-102, MedImpact shall provide Member Pharmacy written notice of the proposed change conspicuously entitled “Notice of Material Change to Contract” at least ninety (90) days before the effective date of the change. If Member Pharmacy objects to the change, Member Pharmacy must notify MedImpact in writing of the objection within fifteen (15) days of the date of the notice. If MedImpact and Member Pharmacy are unable to resolve the objection, either party may terminate the Agreement upon written notice of termination provided to the other not later than sixty (60) days before the effective date of the material change. If Member Pharmacy does not object to the material change as provided herein, the change shall be effective as specified in the notice. Colo. Rev. Stat. § 25-37-104.

15. In the event Member Pharmacy timely objects in writing to a notice of material change to the Agreement that seeks to add a new category of coverage, as defined by Colorado Revised Statute, section 25-37-102, the addition of the category of coverage shall not be effective as to Member Pharmacy, and MedImpact shall not terminate the Agreement based on Member Pharmacy’s objection to the addition of the category of coverage. Colo. Rev. Stat. § 25-37-104(4).

16. MedImpact may make an administrative change to the Agreement, as defined by Colorado Revised Statute section 25-37-102, and such change shall be effective upon at least fifteen (15) days’ notice to Member Pharmacy. Colo. Rev. Stat. § 25-37-101(2)(c).

17. The Agreement may be modified by operation of law as required by any applicable state or federal law or regulation and MedImpact may disclose this change by any reasonable means. Colo. Rev. Stat. § 25-37-105.
18. Member Pharmacy acknowledges and agrees that MedImpact may assign, allow access to, sell, rent, or give its rights to Member Pharmacy’s services to (1) Payors providing coverage for Prescription Drug Benefits to their employees or members when such Payors have contracted with MedImpact for the administration or processing of claims for payment or service provided pursuant to the Agreement and (2) affiliates, subsidiaries, or entities under common ownership or control of MedImpact or third parties providing or receiving administrative services from MedImpact or its affiliates, subsidiaries, or entities under common ownership or control with MedImpact. Member Pharmacy acknowledges and agrees that the Agreement applies to network rental arrangements and that it is for the purpose of assigning, allowing access to, selling, renting, or giving MedImpact’s rights to Member Pharmacy’s services. Colo. Rev. Stat. § 25-37-108.

19. Nothing in the Agreement shall be construed or shall operate to require that Member Pharmacy waive or forego any right or benefit to which Member Pharmacy may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person’s status as a health care provider providing services in Colorado. Colo. Rev. Stat. § 25-37-109.

20. Upon sixty (60) days’ written notice to MedImpact that states the reasons therefore, Member Pharmacy may decline to provide services under the Agreement to Eligible Persons that are "new patients." For purposes of this paragraph, "new patients" mean those patients who have not received services from Member Pharmacy in the immediately preceding three years. A patient shall not become a new patient solely by changing coverage from one Payor or Plan to another Payor or Plan. Colo. Rev. Stat. § 25-37-110.

21. The Agreement shall terminate automatically in the event the federal Drug Enforcement Agency or other federal law enforcement agency ceases the operations of the Member Pharmacy or its pharmacist due to alleged or actual criminal activity. Colo. Rev. Stat. § 25-37-111(3).

22. Nothing in the Agreement shall be construed to preclude use or disclosure of the Agreement to a third party for the purpose of enforcing the provisions of Title 25, Article 37 of Colorado Revised Statutes or other state or federal law provided the third party shall be bound by the confidentiality requirements set forth in the Agreement and required by law. Colo. Rev. Stat. § 25-37-112.

23. Consistent with all state and federal statutes and regulations, Member Pharmacy agrees to share medical record information with other participating providers who have treated the same enrollee to facilitate the continuity of health care services. 6 Colo. Code of Reg. 1011-2.

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

MedImpact CO Addendum 12/31/13
CONNECTICUT ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health care center, health maintenance organization, managed care organization ("MCO"), insurer, or carrier licensed under Connecticut law (collectively and/or individually, "Payor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. In no event, including, but not limited to, nonpayment by MedImpact or Payor, insolvency, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Eligible Persons or a person acting on their behalf, other than MedImpact or Payor for Prescription Drug Benefits provided pursuant to the Agreement. This provision shall not prohibit collection of cost-sharing amounts, or costs for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Eligible Persons in accordance with the terms of the Eligible Person’s Plan. C.G.S.A. §§ 38a-193(c)(1), 38a-479aa(l), 38a-479bb(d)(5).

2. In the event of the insolvency of MedImpact or Payor, Member Pharmacy shall continue providing Prescription Drug Benefits for Eligible Persons for the duration of the period for which premium payment has been made to Payor or until Eligible Person’s discharge from inpatient facilities, whichever time is greater. C.G.S.A. § 38a-193(c)(1)(B), (d).

3. Nothing in the Agreement shall be construed to modify the rights and benefits contained in Eligible Person’s Plan. C.G.S.A. § 38a-193(c)(1)(C).

4. Member Pharmacy shall not bill Eligible Person for covered Prescription Drug Benefits, except for cost-sharing amounts, where Payor or MedImpact denies payment because Member Pharmacy has failed to comply with the terms or conditions of the Agreement or the Plan. C.G.S.A. § 38a-193(c)(1)(D).

5. Member Pharmacy further agrees that paragraphs 1 through 4 above shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Payor’s Eligible Persons, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on their behalf. C.G.S.A. § 38a-193(c)(1)(E).

6. If Member Pharmacy contracts with other providers or facilities who agree to provide Prescription Drug Benefits to Eligible Persons of Payor with the expectation of receiving payment directly or indirectly from Payor or MedImpact, such providers or facilities shall agree to abide by paragraphs 1
through 5 above, and Member Pharmacy shall ensure that such agreement is memorialized in writing. C.G.S.A. § 38a-193(c)(1)(F).

7. Member Pharmacy, or an agent, trustee or assignee of Member Pharmacy shall not maintain any action at law against an Eligible Person to collect sums owed by MedImpact or Payor or request payment from an Eligible Person for such sums. For purposes of this section “request payment” includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase “THIS IS NOT A BILL.” Member Pharmacy acknowledges that pursuant section 20-7f, Connecticut General Statutes, it is an unfair trade practice in violation of chapter 735a for Member Pharmacy to request payment from an Eligible Person, other than a copayment or deductible, for covered Prescription Drug Benefits, or to report to a credit reporting agency an enrollee’s failure to pay a bill for medical services when Payor has primary responsibility for payment of such services. C.G.S.A.

8. Member Pharmacy and MedImpact shall each provide the other at least sixty days’ advance notice to terminate or withdraw from the Agreement. This paragraph shall not apply:

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

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

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

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

9. Neither MedImpact nor Payor shall take or threaten to take any action against Member Pharmacy in retaliation for Member Pharmacy’s assistance to an Eligible Person in filing an internal grievance or appealing a utilization review determination. C.G.S.A. § 38a-478(h).

10. Nothing in the Agreement shall be construed as or shall have the effect of prohibiting or limiting any cause of action or contract rights an Eligible Person otherwise has. C.G.S.A. § 38a-478(i).

11. If Payor requires a percentage coinsurance payment by an Eligible Person, the coinsurance payment shall be calculated on the lesser of Member Pharmacy’s charges for the goods or services or the amount payable by Payor for such goods or services, except as otherwise required by the laws of a foreign state when applicable to Member Pharmacy in such foreign state. C.G.S.A. § 38a-478(j).

12. Nothing in the Agreement shall be construed as prohibiting Member Pharmacy from discussing with an Eligible Person any treatment options and services available in or out of network, including experimental treatments, or the
method that MedImpact uses to compensate Member Pharmacy. C.G.S.A. § 38a-478(k).

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

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health service corporations, managed care organizations, health maintenance organizations, and insurers under Delaware law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. MedImpact shall not refuse to contract with or compensate Member Pharmacy for covered Prescription Drug Benefits solely because Member Pharmacy has in good faith communicated with one or more of Member Pharmacy’s current, former or prospective patients regarding the provisions, terms or requirements of Payor’s products or services as they relate to the need of Member Pharmacy’s patients. 18 Del. Code §§ 3339(a), 6415.

2. MedImpact shall provide Member Pharmacy a minimum of sixty (60) days prior written notice of its intent to terminate or not renew the Agreement with Member Pharmacy. The notice shall include a statement of Member Pharmacy’s right to request a written explanation and to request an internal administrative review within twenty (20) days.

This paragraph shall not apply to a decision by MedImpact to terminate or not renew the Agreement with Member Pharmacy because of breach of contract, loss of professional liability insurance, indictment or arrest or conviction for a felony or crime of moral turpitude, final internal disciplinary action (excluding judicial appeals) by a hospital, licensing board or other governmental agency that impairs Member Pharmacy’s ability to practice, failure to meet the minimum requirements for participating in MedImpact’s networks or Payor’s Plans, as previously disclosed to Member Pharmacy, adjudication of fraud, or in cases involving imminent harm to patient care, provided, however, MedImpact shall provide Member Pharmacy with a written explanation of the reasons for the termination or nonrenewal.

Nothing in this paragraph shall be construed to prohibit MedImpact from terminating or not renewing Member Pharmacy’s Agreement with or without cause for economic reasons or any other reason not prohibited by paragraph 1 above. 18 Del. Code § 3339 (b), (f), (g).

3. To the extent that MedImpact requires Member Pharmacy to submit a request for payment electronically, Member Pharmacy may choose to be reimbursed electronically and MedImpact shall within 45 days following such request begin to electronically reimburse Member Pharmacy and shall provide payment data electronically. 18 Del. Code §§ 3359(b), (c). 3579(b), (c).
4. Nothing in the Agreement shall be construed as prohibiting Member Pharmacy from giving its patients information regarding diagnoses, prognoses and treatment options. 18 Del. Code § 6414.

5. MedImpact shall not terminate or in any way penalize Member Pharmacy solely on the basis of Member Pharmacy’s decision to exercise the right to file a Petition for Arbitration with the Delaware Insurance Department. Code of Del. Reg. 18-1300-1313.

6. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a managed care organization under Delaware law, Member Pharmacy agrees that:

   a. In no event, including but not limited to nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of this Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons or a person (other than Payor or MedImpact) acting on behalf of Eligible Persons for services provided pursuant to this Agreement. This Agreement does not prohibit Member Pharmacy from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Eligible Persons. Code Del. Regs. 18 1400 1403 § 7.1.1.1.

   b. In the event of Payor’s or MedImpact’s insolvency or other cessation of operations, Prescription Drug Benefits to Eligible Persons will continue through the period for which a premium has been paid to Payor on behalf of Eligible Persons or until Eligible Person’s discharge from an inpatient facility, whichever time is greater. Prescription Drug Benefits to Eligible Persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Eligible Person’s continued confinement in an inpatient facility is no longer medically necessary. Code Del. Regs. 18 1400 1403 § 7.1.2.

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

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

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

f. MedImpact shall not offer incentives to Member Pharmacy to provide less than medically necessary services to Eligible Persons. Code of Del Reg. 18 1400 1403 §10.1.

g. MedImpact shall not penalize Member Pharmacy because Member Pharmacy, in good faith, reports to State authorities any act or practice by MedImpact or Payor that jeopardizes patient health or welfare. Code of Del Reg. 18 1400 1403 §10.2.
DISTRICT OF COLUMBIA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations and carriers under District of Columbia law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:


c. MedImpact shall not terminate or refuse to contract with Member Pharmacy based in whole or in part on the fact that Member Pharmacy discussed treatment options with an Eligible Person. D.C. Code Ann § 31-3406(h)(3); Code of D.C. Mun. Reg. 26-A3503.12.

d. To the extent Member Pharmacy provides Prescription Drug Benefits to an Eligible Person of a health maintenance organization, Member Pharmacy agrees:

i. In the event MedImpact or Payor fails to pay Member Pharmacy as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by MedImpact or Payor. D.C. Code Ann. § 31-3412(d)(1); Code of D.C. Mun. Reg. 26-A3506.12.


iv. In the event of the insolvency of MedImpact or Payor, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons for the period for which premium payment has been made or until Eligible Persons’ discharge from inpatient facilities, whichever is longer. D.C. Code Ann. § 31-3412(e)(2)(B); Code of D.C. Mun. Reg. 26-A3506.16(b).
v. If Member Pharmacy terminates the Agreement, Member Pharmacy shall give MedImpact at least 60 days advance notice of termination. D.C. Code Ann. § 31-3412(f).
FLORIDA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organization, prepaid limited health service organization, prepaid health clinic, multiple employer healthcare arrangement, insurers, or carriers under Florida law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy shall be required to exhaust internal dispute-resolution processes set forth in the Agreement as a prerequisite to submission of a claim by Member Pharmacy to the statewide provider dispute resolution program pursuant to Florida Statute §408.7057. Fla. Stat. § 408.7057(2)(c).

2. Nothing in the Agreement shall be construed to require Member Pharmacy as a condition of continuation or renewal of the Agreement to participate in and accept the terms of additional provider network agreements beyond those set forth by the Agreement to the extent prohibited by law. Fla. Stat. §§ 627.6474, 636.035(12), 641.315(10).

3. The Agreement shall be canceled upon issuance of an order by the Florida Department of Insurance pursuant to Fla. Statute §§ 624.4411(3), 641.234(3), 636.036(3).

4. Member Pharmacy shall not bill or otherwise seek reimbursement from or recourse against any Eligible Persons, with the exception of any supplemental charges or coinsurance amounts stated in Eligible Persons’ Plan with Payor. Fla. Stat. § 627.6472(4)(e).

5. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Florida law, Member Pharmacy agrees:

   a. Eligible Persons shall not be liable to Member Pharmacy for any services for which Payor is liable, as specified in Florida Statute §§ 641.3154; 641.315(1).

   b. Member Pharmacy shall provide no less than 60 days advance written notice to MedImpact and the Florida Department of Insurance before terminating the Agreement for any reason. Nonpayment for goods or services rendered by Member Pharmacy shall not be a valid reason for avoiding the 60 days advance notice of cancellation. Fla. Stat. § 641.315(2)(a)(1), (2).

   c. MedImpact shall provide 60 days advance written notice to Member Pharmacy and the Florida Department of Insurance before terminating the Agreement, without cause, except where a patient’s health is subject to imminent danger or Member Pharmacy’s ability to practice
is effectively impaired by an action by a governmental agency. Fla. Stat. § 641.315(2)(b).

d. Nothing in the Agreement shall be construed as restricting Member Pharmacy’s ability to communicate information to Member Pharmacy’s patient regarding care or treatment options for the patient when Member Pharmacy deems knowledge of such information by the patient to be in the best interest of the health of the patient. Fla. Stat. § 641.315(5).

e. Nothing in the Agreement shall be construed to prohibit or restrict Member Pharmacy from entering into a commercial contract with any health maintenance organization. Fla. Stat. § 641.315(6).

f. Nothing in the Agreement shall be construed to prohibit or restrict MedImpact or Payor from entering into a commercial contract with any other health care provider. Fla. Stat. § 641.315(6).

6. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a prepaid limited health service organization under Florida law, Member Pharmacy agrees:

   a. In the event MedImpact or Payor fails to pay for Prescription Drug Benefits already rendered to Eligible Persons by Member Pharmacy, Payor is liable for such fees rather than Eligible Persons. Fla. Stat. § 636.035(1).

   b. Eligible Persons shall not be liable to Member Pharmacy for any services covered by Eligible Persons’ Plan with Payor, with the exception of any deductible or copayment which is not covered by Eligible Person’s Plan or for services not authorized by Payor. Fla. Stat. § 636.035(4), (5).

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

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

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

   f. Nothing in the Agreement shall be construed as restricting Member Pharmacy’s ability to communicate information to Member Pharmacy’s patient regarding care or treatment options for the patient when Member Pharmacy deems knowledge of such information by the patient to be in the best interest of the health of the patient. Fla. Stat. § 636.035(10).
g. Nothing in the Agreement shall be construed as restricting Member Pharmacy from entering into or renewing a contract with any prepaid limited health services organization. Fla. Stat. § 636.035(11).

7. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a prepaid health clinic under Florida law, in the event Payor fails to pay for Prescription Drug Benefits already rendered to an Eligible Person by Member Pharmacy, Payor is liable for such fees rather than Eligible Person. Fla. Stat. § 641.43.

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

9. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization or a prepaid health clinic under Florida law, Member Pharmacy agrees:

   a. In the event the Agreement is terminated for any reason other than for cause:

      i. Member Pharmacy shall allow Eligible Persons for whom treatment was active to continue care with Member Pharmacy when medically necessary, through completion of treatment of a condition for which the Eligible Person was receiving care at the time of the termination, until the Eligible Person selects another treating provider, or during the next open enrollment period offered by Payor, whichever is longer, but not longer than six (6) months after termination of the Agreement.

      ii. Member Pharmacy shall allow an Eligible Person who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care until completion of postpartum care.

      iii. During the period of continued care as provided for in this paragraph, Member Pharmacy shall continue to be bound by the terms of the Agreement. Changes made within thirty (30) days before termination of the Agreement shall be effective only if agreed to by MedImpact and Member Pharmacy.

     Fla. Stat. § 641.51(8).

   b. Member Pharmacy shall post a consumer assistance notice, prominently displaying the notice in the reception area of Member Pharmacy so that the notice will be clearly noticeable by all patients. The consumer assistance notice must state that the addresses and toll-free telephone number of Payor’s grievance department shall be provided upon request. Fla. Stat. § 641.511(11).
GEORGIA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Georgia law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

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

2. To the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a Payor offering a preferred provider arrangement under Georgia law, Member Pharmacy agrees that an Eligible Person shall be held harmless for provider utilization review decisions over which he has no control. Ga. Admin. Code Rule 120-2-44-.04(3).

3. To the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a provider sponsored health care corporation under Georgia law, Member Pharmacy agrees:
   a. In the event that Payor or MedImpact fails to pay for Prescription Drug Benefits as set forth in the Plan or the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by Payor or MedImpact;
   b. In the event of the insolvency of Payor or MedImpact, Member Pharmacy shall continue to provide Prescription Drug Benefits as set forth in the Agreement to Eligible Persons who are confined on the date of insolvency in an inpatient facility until the earlier of the Eligible Person’s discharge or expiration of benefits. Ga. Admin. Code Rule 120-2-75-.06(5)-(6).

5. Notwithstanding anything in the Agreement to the contrary, to the extent required by law:

a. Member Pharmacy is not prohibited from contracting with another party to provide services at a lower reimbursement or payment rate than the reimbursement and payment rates set forth in the Agreement;

b. Member Pharmacy is not required to accept a lower reimbursement or payment rate if Member Pharmacy agrees to provide services to another party at a lower reimbursement or payment rate than the reimbursement and payment rates set forth in the Agreement;

c. Member Pharmacy is not required to terminate or renegotiate the Agreement in the event Member Pharmacy agrees to provide services to any other party at a lower reimbursement or payment rate; and
d. Member Pharmacy is not required to disclose its contractual reimbursement or payment rate with other parties.

GA ADC 120-2-20-.03.
HAwAIi AddENdUM
to medcare pharmacy network agreement

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an insurer, nonprofit health service plan, health insurance service organization, managed care plan, health maintenance organization, and organizations entering into preferred provider arrangements under Hawaii law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. In the event that Payor or MedImpact fails to pay for Prescription Drug Benefits, an Eligible Person shall not be liable to Member Pharmacy for any sums owed by Payor or MedImpact. Member Pharmacy shall not collect or attempt to collect from an Eligible Person sums owed by Payor or MedImpact. Member Pharmacy, or its agent, trustee, or assignee shall not maintain any action at law against an Eligible Person to collect sums owed by Payor or MedImpact. Hawaii Rev. Stat. Ann. § 432D-8.

2. In the event of insolvency by Payor or MedImpact, Member Pharmacy agrees to continue to provide services to Eligible Persons for the duration of the period after the insolvency for which premium payment has been made and until an Eligible Person’s discharge from inpatient facilities, whichever is later. Hawaii Rev. Stat. Ann. § 432D-8.


5. Neither MedImpact nor Payor shall impose any type of prohibition, disincentive, penalty, or other negative treatment upon Member Pharmacy for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by Payor. Hawaii Rev. Stat. Ann. § 432E-4.

6. Member Pharmacy shall comply with MedImpact’s and Payors’ requests for any information necessary for Payor to comply with the requirement of Hawaii Statute, Title 24, Chapter 432E, regarding the measurement of quality outcomes, access, satisfaction, and utilization of services. Hawaii Rev. Stat. Ann. § 432E-10.
IDAHO ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health insurer, hospital services corporation, professional service corporation, managed care organization, health maintenance organization, and organizations entering into preferred provider arrangements under Idaho law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy shall not release or sell any information pertaining to prescriptions, drug orders, records or any other prescription information that specifically identifies an Eligible Person, except as authorized under the provisions of Idaho Code section 54-1727 and not otherwise precluded by the Agreement. Idaho Code § 41-1335.

2. Member Pharmacy shall maintain complete and accurate records reflecting transactions with Eligible Persons for at least seven (7) years. Member Pharmacy shall make all records available to MedImpact, Payor, and the director of the Idaho Department of Insurance or his designee at all reasonable times upon request, subject to any Idaho law limiting or defining such availability. Idaho Code § 41-3909.

3. Neither MedImpact nor Payor shall make a specific payment under this Agreement, in any type or form, to Member Pharmacy as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate Prescription Drug Benefits provided with respect to a specific Eligible Person or group of Eligible Persons with similar medical conditions. Idaho Code §§ 41-1846(1)(f), 41-3928.

4. Member Pharmacy agrees that in no event, including but not limited to nonpayment by Payor or MedImpact shall Member Pharmacy require an Eligible Person to make payments for Prescription Drug Benefits other than specified deductibles, copayments or coinsurance. Idaho Code §§ 41-1846(2), 41-3915(4)-(5).

5. To the extent prohibited by law, MedImpact shall not assign the benefits of the Agreement with Member Pharmacy except as specifically provided for by the Agreement. In the event MedImpact makes an assignment, MedImpact shall comply with the notice provisions of the Agreement and shall include in the notice the name and principal business address of each assignee. Idaho Code § 41-1847(1)-(2).

6. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a hospital or professional service corporation under Idaho law, Member Pharmacy agrees:
a. If MedImpact or Payor proposes to terminate or not renew the Agreement based on Member Pharmacy's breach of the Agreement, MedImpact or Payor shall provide Member Pharmacy written notice identifying the breach and providing a reasonable period of time for Member Pharmacy to cure the breach prior to termination or nonrenewal. If the breach has not been cured within the time period stated, MedImpact or Payor may terminate or not renew the Agreement. Provided, however, that if the breach for which MedImpact or Payor proposes to terminate or not renew the Agreement is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, MedImpact or Payor may terminate or not renew the Agreement immediately. Idaho Code § 41-3408(5).

b. Member Pharmacy shall provide Eligible Persons with Prescription Drug Benefits and Member Pharmacy's obligation to so furnish such Prescription Drug Benefits as provided for in the Plan, shall be a direct obligation of Member Pharmacy to Eligible Persons, MedImpact, and Payor. Idaho Code §41-3415A(1).

c. Member Pharmacy shall be compensated as set forth in the Agreement and the attachments thereto. Member Pharmacy shall not request or receive from MedImpact, Payor, or Eligible Persons any compensation for Prescription Drug Benefits which is not in accord with the Agreement. Idaho Code § 41-3415A(2)(a).

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

e. If Member Pharmacy terminates the Agreement, the termination shall not be effective as to any Eligible Person enrolled in a Plan in force on the date of such termination and Member Pharmacy shall continue to provide Prescription Drug Benefits pursuant to the Agreement until the termination of Eligible Person’s Plan or the next following anniversary of Eligible Person’s Plan, whichever date is earlier. Idaho Code § 41-3415A(2)(c).

f. The Agreement may be filed with the Idaho Director of Insurance and subject to his or her approval as provided in Section 41-3419, Idaho Code. Idaho Code § 41-3415A(3).

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

8. The Agreement shall not limit Member Pharmacy’s ability to treat an Eligible Person even at that person’s request and expense if Member Pharmacy had been, but is no longer, a participating Member Pharmacy under the Plan and Member Pharmacy has notified the Eligible Person that Member Pharmacy is no longer a participating Member Pharmacy under the Plan. Idaho Code § 41-3927(4)(b).
9. Notwithstanding anything in the Agreement, Member Pharmacy shall not be required to accept the unnegotiated adjustment by MedImpact or Payor of Member Pharmacy’s contractual reimbursement rate to equal the lowest reimbursement rate Member Pharmacy has agreed to charge any other payor. Idaho Code §§ 41-3927(4)(c), 41-3443.

10. Notwithstanding anything in the Agreement, Member Pharmacy shall not be required to adjust, or enter into negotiations to adjust, its charges to MedImpact or Payor if Member Pharmacy agrees to charge another payor lower rates. Idaho Code §§ 41-3927(4)(d), 41-3443.

11. Member Pharmacy shall not be required to disclose its contractual reimbursement rates from other payors. Idaho Code §§ 41-3927(4), 41-3443.

12. Neither MedImpact nor Payor shall refuse to contract with Member Pharmacy or reimburse Member Pharmacy solely because Member Pharmacy has in good faith communicated with one or more current, former, or prospective patients regarding the provisions, terms or requirements of Payors’ Plans as they relate to the needs of Member Pharmacy’s patients. Idaho Code § 41-3927(5).

13. MedImpact or Payor shall provide written notice to Member Pharmacy setting forth any breach of the Agreement for which MedImpact or Payor proposes that the Agreement be terminated or not renewed and shall provide for a reasonable period of time for Member Pharmacy to cure such breach prior to termination or nonrenewal; provided, however, that if the breach of Agreement is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the Agreement may be terminated or not renewed by MedImpact or Payor immediately. Idaho Code § 41-3927(2).

14. Neither MedImpact nor Payor shall terminate or otherwise penalize Member Pharmacy solely because Member Pharmacy advocates for Member Pharmacy’s patients, so long as Member Pharmacy is practicing in conformity with community standards. Idaho Code § 41-3927(8).

15. To the extent the Agreement requires Member Pharmacy to indemnify and hold harmless a managed care organization Payor under certain circumstances, to the extent required by law, such indemnification applies so long as the managed care organization payor also agrees to indemnify and hold harmless the provider under comparable circumstances. Idaho Code § 41-3927(6).

16. Member Pharmacy shall not charge or collect from any Eligible Person any amount in excess of that amount of compensation determined or allowed for a particular service by Payor or MedImpact. Nothing in this paragraph shall be construed to prevent the collection of any copayments, coinsurance or deductibles allowed for in the Plan design. Idaho Admin. Code 18.01.26.015.

17. Member Pharmacy shall not pay another for the referral of an Eligible Person to Member Pharmacy. Member Pharmacy shall not provide or
claim or represent to have provided services to an Eligible Person, knowing that the Eligible Person was referred in violation of this paragraph. Idaho Code § 41-348.

18. Member Pharmacy shall not engage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give or pay all or part of an Eligible Person’s deductible or claim for health insurance. Idaho Code § 41-348.
ILLINOIS ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Illinois law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees to participate in the quality assurance programs instituted by MedImpact and Payors. 215 ILCS 125/2-8(b) and 215 ILCS 130/2008(b); 50 Ill. Admin. Code § 5421.50(4).

2. Member Pharmacy agrees that in no event including, but not limited to, nonpayment by MedImpact and/or Payor of amounts due Member Pharmacy under the Agreement, insolvency of MedImpact and/or Payor or any breach of the Agreement, shall Member Pharmacy or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from or have any recourse against the Eligible Person, persons acting on the Eligible Person’s behalf (other than MedImpact or Payor), the employer or group contract holder for services provided pursuant to the Agreement except for the payment of applicable copayments for services covered by Payor or fees for services not covered by Payor. The requirements of this clause shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Payors’ Eligible Persons shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between Member Pharmacy and an Eligible Person or persons acting on the Eligible Person’s behalf (other than MedImpact or Payor). 215 ILCS 130/2008(a).

3. Nothing in the Agreement shall be construed to prohibit or discourage Member Pharmacy from discussing any health care services and health care providers, utilization review and quality assurance policies, terms and conditions of Plan and Plan policy with Eligible Persons, prospective Eligible Persons, providers, or the public. 215 ILCS 134/30.

4. Nothing in the Agreement shall be construed as permitting or allowing Member Pharmacy to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act. 215 ILCS 134/30.

5. MedImpact shall not retaliate against Member Pharmacy based on Member Pharmacy advocating for appropriate health care services for patients. For purposes of this paragraph, “advocating for medically appropriate health care...
services” means to appeal a decision to deny payment for a health care service pursuant to the reasonable grievance or appeal procedure established by MedImpact and/or Plan or to protest a decision, policy, or practice that Member Pharmacy, consistent with that degree of learning and skill ordinarily possessed by other pharmacy providers practicing in the same or similar locality and under similar circumstances, reasonably believes impairs the provider’s ability to provide appropriate health care services to his or her patients. 215 ILCS 134/35.

6. MedImpact shall not take future contractual action regarding Member Pharmacy based solely on Member Pharmacy’s participation in health care services appeals, complaints, or external independent reviews under the Illinois Health Carrier External Review Act. 215 ILCS 134/45.

7. Nothing in the Agreement shall be construed in a manner so as to discriminate against Member Pharmacy. 215 ILCS 134/72.

8. Notwithstanding anything to the contrary in the Agreement, liability relating to the activities, actions, or omissions of MedImpact, Payor and/or their officer, employees, or agents shall not be transferred to Member Pharmacy by indemnification, hold harmless provisions, or otherwise. Nothing in this paragraph shall relieve Member Pharmacy from liability for its own negligence in the performance of its duties arising from treatment of a patient. 215 ILCS 134/95.

9. MedImpact shall give Member Pharmacy at least sixty (60) days’ notice of nonrenewal or termination of Member Pharmacy. The notice shall include a name and address to which Member Pharmacy may direct comments and concerns regarding the nonrenewal or termination. However, immediate written notice may be provided without sixty (60) days’ notice when Member Pharmacy’s license has been disciplined by a state licensing board. 215 ILCS 134/20; 50 Ill. Admin. Code §§ 2051.290(f), 5420.50(b). MedImpact may terminate the Agreement immediately for cause. 50 Ill. Admin. Code § 2051.290(f)(2).

10. Member Pharmacy shall give MedImpact at least sixty (60) days’ notice for termination with cause, as defined in the Agreement, and at least ninety (90) days’ notice for termination without cause. 50 Ill. Admin. Code §§ 2051.290(f), 5420.50(a), 5421.50(a)(5).

11. Member Pharmacy must maintain and provide evidence of adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to MedImpact, effective as of the date of the Agreement. Member Pharmacy must give MedImpact at least fifteen (15) days advance notice of cancellation of such coverage and must notify MedImpact within no less than ten (10) days after Member Pharmacy’s receipt of notice of any reduction or cancellation of the required coverage. 50 Ill. Admin. Code §§ 2051.290(i), 5421.50(a)(7).

12. Member Pharmacy shall be responsible for providing Prescription Drug Benefits as set forth in the Agreement, including the application of discount services, copayments, benefit maximums, limitations and exclusions, and discounted amounts or rates as further set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(a).
13. Member Pharmacy agrees to comply with all administrative policies and procedures of MedImpact and Payor, including, but not limited to, credentialing or recredentialing requirements, utilization review requirements, and referral procedures. 50 Ill. Admin Code § 2051.290(b).

14. Member Pharmacy shall maintain and make medical records available to MedImpact and/or Payor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Eligible Persons, and to make such medical records available to appropriate state and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating grievances or complaints and to show compliance with the applicable state and federal laws related to privacy and confidentiality of medical records. 50 Ill. Admin Code § 2051.290(c).

15. Member Pharmacy shall be licensed by the State of Illinois to provide Prescription Drug Benefit Services and shall notify MedImpact immediately whenever there is a change in licensure or certification status. 50 Ill. Admin. Code § 2051.290(d).

16. Upon the termination of the Agreement, Member Pharmacy shall be responsible for continuation of Prescription Drug Benefits to the extent required by law or regulation or as otherwise set forth in the Agreement. 50 Ill. Admin. Code § 2051.290(g).

17. Neither MedImpact nor Member Pharmacy shall sell, lease, assign or otherwise delegate the rights and responsibilities under the Agreement without the prior written and informed consent of the other party. Member Pharmacy’s written consent must also be obtained for any assignment or assumption of the Agreement in the event that MedImpact is bought by another administrator or insurer. Member Pharmacy hereby gives its consent to such assignment or assumption of the Agreement. 50 Ill. Admin. Code § 2051.290(h).

18. Member Pharmacy shall provide Prescription Drug Benefits without discrimination against any Eligible Person on the basis of participation in the Plan, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability. 50 Ill. Admin. Code § 2051.290(j).

19. Member Pharmacy shall collect all applicable copayments, coinsurance and/or deductibles from Eligible Persons, and shall provide notice to Eligible Persons of their personal financial obligations for services that are not covered. Member Pharmacy’s rates for providing Prescription Drug Benefits to Eligible Persons shall be in accordance with the Agreement. Member Pharmacy shall not charge Eligible Persons more than the discounted rates provided by the Agreement for Prescription Drug Benefits. 50 Ill. Admin. Code § 2051.290(k).

20. Member Pharmacy shall comply with Payors’ requirements regarding operating hours and availability. 50 Ill. Admin. Code § 2051.290(l).

21. MedImpact’s payment obligations to Member Pharmacy, including the method and amount of reimbursement and the frequency of payment, shall be as set
forth in the Agreement, and any attachments thereto. 215 ILCS 5/512-7(a); 50 Ill. Admin. Code § 2051.290(m).

22. MedImpact’s services, the types of information that will be submitted to Member Pharmacy, and the types of information that will be accessible to the Member Pharmacy shall be as set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(n).

23. MedImpact shall provide a method for Member Pharmacy to obtain each Payor’s initial information and adequate notice of change in benefits and copayments. MedImpact shall provide Member Pharmacy with all of MedImpact’s operational policies, which may be included in the attachments to the Agreement. 50 Ill. Admin. Code § 2051.290(o).

24. Internal appeal or arbitration procedures for settling contractual disputes or disagreements between MedImpact and Member Pharmacy shall be as set forth in the Agreement, and any attachments thereto. 50 Ill. Admin. Code § 2051.290(p).
INDIANA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, health maintenance organizations ("HMOs), limited service HMOs, or preferred provider organizations under Indiana law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees to participate in audits as set forth in the Agreement. To the extent of a direct conflict between the audit provisions in the Agreement and those provided by Indiana Code Title 25, Article 26, Chapter 22, the provisions of Chapter 22 shall control. Ind. Code §§ 25-26-22-5 et seq.

2. Member Pharmacy acknowledges and agrees that MedImpact may lease, rent, or otherwise grant access to Member Pharmacy’s services under the Agreement to third parties that are (1) employers or entities providing coverage for Prescription Drug Benefits to their employees or members when such employers and/or entities have contracted with MedImpact or its affiliate for the administration or processing of claims for payment or service provided under the Agreement and (2) affiliates or subsidiaries of MedImpact or entities providing or receiving administrative services from MedImpact or its affiliates or subsidiaries. Any such third party that is granted access to Member Pharmacy’s services under the Agreement shall be obligated to comply with the applicable terms of the Agreement. Member Pharmacy further acknowledges and agrees that contemporaneously with the execution of the Agreement, MedImpact has identified to Member Pharmacy those third parties known at the time of contracting to which MedImpact will grant access to Member Pharmacy’s services. Ind. Code §§ 27-1-37.3-7, 27-1-37.3-8.


4. Nothing in the Agreement shall be construed to prevent Member Pharmacy from disclosing all treatment options available to an Eligible Person, including those not covered by Payors’ Plan(s). Ind. Code §§ 27-8-11-4.5(a)(2); 27-13-15-1(a)(1)(2)(B).

5. MedImpact shall not penalize Member Pharmacy financially, or in any other manner, for making a disclosure permitted under paragraphs 4 and 5 of this Regulatory Addendum. Ind. Code §§ 27-8-11-4.5(b); 27-13-15-1(a)(3).

6. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be (1) prohibited from contracting with other payors to accept lower payment for Prescription Drug Benefits than the payment
specified in the Agreement; (2) required to accept a lower payment under the Agreement if Member Pharmacy agrees with another payor to accept lower payment for Prescription Drug Benefits; (3) subject to termination or renegotiation of the Agreement if Member Pharmacy agrees with another payor to accept lower payment for Prescription Drug Benefits; or (4) required to disclose Member Pharmacy’s reimbursement rates under contracts with other payors. Ind. Code §§ 27-8-11-9, 27-13-15-4.

7. In the event Payor or MedImpact fails to pay for Prescription Drug Benefits for any reason, including insolvency or breach of the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by Payor or MedImpact. This provision does not prohibit the collection of copayments or uncovered charges consented to by Eligible Persons. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-1(a)(4); 27-13-34-15.

8. Member Pharmacy or its trustee, agent, representative, or assignee shall not bring or maintain a legal action against an Eligible Person to collect sums owed to Member Pharmacy by Payor or MedImpact. If Member Pharmacy brings or maintains a legal action against an Eligible Person for an amount owed to Member Pharmacy by Payor or MedImpact, Member Pharmacy shall be liable to the Eligible Person for costs and attorney’s fees incurred by the Eligible Person in defending the action. This provision does not prohibit the collection of copayments or uncovered charges consented to by the Eligible Person. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-3(a); 27-13-34-15.

9. In the event of termination of the Agreement, Member Pharmacy shall, for a period not to exceed ninety (90) days, complete procedures in progress on Eligible Persons receiving treatment for a specific condition at the same schedule of copayment or other applicable charge in effect on the date the Agreement terminates. Ind. Code § 27-13-34-15(6).

10. Any amendment to the provisions set forth in paragraphs 8 through 10 of this Regulatory Addendum must be submitted to and approved by the Indiana Commissioner of Insurance before it becomes effective. Ind. Code § 27-13-34-15(7).

11. Member Pharmacy shall give MedImpact at least sixty (60) days advance notice before terminating the Agreement unless Member Pharmacy provides thirty percent (30%) or more of an HMO Payor’s services, in which case Member Pharmacy must give at least one hundred twenty (120) days advance notice. Ind. Code § 27-13-17-1.

12. In the event of termination of the Agreement, for reasons other than quality of care, Member Pharmacy shall, upon request, continue to treat Eligible Persons for up to sixty (60) days following termination or, in the case of an Eligible Person in the third trimester of pregnancy, throughout the term of the pregnancy. During this continuation period, Member Pharmacy shall accept the terms and conditions of the Agreement, together with applicable deductibles and copayments, as payment in full. Member Pharmacy is prohibited from billing Eligible Persons for any amount in excess of the Eligible Person’s applicable deductible or copayment for treatment given during this continuation period. Ind. Code § 27-13-36-6.
13. Nothing in the Agreement shall be construed to require Member Pharmacy to substitute a different single source brand name drug for a single source brand name drug written on a prescription form or electronically transmitted to Member Pharmacy unless the substitution is approved by the prescribing provider. Ind. Code §27-13-38-2.
IOWA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Iowa law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be responsible for recordkeeping that is more stringent than that required by state or federal law or regulation. Iowa Code §510B.7(1).

2. Notwithstanding anything to the contrary in the Agreement, an audit of Member Pharmacy shall be conducted in accordance with Section 191-59.6, Iowa Administrative Code Iowa Admin. Code § 191-59.6.

3. The Agreement shall not be terminated, nor shall Member Pharmacy be penalized (a) solely because Member Pharmacy filed a complaint, grievance or appeal, (b) because of any disagreement with MedImpact’s or Payor’s decision to deny or limit benefits to Eligible Persons, or (c) due to any assistance provided to Eligible Persons by Member Pharmacy in obtaining reconsideration of a decision by MedImpact or Payor. Iowa Admin. Code § 191-59.7(1), (2).

4. Notwithstanding anything to the contrary in the Agreement, and subject to paragraphs (6) and (7) below, the parties must provide at least sixty (60) days prior written notice before terminating the Agreement; provided, however, in the event MedImpact has evidence that Member Pharmacy has engaged in fraudulent conduct or poses a significant risk to patient care or safety, MedImpact may immediately suspend Member Pharmacy from further performance under the Agreement upon written notice of termination. Iowa Admin. Code § 191-59.7(3), (4).

5. In the event that MedImpact terminates the Agreement with Member Pharmacy, Member Pharmacy nonetheless agrees to continue to provide Prescription Drug Benefits to Eligible Persons in their second or third trimester of pregnancy through postpartum care related to the childbirth and delivery. Payment for Prescription Drug Benefits shall be according to the terms and conditions of the Agreement. Notwithstanding the above, if MedImpact terminates Member Pharmacy for cause, MedImpact shall not be obligated to reimburse Member Pharmacy for Prescription Drug Benefits provided following the date of termination. Iowa Code § 514C.14(1), (3).

6. In the event that MedImpact terminates the Agreement with Member Pharmacy, Member Pharmacy nonetheless agrees to continue to provide
Prescription Drug Benefits for a period of up to ninety (90) days to Eligible Persons who are undergoing a specified course of treatment for a terminal illness or a related condition. Payment for Prescription Drug Benefits shall be according to the terms and conditions of the Agreement. Notwithstanding the above, if MedImpact terminates Member Pharmacy for cause, MedImpact shall not be obligated to reimburse Member Pharmacy for Prescription Drug Benefits following the date of termination. Iowa Code § 514C.17(1), (3).

7. Nothing in the Agreement shall be construed to either: (1) penalize or otherwise reduce or limit Member pharmacy’s reimbursement because Member Pharmacy provides contraceptive services; or (2) provide incentives, monetary or otherwise, to Member Pharmacy to induce Member Pharmacy to withhold from an Eligible Person contraceptive drugs or devices, or contraceptive services. Iowa Code §510B.7(1).

8. Nothing in the Agreement shall be construed as prohibiting or penalizing Member Pharmacy from either: (i) discussing treatment options with an Eligible Person, notwithstanding Payor’s position on such treatment option; (ii) advocating on behalf of an Eligible Person within the review or grievance process established by Payor or MedImpact; or (iii) reporting to state or federal authorities any act or practice by Payor that, in the opinion of Member Pharmacy, jeopardizes patient health or welfare. Iowa Code § 514C.15; Iowa Admin. Code §§ 191-35.20(6) (509A); 191-35.32 (514C); 191-40.22 (514B); 191-41.20 (514B); 191-71.20 (514C); 191-75.13 (514C).

9. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization or a limited service organization under Iowa law, Member Pharmacy agrees as follows:

   a. Member Pharmacy, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Payor, Payor’s insolvency, or breach of this Agreement, shall Member Pharmacy, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Person or persons other than Payor acting on their behalf for Prescription Drug Benefits pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Payor’s behalf made in accordance with the terms of the agreement between Payor and the Eligible Person. Iowa Admin. Code §§ 191-40.18 (514B); 191-41.16 (514B).

   b. Member Pharmacy, or its assignee or subcontractor, further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Eligible Person and that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and the Eligible Person or persons acting on their behalf. Iowa Admin. Code § 191-40.18 (514B); 191-41.16 (514B).
This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, health maintenance organizations, nonprofit medical and hospital service corporations, or preferred provider organizations under Kansas law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a nonprofit medical and hospital service corporation, Member Pharmacy agrees:
   a. The Agreement constitutes a direct obligation of Member Pharmacy to Eligible Persons; and
   b. Nothing in the Agreement shall be construed to impose upon Member Pharmacy any obligation or liability for any act, omission or default of any other participating health care providers or hospitals or of MedImpact or Payor. Kan. Stat. Ann. § 40-19c04.

2. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of HMOs and Medicare Provider Organizations, if there is valid Medicaid coverage providing benefits for Prescription Drug Benefits, the Medicaid coverage shall be the source of last resort of any payment to Member Pharmacy. Kan. Stat. Ann. § 40-3208(b).

3. Nothing in the Agreement shall be construed to require Eligible Persons to guarantee payment to Member Pharmacy, other than copayments and deductibles, in the event of nonpayment by Payor or MedImpact for Prescription Drug Benefits performed under the Agreement. If Payor or MedImpact fails to pay for Prescription Drug Benefits as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any amounts owed by Payor or MedImpact. Any action by Member Pharmacy to collect or attempt to collect from an Eligible Person any sum owed by Payor or MedImpact to Member Pharmacy is expressly prohibited. Kan. Stat. Ann. § 40-3209(b).

4. In the event of the insolvency of Payor or MedImpact, Member Pharmacy shall continue providing Prescription Drug Benefits to Eligible Persons for the period of time for which premiums have been paid to Payor by an Eligible Person and, with respect to Eligible Persons who are confined to an inpatient facility, until their discharge or expiration of benefits. Kan. Stat. Ann. § 40-3227(k)(2).

5. Where Member Pharmacy is responsible for obtaining prior authorization before receiving payment for the treatment of emergency medical
conditions and an Eligible Person is eligible at the time when Prescription Drug Benefits are provided, Member Pharmacy shall not hold Eligible Person responsible for payment for Prescription Drug Benefits if prior authorization for emergency services has not been sought and received, other than for what Eligible Person would otherwise be responsible, such as copayments and deductibles. Kan. Stat. Ann. § 40-3229(c).

6. If Member Pharmacy’s participation under the Agreement is terminated for any reason, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons for a period up to 90 days in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the Eligible Person has special circumstances such as a disability, a life threatening illness, or is in the third trimester of pregnancy. Eligible Persons shall not be liable to Member Pharmacy for Prescription Drug Benefits during this continuation period other than for any deductibles or copayment amounts specified in the certificate of coverage or other contract between Eligible Persons and Payor. Member Pharmacy shall be entitled to payment for Prescription Drug Benefits during this continuation period at the rate specified in the Agreement. Kan. Stat. Ann. § 40-3230.

7. Member Pharmacy may discuss with or disclose to any Eligible Person or other individual any medically appropriate health care information that Member Pharmacy deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by Payor or MedImpact to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of Eligible Person within the utilization review or grievance processes established by Payor or MedImpact. Kan. Stat. Ann. § 40-4604.

8. Nothing in the Agreement shall directly or indirectly provide an inducement to Member Pharmacy to reduce or limit the delivery of medically necessary services with respect to an Eligible Person. Kan. Stat. Ann. § 40-4605.

9. Notwithstanding anything to the contrary in the Agreement, audits of Member Pharmacy shall be conducted in accordance with the Kansas Pharmacy Audit Integrity Act and applicable Kansas law. Kan. Stat. Ann. §§ 40-2442 and 65-16,121 et seq.
KENTUCKY ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an accident or health insurer, nonprofit hospital services corporation, nonprofit medical service corporation, health maintenance organization, and organizations entering into preferred provider arrangements under Kentucky law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy may not, under any circumstance, including nonpayment of moneys due Member Pharmacy by Payor and/or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, bill charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Eligible Persons, or any persons acting on their behalf, for services provided in accordance with the Agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for services that are not covered. This provision shall survive the termination of the Agreement. Ky. Rev. Stat. Ann. §§ 304.17A-254(2); 304.17A-527(1)(a), (c); 304.17A-310(5); 304.17C-060(1)(a), (b); 806 KAR 17:300 (Section 3); 806 KAR 17:440 (Section 3).

2. In the event the Agreement is terminated for any reason, other than a quality of care issue or fraud, Member Pharmacy shall continue to provide services and MedImpact shall continue to reimburse Member Pharmacy in accordance with the Agreement until the Eligible Person is discharged from an inpatient facility, or the active course of treatment is completed, whichever is greater. In the case of a pregnant woman, Member Pharmacy shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement terminates. This provision shall survive termination of the agreement. Ky. Rev. Stat. Ann. § 304.17A-527(1)(b)-(c); 806 KAR 17:300 (Section 3).

3. In the event of the insolvency of Payor or MedImpact, Member Pharmacy shall continue providing Prescription Drug Benefit Services to Eligible Persons for the duration of the contract period for which premiums have been paid or until the date of discharge from an inpatient facility, whichever is longer. Ky. Rev. Stat. Ann. § 304.17A-310(6).

4. Upon written request, MedImpact shall provide or make available to Member Pharmacy, when contracting or renewing an existing contract with Member Pharmacy, the payment or fee schedules or other information sufficient to enable Member Pharmacy to determine the manner and amount of payments for Member Pharmacy’s services under
the Agreement prior to the final execution or renewal of the contract and
shall provide Member Pharmacy any change in such payment or fee
schedules at least ninety (90) days prior to the effective date of the
304.17A-577; 806 KAR 17:300 (Section 3).

5. MedImpact shall not discriminate against Member Pharmacy or any
provider who is located within the geographic area of Payors’ Plans and is
willing to meet the terms and conditions for participation established by

6. Member Pharmacy acknowledges that MedImpact allows all providers who
desire to apply for participation with MedImpact and/or Payors an
opportunity to apply at any time during the year, or with respect to those
Payors that do not conduct open continuous provider enrollment, allowing
for a provider enrollment period at least annually with the date publicized
to providers located in the geographic service area of the applicable Plan
at least thirty (30) days in advance of the enrollment period. Kan. Rev.

7. If Member Pharmacy enters into any subcontract agreement with another
provider to provide Prescription Benefit Services to Eligible Persons where
the subcontracted provider will bill MedImpact or Eligible Persons directly
for the subcontracted services, the subcontract agreement must meet all
requirements of Title XXV, Chapter 304, Subtitle 17A of the Kentucky
Insurance Code and be filed with the Kentucky Commissioner of
060(1)(c); 806 KAR 17:300 (Section 3); 806 KAR 17:440 (Section 3).

8. The reimbursement rate identified in the Member Pharmacy Agreement
shall apply to all Prescription Drug Benefit Services rendered by Member
728; 806 KAR 17-300 (Section 3).

9. Nothing in the Agreement shall be construed to limit Member Pharmacy’s
disclosure to an Eligible Person, or to another person on behalf of an
Eligible Person, any information relating to the Eligible Person’s medical
304.17A-530(1); 304.17C-070(1); 806 KAR 17:300 (Section 3); 806 KAR
17:440 (Section 3).

10. Neither MedImpact nor Payor shall penalize Member Pharmacy or
terminate Member Pharmacy’s contract because Member Pharmacy
discusses medically necessary or appropriate care with an Eligible Person
or another person on behalf of an Eligible Person. Neither MedImpact nor
Payor shall prohibit Member Pharmacy from discussing all treatment
options with Eligible Persons. Member Pharmacy may disclose to Eligible
Persons or to another person on behalf of an Eligible Person, all
information determined by Member Pharmacy to be in the best interests of
304.17A-530(2); 304.17C-070(2); 806 KAR 17:300 (Section 3); 806 KAR
17:440 (Section 3).
11. Neither MedImpact nor Payor shall penalize Member Pharmacy for discussing financial incentives and financial arrangements between Member Pharmacy and MedImpact with an Eligible Person. Ky. Rev. Stat. Ann. §§ 304.17A-530(3); 304.17C-070(3); 806 KAR 17:300 (Section 3); 806 KAR 17:440 (Section 3).

12. Notwithstanding anything to the contrary in the Agreement Member Pharmacy shall not be subject to a most-favored-nation provision; provided, however, that nothing in this paragraph shall be construed to prohibit MedImpact and Member Pharmacy from negotiating payment rates and performance-based contract terms that would result in MedImpact receiving a rate that is as favorable, or more favorable, than the rates negotiated between Member Pharmacy and other payors. Ky. Rev. Stat. Ann. §§ 304.17A-560; 806 KAR 17:300 (Section 3).

13. Nothing in the Agreement shall require Member Pharmacy, as a condition of participation in a health benefit plan of a Payor, to participate in any of the Payor’s other health benefit plans. Ky. Rev. Stat. Ann. § 304.17A-150(4); 806 KAR 17:300 (Section 3).


15. To the extent the Agreement requires Member Pharmacy to submit claims electronically, payment shall be made electronically, if requested by Member Pharmacy, for clean claims submitted electronically in the form required by MedImpact and/or Payor if Member Pharmacy agrees to accept claims details for these payments electronically and provides accurate electronic funds transfer information to MedImpact and the claims comply with 45 CFR Part 142. Ky. Rev. Stat. Ann. § 304-17A-705.


17. The Addendum and Agreement shall be governed by Kentucky law. 806 KAR 17:440 (Section 3).

18. Nothing in the Agreement shall be construed to require Member Pharmacy to provide Eligible Persons services that are not covered Prescription Drug Benefits at a fee set by or subject to the approval of MedImpact or Payor. Ky. Rev. Stat. Ann. § 304.17C-085.


20. To the extent applicable and required by Ky. Rev. Stat. Ann. § 304.17A-1 and 2, the following shall apply with respect to MedImpact’s MAC lists:
a. The national drug pricing compendia and/or sources used to obtain drug price data utilized by MedImpact in establishing maximum allowable cost pricing are identified on the MedImpact MAC lists.

b. MedImpact’s MAC lists are available to Kentucky Member Pharmacies subject to such MAC lists. Kentucky Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s MAC lists.

c. Pricing on MedImpact’s MAC lists may be updated daily, but in all cases at least every fourteen (14) days.

d. MedImpact MAC lists, which are updated at least weekly, are available to Kentucky Member Pharmacies online 24/7, 365 days a year (except for scheduled maintenance) through the Pharmacy Verification Network (PVN) at www.pharmacyverification.com. Kentucky Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s MAC lists through PVN.

e. Kentucky Member Pharmacies subject to MedImpact MAC lists may appeal a maximum allowable cost for a specific drug or drugs on MedImpact’s MAC lists as follows:

   i. Member Pharmacy must initiate the appeal within sixty (60) days following the initial claim by submitting an email to mac@medimpact.com, detailing the challenge to the MedImpact maximum allowable cost, along with supporting information and/or documentation.

   ii. MedImpact will investigate and resolve the appeal within ten (10) days.

      1. If the appeal is denied, MedImpact will provide the reason for the denial and identify the NDC of a drug product that may be purchased by pharmacies at a price at or below the maximum allowable cost.

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

f. This Section 20 applies only with respect to MAC lists owned and/or controlled by MedImpact.

21. MedImpact’s MAC Lists are CONFIDENTIAL AND PROPRIETARY to MedImpact and contain material MedImpact may consider Trade Secrets. By providing Kentucky Member Pharmacies access to the MedImpact MAC lists hereunder, they are being provided for specified use by the Kentucky Member Pharmacy and may not otherwise be used, reproduced, transmitted, published, or disclosed to others without prior written authorization from MedImpact. MedImpact maintains the sole and exclusive ownership, right, title, and interest in and to its MAC lists. Without limiting the generality of the foregoing, Kentucky Member Pharmacies shall not attempt to replicate the information contained in the
MedImpact MAC lists and shall not use the information contained therein in a manner that places MedImpact at a commercial disadvantage. Kentucky Member Pharmacies shall allow only designated individuals who agree to the confidentiality protections herein to have access to the information in the MedImpact MAC lists.
LOUISIANA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health insurer, health maintenance organization (“HMO”), managed care organization, and preferred provider organizations under Louisiana law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy may communicate with patients regarding their health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. Member Pharmacy shall not, however, solicit alternative coverage arrangements for the primary purpose of securing financial gain. La. Stat. Ann – Rev. Stat. § 22:1007(B).

2. Member Pharmacy may make medical communications without retaliatory action by MedImpact or Payor. Neither MedImpact nor Payor shall refuse to contract, renew, cancel, restrict or otherwise terminate the Agreement with Member Pharmacy; refuse to refer patients to or allow others to refer patients to Member Pharmacy, refuse to compensate Member Pharmacy for Prescription Drug Benefits, or take other retaliatory action against Member Pharmacy based on medical communications. As used in this section, medical communications means information regarding the mental or physical health care needs or the treatment of a patient. La. Stat. Ann – Rev. Stat. § 22:1007(C).


4. Neither MedImpact nor Payor shall prohibit or restrict Member Pharmacy from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of Payor or MedImpact which may negatively impact upon the quality of, or access to, patient care. La. Stat. Ann – Rev. Stat. § 22:1007(E).


7. No provision of the Agreement shall operate to provide an incentive or specific payment made directly, in any form, to Member Pharmacy as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific Eligible Person or groups of Eligible Persons with similar medical conditions. La. Stat. Ann – Rev. Stat. § 22:263(E); La. Admin. Code tit. 37, § XIII.5307(A)(3).

8. In the event an HMO Payor fails to pay for Prescription Drug Benefits as set forth in the evidence of coverage, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by HMO Payor to Member Pharmacy. Neither Member Pharmacy, its agents, trustee, nor assignee may maintain an action at law against an Eligible Person of an HMO Payor to collect sums owed by the HMO Payor. La. Stat. Ann – Rev. Stat. § 22:263(A)(1) and (C).


MAINE ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization, insurer or carrier licensed under Maine law (collectively and/or individually, “Payor”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. In the event that MedImpact or Payor fails to pay for Prescription Drug Benefits as set forth in the Agreement, the Eligible Person may not be held liable to Member Pharmacy, and its agent, trustee or assignee may not maintain any action at law against an Eligible Person to collect sums owed by MedImpact or Payor. If a petition to liquidate MedImpact or Payor is filed with a court of competent jurisdiction, then after the date of filing the petition for liquidation:
   a. Member Pharmacy is prohibited from collecting or attempting to collect from an Eligible Person amounts normally payable by MedImpact or Payor;
   b. Member Pharmacy or its agent, trustee or assignee may not maintain any action at law against an Eligible Person to collect amounts for Prescription Drug Benefits normally payable by MedImpact or Payor.

   Nothing in this paragraph prohibits Member Pharmacy from collecting or attempting to collect from an Eligible Person any amounts for services not normally payable by MedImpact or Payor, including applicable copayments or deductibles. 24-A M.R.S. § 4204(6).

2. In the event of the insolvency of MedImpact or Payor, Member Pharmacy shall continue providing Prescription Drug Benefits for Eligible Persons for the duration of the period for which premium payment has been made to Payor and until Eligible Person’s discharge from inpatient facilities. 24-A M.R.S. § 4204(7).

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

4. In the event of the insolvency of MedImpact, Payor may require the assignment of this Agreement to itself and Member Pharmacy shall continue to provide services to Eligible Persons. CMR 02-031-191 § 11.

5. Member Pharmacy shall allow appropriate access to medical records of Eligible Persons for purposes of quality management, and quality reviews and complaint investigations conducted by MedImpact, Payor, the State, or the State’s designee. CMR 10-144-109 § 1.03 E.3.
6. Member Pharmacy shall have policies and procedures for 1) protecting the confidentiality of Eligible Person health information; 2) limiting access to health care information on a need-to-know basis, consistent with existing law; 3) holding all health care information confidential and not divulging it without Eligible Person’s authorization, except as consistent with existing law; and 4) allowing Eligible Persons access to their medical records, consistent with existing law. CMR 10-144-109 § 1.03 E.4.

7. Member Pharmacy shall retain records of its affairs and transactions with MedImpact and Payor for a period of at least six (6) years. CMR 02-031-191 §10.B.
MARYLAND ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health insurer, nonprofit health service plan, health maintenance organization, or carrier under Maryland law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy shall not, under any circumstances, including nonpayment of moneys due Member Pharmacy by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Eligible Persons or any persons other than Payor acting on their behalf, for Prescription Drug Benefits provided in accordance with the Agreement. This provision shall not operate to preclude collection from Eligible Persons of copayments or supplemental charges in accordance with the terms of the Plan, or charges for services not covered. Member Pharmacy agrees that this provision shall survive termination of this Agreement regardless of the cause giving rise to termination. Md. Code Health-General § 19-710(i).

2. Nothing in the Agreement shall be construed to require Member Pharmacy to indemnify or hold Payor harmless from a coverage decision or negligent act of the Payor. Md. Code Health-General § 19-710(t); Md. Code Ins. § 15-117.

3. MedImpact and Member Pharmacy shall provide written notice to the other of intent to terminate the Agreement at least ninety (90) days prior to the termination. This provision shall not apply to MedImpact, however, in the event MedImpact terminates Member Pharmacy for fraud, patient abuse, incompetence, or loss of Member Pharmacy’s license. Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons from the date of Member Pharmacy’s notice of intent to terminate until the effective date of termination. Md. Code Ins. §§ 15-112(ii)(5); 15-112.2(e).

4. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not, as a condition of the Agreement, be required to participate in all MedImpact Networks. Md. Code Ins. § 15-112(l).

5. MedImpact shall not terminate this Agreement on basis of: (a) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act; (b) the type or number of appeals that Member Pharmacy files; (c) the number of grievances or complaints that Member Pharmacy files on behalf of a patient; or (d) the type or number of complaints or grievances that Member Pharmacy files or requests for review under Payor’s internal review system. Md. Code Ins. § 15-112(e).
6. MedImpact shall not terminate this Agreement or otherwise penalize Member Pharmacy for: (a) advocating the interests of a patient through a Payor’s internal review system; (b) filing an appeal; or (c) filing a grievance or complaint on behalf of a patient. Md. Code Ins. § 15-112(g).

7. To the extent required by law, nothing in the Agreement shall operate: (a) to preclude Member Pharmacy from providing services at a lower rate of reimbursement to members of carriers who are not contracted with MedImpact; (b) to require Member Pharmacy to accept from MedImpact the same reimbursement arrangement that Member Pharmacy has with a carrier not contracted with MedImpact if the reimbursement arrangement with that carrier is for a lower rate of reimbursement; or (c) to require Member Pharmacy to certify that the reimbursement rates in this Agreement are not higher than the reimbursement rates being received by Member Pharmacy from carriers not contracted with MedImpact. Md. Code Ins. § 15-112(l).

8. MedImpact and Payor shall not, as a condition to this Agreement, prohibit Member Pharmacy from discussing with or communicating to an Eligible Person, public official, or other person information that is necessary or appropriate for the delivery of health care services, including: (a) communications that relate to treatment alternatives; (b) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under Member Pharmacy’s care; (c) communications that relate to an Eligible Person’s right to appeal a coverage determination of a Payor with which Member Pharmacy, or the Eligible Person does not agree; and (d) opinions and the basis of an opinion about public policy issues. Md. Code Ins. § 15-116.

9. For purposes of this Agreement, “Experimental Medical Care” shall have the meaning set forth in the Plan documents. Md. Code Ins. § 15-123(d).

10. MedImpact shall not assign, transfer, or subcontract this Agreement, wholly or partly, to an insurer that offers personal injury protection under Md. Code Ins. § 19-505 without first informing Member Pharmacy and obtaining Member Pharmacy’s written consent. MedImpact shall not terminate, limit, or otherwise impair Member Pharmacy’s rights under the Agreement based on Member Pharmacy’s refusal to agree to an assignment, transfer, or subcontract of all or part of the Agreement to an insurer that offers personal injury protection coverage under Md. Code Ins. § 19-505. Md. Code Ins. § 15-125(b).

11. Member Pharmacy’s participation under this Agreement shall not be conditioned of Member Pharmacy’s participation in a Network for workers’ compensation services. MedImpact shall not terminate, limit, or otherwise impair Member Pharmacy’s rights under this Agreement based on Member Pharmacy’s election not to participate in a Network for workers’ compensation services. Md. Code Ins. § 15-125(c).

12. Member Pharmacy shall have at least 180 days from the date of providing Prescription Drug Benefits to an Eligible Person to submit a claim for reimbursement pursuant to the terms of the Agreement, and Member Pharmacy shall have at least ninety (90) working days after notice that a claim has been denied to appeal such denial pursuant to the terms of the Agreement. MedImpact or Payor shall make or deny reimbursement in

13. Member Pharmacy acknowledges that MedImpact has provided Member Pharmacy with a manual or other document that sets forth the claims filing procedures, including: (a) the address where the claims should be sent for processing; (b) the telephone number at which Member Pharmacy’s questions and concerns regarding claims may be addressed; (c) the name, address, and telephone number of MedImpact; and (d) the address and telephone number of any separate claims processing center for specific types of applicable services. MedImpact shall update this information as appropriate. Md. Code Ins. § 15-1004(d)(1).

14. Upon execution of the Agreement, MedImpact shall provide Member Pharmacy with a written copy of (a) a schedule of fees for up to the fifty (50) most common services billed by participating pharmacies; (b) a description of the coding guidelines used by MedImpact or Payor that are applicable to Member Pharmacy’s services; and (c) information about Member Pharmacy and the methodology that MedImpact or Payor uses to determine whether to increase or reduce Member Pharmacy’s level of reimbursement or to provide a bonus or other incentive-based compensation to Member Pharmacy. MedImpact shall also provide this information to Member Pharmacy, in writing or electronically, thirty (30) days prior to a change and upon request by Member Pharmacy. Md. Code Ins. §§ 15-113(d).

15. Upon execution of the Agreement, and at least thirty (30) days prior to a change, MedImpact shall disclose to Member Pharmacy: (a) applicable terms, conditions, and reimbursement rates; (b) the process and procedures for verifying Prescription Drug Benefits and beneficiary eligibility; (c) the process and procedures for dispute resolution and audit appeals process; and (d) the process and procedures for verifying the prescription drugs included on the Plan’s formularies. Md. Code Ins. § 15-1628.

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

17. No amendment to the following provisions or information provided in connection with such provisions shall be effective until thirty (30) days following its submission to the Maryland Insurance Commissioner: (a) Section 1 of this Addendum (hold-harmless clause); (b) Section 2 of this Addendum (indemnification); (c) Section 4 of this Addendum (participation in other Networks); (d) Section 10 of this Addendum (assignment to insurers offering personal injury protection); (e) Sections 12 and 13 of this Addendum (filing and payment of claims); (f) Section 14(c) of this Addendum (bonuses and incentive-based compensation);(g) Sections 18 and 19 of this Addendum (retroactive denials and pre-authorizations); (h) any provision dealing with the administration of a coordination of benefits clause; (i) termination of this Agreement; (j) any provision dealing with the applicability of Maryland law; and (k) any provision revised to comply with Maryland law. COMAR 31.12.02.13(C)(4).

18. MedImpact or Payor shall not retroactively deny Member Pharmacy reimbursement on a claim beyond the 6-month period following the date that
MedImpact or Payor paid Member Pharmacy except for services subject to coordination of benefits with another payor, the Maryland Medical Assistance Program, or the Medicare Program, in which case MedImpact or Payor may retroactively deny reimbursement during the 18-month period following the date that MedImpact or Payor paid Member Pharmacy. This provision shall not apply if: (a) the information submitted by Member Pharmacy was fraudulent; (b) the information submitted by Member Pharmacy was improperly coded and MedImpact has provided to Member Pharmacy sufficient information regarding coding guidelines used by MedImpact or Payor at least thirty (30) days prior to the date the services subject to the retroactive denial were rendered; or (c) the claim submitted by Member Pharmacy was a duplicate claim. Md. Ins. Code § 15-1008(c).

19. MedImpact or Payor shall not deny reimbursement to Member Pharmacy if services have been preauthorized or approved by MedImpact or Payor unless: (a) the information submitted by Member Pharmacy regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative; (b) critical information requested by MedImpact or Payor regarding the service to be delivered to the patient was omitted such that the determination would have been different had MedImpact or Payor known the critical information; (c) the planned course of treatment for the patient that was approved by MedImpact or Payor was not substantially followed by Member Pharmacy; or (d) on the date the preauthorized or approved service was delivered: (i) the patient was not an Eligible Person; (ii) MedImpact or Payor maintained an automated eligibility verification systems that was available to Member Pharmacy by telephone or via the Internet; and (iii) according the verification systems, the patient was not an Eligible Person. Md. Ins. Code § 15-1009(b).
MASSACHUSETTS ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a Health Maintenance Organization ("HMO"), Insurer, or Carrier licensed under Massachusetts law (collectively and/or individually, "Payor").

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. MedImpact shall not refuse to contract with or compensate for covered pharmacy services of an otherwise eligible Member Pharmacy solely because Member Pharmacy has in good faith:

   (a) communicated with or advocated on behalf of one of more of his/her/its prospective, current or former patients regarding the provisions, terms or requirements of MedImpact or Payor’s health benefit plans as they relate to the needs of Member Pharmacy's patients; or

   (b) communicated with one or more of his/her/its prospective, current, or former patients with respect to the method by which Member Pharmacy is compensated by MedImpact or Payor for services provided to patient. 211 CMR 52.12(1).

2. Member Pharmacy is not required to indemnify Payor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys’ fees, court costs and any associated charges, incurred in connection with any claim or action brought against Payor based on Payor’s management decisions, utilization review provisions or other policies, guidelines or actions. 211 CMR 52.12(2).

3. Neither party shall terminate this Agreement without cause. 211 CMR 52.12(5); 105 CMR 128.509(A).

4. MedImpact shall provide a written statement to Member Pharmacy of the reason or reasons for termination of this Agreement. 211 CMR 52.12(6); 105 CMR 128.509(B).

5. MedImpact shall notify Member Pharmacy in writing of modifications in payments, modifications in covered services or modifications in MedImpact’s procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Member Pharmacy, and the effective date of the modifications. The notice shall be provided sixty (60) days before the effective date of such modification unless such other date
for notice is mutually agreed upon between MedImpact and Member Pharmacy. 211 CMR 52.12(7).

6. Member Pharmacy shall not bill Eligible Persons for charges for covered pharmacy services other than for deductibles, copayments, or coinsurance. 211 CMR 52.12(8).

7. Member Pharmacy shall not bill Eligible Persons for nonpayment by MedImpact or Payor of amounts owed under this Agreement due to the insolvency of MedImpact or Payor. This requirement shall survive the termination of this Agreement for services rendered prior to the termination of this Agreement, regardless of the cause of the termination. 211 CMR 52.12(9).

8. Member Pharmacy shall comply with MedImpact’s and Payor’s requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services. 211 CMR 52.12(10).

9. Member Pharmacy agrees that in no event, including but not limited to nonpayment by MedImpact or Payor of amounts due Member Pharmacy under this Agreement, insolvency of MedImpact or Payor or any breach of this Agreement by MedImpact or Payor, shall Member Pharmacy or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Eligible Person, persons acting on the Eligible Person’s behalf, other than MedImpact or Payor, the employer or the group contract holder for services provided pursuant to this Agreement except for the payment of applicable co-payment, co-insurance, or deductibles for services covered by the Payor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. Payor’s Eligible Persons, any persons acting on the Eligible Person’s behalf, other than MedImpact or Payor, and the employer or group contract holder shall be third party beneficiaries of this clause. This provision supersedes any oral or written agreement hereafter entered into between Member Pharmacy and the Eligible Person, persons acting on the Eligible Person’s behalf, other than MedImpact or Payor, and employer or group contract holder. Mass. Gen. Ann. Laws Ann. 176G, § 21.

10. Within forty-five (45) days after the receipt by MedImpact of a claim for reimbursement to Member Pharmacy for pharmacy services, Payor through MedImpact shall (1) make payment for such services provided, (2) notify Member Pharmacy in writing of the reason or reasons for nonpayment, or (3) notify Member Pharmacy in writing of what additional information or documentation is necessary to complete claims for such reimbursement. If Payor fails to comply with this provision for any claims related to the provision of health care services, Payor shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning forty-five (45) days after MedImpact’s receipt of request for reimbursement at the rate of one and one half percent (1.5%) per month, not to exceed eighteen percent (18%) per year. This provisions relating to interest payments shall not apply to a claim that MedImpact or Payor is investigating because of suspected
fraud. Mass. Gen. Laws Ann. 175 § 110(G); 176A § 8(e); 176B §§ 4 and 7; 176G § 6; 176I § 2.

11. Reimbursement shall not be made to Member Pharmacy as an inducement to reduce, delay or limit specific, medically necessary Prescription Drug Benefits under a Plan. Member Pharmacy shall not profit from the provision of Prescription Drug Benefits that are not medically necessary or medically appropriate. Payor shall not profit from the denial or withholding of Prescription Drug Benefits that are medically necessary or medically appropriate. 211 CMR 52.12(3).

12. Member Pharmacy agrees that following Member Pharmacy’s involuntary disenrollment, if requested to do so, Member Pharmacy shall continue to provide Prescription Drug Benefits to: (1) female Eligible Persons who are in their second or third trimester of pregnancy for the period up to and including the first postpartum visit and (2) Eligible Persons who are terminally ill until their death. Member Pharmacy agrees that in such circumstances Member Pharmacy shall accept reimbursement at the rates applicable under the Agreement prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Eligible Person in an amount that would exceed the cost sharing that could have been imposed if Member Pharmacy had not been disenrolled. Member Pharmacy further agrees to adhere to PBM and Payor’s quality assurance standards and to provide PBM and Payor with necessary medical information related to the care provided. Member Pharmacy further agrees to adhere to PBM and Payor’s policies and procedures, including those related to referrals, prior authorization, and treatment plans. Mass. Gen. Laws. Ann. 176O § 15.

Member Pharmacy shall not charge a fee to Eligible Persons as a condition to be part of Member Pharmacy’s panel of patients. Mass. Managed Care Checklist: Requirements for Provider Contracts, (Rev. 11/08/2012) published by Mass. Div. of Ins.

13. MedImpact shall not revise the risk arrangement under the Agreement, or revise a fee schedule under the Agreement which imposes financial risk on Member Pharmacy for the costs of care, services or equipment provided or authorized by another provider without including specific provisions with respect to: (a) stop loss protection; (b) minimum patient population size for Member Pharmacy; and (c) identification of the health care services for which Member Pharmacy is at risk. 211 CMR 52.12(4)(a)-(c).

14. Nothing in the Agreement shall be construed to:

a. (i) Limit the ability of MedImpact to introduce or modify a select network plan or tiered network plan by granting Member Pharmacy a guaranteed right of participation; (ii) Require MedImpact or Payor to place all members in the same tier of a tiered network plan; (iii) Require MedImpact or Payor to include all members in a select network plan on an all or nothing basis; or (iv) Require Member Pharmacy to participate in a new select network or tiered network plan introduced by MedImpact without granting Member Pharmacy the right to opt-out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval; or
b. Require or permit MedImpact or Member Pharmacy to alter or terminate the Agreement, in whole or in part, to affect parity with an agreement or contract with other payors or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

c. Require or permit MedImpact or Payor to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the Massachusetts Insurance Commissioner as a condition of accreditation, including the amount and purpose of each payment and whether or not each payment is included within Member Pharmacy’s reported relative prices and health status adjusted total medical expenses under section 10 of chapter 12C; or

d. Limit the ability of MedImpact or Member Pharmacy from disclosing the allowed amount and fees of services to an Eligible Person or Eligible Person’s treating health care provider; or

e. Limit the ability of MedImpact or Member Pharmacy from disclosing out-of-pocket costs to Eligible Persons.

MICHIGAN ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations and health care service corporations, under Michigan law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payor, MedImpact or any Payor’s insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Member Pharmacy shall not add additional charges to the Copayment for the provision of Prescription Drug Benefits under this Agreement. If MedImpact determines that Member Pharmacy has overcharged an Eligible Person, Member Pharmacy will promptly pay such overpayment to MedImpact or such Eligible Person as directed upon notification by MedImpact. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Person or someone acting on Eligible Person’s behalf. Mich. Compiled Laws § 500.3529(3); Mich. Admin. Code § 325.6345(2).

2. Member Pharmacy represents and warrants that it is, and will maintain, in good standing, all federal, state, and local licenses and certifications as required by Law. Member Pharmacy further represents and warrants that it can legally dispense prescriptions for Medicare, Medicaid, and MediCal healthcare programs; and that it is not subject to exclusion, suspension or debarment from the Medicare, Medicaid, MediCal or other government healthcare programs. Member Pharmacy agrees to immediately notify MedImpact in writing of any suspension, revocation, limitation, or disciplinary action taken by any State Board of Pharmacy or other licensing or regulatory authority (including Medicare, Medicaid, and MediCal) and of any suspensions, cancellations, or material changes of insurance coverage. Member Pharmacy acknowledges that failure to maintain the appropriate license, certifications, and/or insurance policies will result in immediate termination of Member Pharmacy from the Networks. Member Pharmacy must provide to MedImpact evidence of such licenses, certifications, and insurance policies upon request. Mich. Compiled Laws § 500.3529(4)(a); Mich. Admin. Code § 325.6345(3)(a).
3. Unless otherwise agreed to in writing by MedImpact, when providing Prescription Drug Benefits to Eligible Persons, Member Pharmacy must obtain the signature of the Eligible person, or his or her authorized representative, on a third party signature log to confirm that he or she has received the Prescription Drug Benefit provided. The third party signature log must be in accordance with industry standards and contain all information required by MedImpact. As permitted by Law, in lieu of a third party signature log, Member Pharmacy may maintain an electronic tracking system to record and confirm the receipt of Prescription Drug Benefits and must be in accordance with industry standards and contain all information required by MedImpact. Mich. Compiled Laws § 500.3529(4)(b); Mich. Admin. Code § 325.6345(3)(b).

4. MedImpact, and its authorized agents, have the right to audit compliance with the Agreement during the term of the Agreement and for six (6) years after its expiration, or any longer period as required by applicable law. Upon reasonable notice from MedImpact, during regular business hours, Member Pharmacy must provide auditors with or access to examine and/or copy any and all documents and records that MedImpact deems necessary to determine whether the Member Pharmacy is compliant with the Agreement. Member Pharmacy must promptly comply with all requests for documentation and records. If MedImpact is denied admission to the Member Pharmacy or if Member Pharmacy does not timely present requested documentation and records, Member Pharmacy may be assessed a $500 fee or MedImpact may deem 100% of the Claims to be audited as noncompliant, with all such amounts previously paid to Member Pharmacy for such Claims to be immediately due and owing to MedImpact and may be deducted from any amounts payable to Member Pharmacy.

In addition, where based on a sampling of audited claims, MedImpact determines that Member Pharmacy has engaged in fraud or abuse or has made common errors in the submission of Claims, MedImpact has the right to extrapolate for purposes of determining the amount due and owing to MedImpact for noncompliant Claims, which amount shall become immediately due and owing to MedImpact. Member Pharmacy shall have 30 days to provide documentation to MedImpact to dispute such findings.

If Member Pharmacy is deemed noncompliant, certain penalties may apply, including, but not limited to fees, interest, penalties, damages, or other charges imposed upon MedImpact by governmental entities, regulatory agencies, and/or Payors. If discrepancies are found, overpayments from discrepant claims and/or any other charges resulting from non-compliance become immediately due and owing by Member Pharmacy and owed MedImpact. MedImpact has the right to deduct any such amounts from any amounts payable to Member Pharmacy. MedImpact may report its audit findings to Payors, appropriate governmental entities, and regulatory agencies.

Member Pharmacy must comply with all applicable Medicare Laws and regulations and instructions of Centers for Medicare and Medicaid Services (“CMS”) pursuant to Medicare+Choice Laws. At the request of CMS, Member Pharmacy must allow the Comptroller General of the United States, the Department of Health and Human Services (“DHHS”), and their duly authorized representatives’ access to any of books, contracts or other records. Mich. Compiled Laws § 500.3529(4)(b); Mich. Admin. Code § 325.6345(3)(b).
5. Member Pharmacy must comply with the credentialing and quality assurance initiatives required by MedImpact, including any special quality management requirements and programs established by MedImpact or Payors. Member Pharmacy must meet all standards of operation as required by Law. Member Pharmacy must maintain an internal quality assurance program and, upon request, report on such program to MedImpact, along with remedial action plans. Mich. Compiled Laws § 500.3529(4)(c); Mich. Admin. Code § 325.6345(3)(c).

6. In the event of a Payor’s insolvency, Member Pharmacy agrees to continue providing Prescription Drug Benefits to Eligible Persons. Member Pharmacy acknowledges that Payor is required by law to provide a mechanism for appropriate sharing of the continuation of provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of Member Pharmacy. Mich. Compiled Laws § 500.3561.


   a. Prohibit, or grant MedImpact an option to prohibit, Member Pharmacy from contracting with another party to provide health care services at a lower rate than the payment specified in the contract.

   b. Require, or grant MedImpact an option to require, Member Pharmacy to accept a lower reimbursement rate in the event that the Member Pharmacy agrees to provide health care services to any other party at a lower rate than the payment specified in the contract.

   c. Require, or grant MedImpact an option to require, termination or renegotiation of an existing health care contract in the event that Member Pharmacy agrees to provide health care services to any other party at a lower rate than the payment specified in the contract.

   d. Require, or grant MedImpact an option to require, Member Pharmacy to disclose Member Pharmacy’s contractual payment or reimbursement rates with other parties.
MINNESOTA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health plan company, health maintenance organization (“HMO”), or insurer licensed under Minnesota law (collectively and/or individually, “Payor”).

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

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

2. Any amendment or change in the terms of the Agreement must be disclosed to Member Pharmacy at least forty-five (45) days prior to the effective date of the proposed change, with the exception of amendments required by law or governmental regulatory authority, when notice shall be given to the Member Pharmacy when the requirement is made known to MedImpact. M.S.A. 62Q.735, subdiv. 2(a).

3. Any amendment or change in the Agreement that alters the fee schedule or materially alters the written contractual policies and procedures must be disclosed to Member Pharmacy not less than 45 days before the effective date of the proposed change and Member Pharmacy shall have the opportunity to terminate the Agreement before the amendment or change is deemed to be in effect. M.S.A. 62Q.735, subdiv. 2(b).

4. By mutual consent, evidenced in writing in amendments separate from the Agreement and not contingent upon participation, the parties may waive the disclosure requirements under paragraphs 2 and 3, above. M.S.A. 62Q.735, subdiv. 2(c).

5. Notwithstanding paragraphs 2 and 3, above, the effective date of termination of the Agreement shall comply with the terms of the Agreement when Member Pharmacy terminates the Agreement. M.S.A. 62Q.735, subdiv. 2(d).

6. Member Pharmacy is not required to provide notice of intention to terminate the Agreement before MedImpact communicates with Member Pharmacy regarding contract renewals. M.S.A. 62Q.735, subdiv 4.

7. In the event reimbursement to Member Pharmacy is related to tiering of providers, MedImpact shall provide to Member Pharmacy upon request an explanation of the methodology used to calculate tier ranking, including information on cost and quality. In the event MedImpact or Payor uses a tiered product, MedImpact shall provide notification to Member Pharmacy of
the tier in which Member Pharmacy is included prior to the effective date of the tiered product. M.S.A. 62Q.735, subdiv 6.

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

MedImpact shall indemnify and hold harmless Member Pharmacy and its employees, agents, and representatives against loss, expense, liability, or damage, including, without limitation, any and all claims, causes of action, judgments, awards, settlements, costs, fees, or debts of whatever nature, including without limitation reasonable attorneys’ fees and costs, arising out of or in connection with MedImpact’s breach of this Agreement. Such indemnification shall include the duty to defend any such legal action against Member Pharmacy and its employees, agents, or representatives. This paragraph will survive the termination of this Agreement.

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

10. Notwithstanding anything to the contrary in the Agreement, with respect to Insurers (as defined at M.S.A. 62A.63), the Agreement shall not: (a) prohibit, or grant MedImpact an option to prohibit, Member Pharmacy from contracting with other insurers or payors to provide services at a lower price than the payment specified in the Agreement; (b) require, or grant MedImpact an option to require, Member Pharmacy to accept a lower payment in the event Member Pharmacy agrees to provide services to any other insurer or payor at a lower price; or (c) require, or grant MedImpact an option of, termination or renegotiation of the existing Agreement in the event Member Pharmacy agrees to provide services to any other insurer or payor at a lower price. M.S.A. 62A.64 and M.S.A. 62Q.736.

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

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF ELIGIBLE PERSONS. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THE AGREEMENT TERMINATES.
THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE MEMBER PHARMACY AND THE ELIGIBLE PERSON OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THE AGREEMENT.

M.S.A. 62D.123, subdiv. 1.

12. Member Pharmacy must cooperate with and participate in the quality assurance programs, dispute resolution procedures, and utilization review programs of MedImpact and Payor. M.S.A. 62D.123, subdiv. 2.

13. If MedImpact terminates the Agreement and the termination was not for cause, Member Pharmacy will be provided with notification of the rights of Eligible Persons being treated by Member Pharmacy to continuity of care with Member Pharmacy. Following termination without cause, Member Pharmacy agrees to continue providing Prescription Drug Benefits to Eligible Persons for the following periods:

   (a) For up to 120 days if the Eligible Person is engaged in a current course of treatment for one or more of the following conditions: (i) an acute condition; (ii) a life-threatening mental or physical illness; (iii) pregnancy beyond the first trimester of pregnancy; (iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or (v) a disabling or chronic condition that is in an acute phase; or

   (b) For the rest of the Eligible Person’s life if a physician certifies that the Eligible Person has an expected lifetime of 180 days or less; or

   (c) For up to 120 days if the Eligible Person: (1) is receiving culturally appropriate services and the Payor does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements; or (2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the Eligible Person, either directly or through an interpreter, within the time and distance requirements.

Member Pharmacy agrees during this period of continued care to: (i) accept as payment in full the lesser of the reimbursement rate under the Agreement or Member Pharmacy’s usual and customary charge for that service; (ii) adhere to the preauthorization requirements; and (iii) provide MedImpact and/or Payor with all necessary medical information related to the care provided to the Eligible Person. Nothing herein requires coverage for a service or treatment that is not covered under the Eligible Person’s health plan. M.S.A. 62Q.56, subdiv. 1(a).

14. Member Pharmacy shall not have recourse against Eligible Persons or persons acting on their behalf for amounts above those specified in the evidence of coverage as co-payments for health care services. This subdivision applies but is not limited to the following events: (1) nonpayment by the Payor; (2) insolvency of the Payor; and (3) breach of the Agreement. This does not limit Member Pharmacy’s ability to seek payment from any person other than the Eligible Person, the Eligible
Person’s guardian or conservator, the Eligible Person’s immediate family members, or the Eligible Person’s legal representative in the event of nonpayment. M.S.A. 62D.12.

15. Nothing in the Agreement shall be construed to prohibit Member Pharmacy from:

(a) Communicating with a Eligible Person with respect to the Eligible Person’s health status, health care, or treatment options, if Member Pharmacy is acting in good faith and within the Member Pharmacy’s scope of practice as defined by law;

(b) Making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for an Eligible Person, unless Member Pharmacy has a financial conflict of interest in the Eligible Person’s choice of health plan company, health insurer, or health coverage plan;

(c) Providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(d) Disclosing accurate information about whether services or treatment will be paid for by the Eligible Person’s health plan company or health insurer or health coverage plan; and

(e) Informing Eligible Persons about the nature of the reimbursement methodology used by the Eligible Person’s health plan company, health insurer, or health coverage plan to pay Member Pharmacy, except to the extent the Agreement requires Member Pharmacy to keep confidential the specific amounts paid to Member Pharmacy, fee schedules, or other information proprietary to MedImpact or Payor.

M.S.A. 62J.71(1)-(2).

16. Neither MedImpact nor Payor may take retaliatory action against Member Pharmacy solely on the grounds that Member Pharmacy:

(a) Refused to enter into an agreement or provide services or information in a manner that is prohibited in paragraph 14 above;

(b) Disclosed accurate information about whether a health care service or treatment is covered by Payor;

(c) Discussed diagnostic, treatment, or referral options that are not covered or are limited by Payor;

(d) Criticized coverage offered by Payor;

(e) Expressed personal disagreement with a decision made by a person, organization, or health care provider regarding treatment or coverage provided to Eligible Persons, or assisted or advocated for Eligible Persons in seeking reconsideration of such a decision, provided that Member Pharmacy made clear that Member Pharmacy was acting in an individual
capacity and not as a representative of or on behalf of MedImpact or Payor; or

(f) Discussed accurate interpretations of provisions of the Agreement that limit the prescribing, providing, or ordering of care.


17. Nothing in the Agreement shall be construed to restrict Member Pharmacy’s right to provide health services or procedures to another provider, group of providers, health plan company, or health care cooperative. Member Pharmacy shall remain free to contract with other health plan companies and health care cooperatives. M.S.A. 62J.73, 62R.08.

18. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy, at the request of an Eligible Person, may provide the Eligible Person with a good faith estimate of the allowable payment Member Pharmacy has agreed to accept from the Eligible Person’s Payor for the services specified by the Eligible Person, specifying the amount of the allowable payment due from the Payor. M.S.A. 62J.81.

19. Member Pharmacy shall timely cooperate in the investigation and resolution of any complaint or grievance filed by an Eligible Person or their authorized representative. M.S.A. 62D.11.

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

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

22. Member Pharmacy agrees to participate in pharmacy audits as set forth in the Agreement. To the extent of a direct conflict between the Agreement and the provisions of the Minnesota Pharmacy Audit Integrity Program as set forth in Minnesota Statutes Chapter 151, sections 151.60 to 151.70, the provisions of Chapter 151 shall control. Any amendment to terms in the Agreement affecting pharmacy audits shall be disclosed to Member Pharmacy at least 60 days prior to the effective date of the proposed change. M.S.A. 151.62.

23. Member Pharmacy understands that the Agreement may involve the receipt by Member Pharmacy of state and federal funds, and that Member Pharmacy may,
therefore, be subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to its obligations under this Agreement. Member Pharmacy will, upon the request of the applicable state fraud control unit or attorney General’s Office or the Comptroller General or Centers for Medicare and Medicaid Services make available to such requesting unit or office all administrative, financial, medical and any other records that relate to the delivery of items or services under the Agreement. Member Pharmacy will allow the investigating fraud control unit or office access to these records during normal business hours. To the extent legally permitted and not prohibited by the requesting state fraud control unit or office, Member Pharmacy will notify MedImpact in the event of a request by a state fraud control unit or Attorney General’s Office to review any Member Pharmacy records. Member Pharmacy will immediately report to MedImpact any suspected insurance fraud relating to MedImpact or Payor.
MISSISSIPPI ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of hospital and medical service associations, health maintenance organizations, managed care entities, and insurers under Mississippi law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. MedImpact and Member Pharmacy shall comply with the Mississippi Pharmacy Benefit Prompt Pay Act. Notwithstanding anything to the contrary, the Agreement shall be interpreted so as to afford timely claim payment processes which are at least as stringent as those set forth under Miss. Code Ann. § 73-21-155(3). To the extent that the Agreement contains timely claim payment provisions, which differ from, but are at least as stringent as the provisions § 73-21-155(3), the provisions of the Agreement shall control. Miss. Code Ann. §73-21-151 to 73-21-159.

2. Member Pharmacy agrees to participate in pharmacy audits in the manner detailed in the Agreement. To the extent of a direct conflict between the terms of the Agreement and the Mississippi Pharmacy Audit Integrity Act codified at Miss. Code Ann. §§ 73-21-175 et seq., the provisions of the Mississippi Pharmacy Audit Integrity Act shall control. Miss. Code Ann. §§ 73-21-175 to 73-21-189.

3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Mississippi law, Member Pharmacy agrees:
   a. If MedImpact or Payor fails to pay for Prescription Drug Benefits as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by MedImpact or Payor. Miss. Code Ann. § 83-41-325(13).
   b. Member Pharmacy shall continue to provide Prescription Drug Benefits pursuant to the terms of the Agreement to Eligible Persons following the insolvency of a Payor or MedImpact for the duration of the period for which premium payment has been made to Payor or, for those Eligible Persons confined on the date of insolvency, until the Eligible Person’s discharge from inpatient facilities, whichever is later. Miss. Code Ann. 83-41-325(16).
   c. If Member Pharmacy terminates the Agreement, Member Pharmacy shall give MedImpact at least sixty (60) days advance notice of termination. Miss. Code Ann. § 83-41-325(17).
MISSOURI ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization, health plan, insurer or carrier licensed under Missouri law (collectively and/or individually, “Payor”).

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

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

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

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

4. In the event of Payor’s or MedImpact’s insolvency or other cessation of operations, Prescription Drug Benefits to Eligible Persons shall continue to be provided by Member Pharmacy through the period for which a premium
Paragraphs 4 and 5 above shall: (1) be construed in favor of the Eligible Persons; (2) survive the termination of this Agreement regardless of the reasons for termination, including the insolvency of Payor, MedImpact or Payor's intermediary; (3) supersede any oral or written contrary agreement between Member Pharmacy and Eligible Person or the representative of Eligible Person if the contrary agreement is inconsistent with the hold harmless and continuation of Prescription Drug Benefit provisions required by paragraphs 4 and 5 above; and (4) be binding upon all individuals with whom a Member Pharmacy may subcontract to provide services to Eligible Persons. RSMo. 354.606.4; Mo. 20 CSR 400-7.080(3).

The Payor, MedImpact, and the Member Pharmacy are independent contractors. Mo. 20 CSR 400-7.080(2).

In no event shall Member Pharmacy collect or attempt to collect from an Eligible Person any money owed to the Member Pharmacy by Payor or MedImpact nor shall Member Pharmacy collect or attempt to collect from an Eligible Person any money in excess of the coinsurance, co-payment, or deductibles. RSMo. 354.606.5.

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

The rights and responsibilities of Member Pharmacy under this Agreement shall not be assigned or delegated by Member Pharmacy without the prior written consent of MedImpact or Payor, as applicable. RSMo. 354.606.13. Payor shall have the right, in the event of MedImpact’s insolvency, to require the assignment to Payor of the provisions of this Agreement addressing the Member Pharmacy’s obligation to furnish Prescription Drug Benefits. RSMo. 354.621.(6).

Member Pharmacy must furnish Prescription Drug Benefits to all Eligible Persons without regard to the Eligible Person’s enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care services. RSMo. 354.606.14.

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

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

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

14. Upon termination of this Agreement, Member Pharmacy must continue care to Eligible Persons for a period of up to ninety (90) days where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. In such circumstances, Eligible Person shall not be liable to Member Pharmacy for any amounts owed for medical care other than deductibles or co-payment amounts specified in the certificate of coverage or other contract between the Eligible Person and Payor as set forth in paragraph 2 above. In the event the terminated Member Pharmacy is authorized to continue treating Eligible Person pursuant to this paragraph, Member Pharmacy shall have the right to be paid at the previously contracted rate for services provided to the Eligible Person as required by RSMo. 354.612.1. RSMo. 354.612.

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

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

17. Member Pharmacy agrees to participate in pharmacy audits as set forth in the Agreement. In the event of a direct conflict between the terms of the Agreement and Section 338.600 of the Revised Statutes of Missouri concerning pharmacy audits, Section 338.600 shall control. RSMo. 338.600.

4/16/2014
18. Member Pharmacy will be notified on an ongoing basis of specific covered Prescription Drug Benefits via the On-Line System. RSMO 354.606.1.

19. MedImpact shall notify Member Pharmacy in accordance with the applicable terms and conditions set forth in the Agreement of Member Pharmacy's responsibilities with respect to MedImpact's and Payors' applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs. RSMo. 354.606.8.

20. The parties acknowledge and agree that the Agreement does not require the use of hospitalists as a condition for Member Pharmacy participation under this Agreement. RSMo. 354.606.9.

21. Nothing in the Agreement shall be construed to induce Member Pharmacy to provide less than medically necessary services to an Eligible Person. RSMo. 354.606.10.

22. Nothing herein prohibits Member Pharmacy from advocating on behalf of Eligible Persons within the utilization review or grievance processes established by MedImpact or the Payor. RSMo. 354.606.11.

23. MedImpact will not penalize Member Pharmacy because provider reports in good faith to state or federal authorities any act or practice by MedImpact or Payor that may jeopardize patient health or welfare. RSMo. 354.606.16.

24. Member Pharmacy can determine in a timely manner whether a person is covered as set forth in the Agreement (e.g., On-Line System). RSMo. 354.606.17.

25. Resolution of administrative, payment, or other disputes between MedImpact and Member Pharmacy shall be handled in accordance with the dispute resolution provisions set forth in the Agreement (to the extent not inconsistent with the provisions of RSMo. 354.600-354.636). RSMo. 354.606.19.

26. To the extent that any definitions or provisions of the Agreement conflict with definitions or provisions contained in Plans or in sections 354.600 to 354.636 of the Revised Statutes of Missouri, the conflicting definitions and/or provisions of the Agreement shall not control. RSMo. 354.606(20).

27. MedImpact will not terminate the Agreement solely or in part because Member Pharmacy in good faith: (i) advocates on behalf of an Eligible Person; (ii) files a complaint against MedImpact or Payor; (iii) appeals a decision of MedImpact or Payor; (iv) provides information or files a report with the department of insurance, financial institutions, and professional registration; or (v) requests a hearing or review pursuant to RSMo. 354.609. RSMo. 354.609.5.
28. Notwithstanding anything to the contrary, to the extent required by law, Member Pharmacy shall have at least thirty (30) days to review a managed care contract. RSMo. 354.609.6.

29. Notwithstanding legitimate and medically based referral patterns, neither party shall act in a manner that unreasonably restricts an Eligible Person's access to the entire network, unless the HMO Payor has a written agreement with the holder of the benefits contract (not this Agreement) to a reduced network, and has requested an exception for a reduced network per 20 CSR 400-7.095 and filed an access plan for the reduced network prior to selling a new product per RSMo. 354.603.2. RSMo. 354.603.1(4).

30. Nothing in this Agreement shall be construed to conflict with an enrollee's right to sue someone under RSMo. 538.205(4).

31. Nothing in this Agreement shall be construed to conflict with Missouri's Coordination of Benefits regulation or Missouri case law that prohibits subrogation from liable third parties in connection with fully insured contracts. 20 CSR 400-2.030.

32. MedImpact and Member Pharmacy shall comply with RSMo. Sections 354600 to 354.636. RSMo. 354.621.1.

33. MedImpact will transmit utilization documentation and claims paid data to the HMO Payor to the extent required by RSMo. 354.621.3.

34. MedImpact will maintain the documents hereunder to the extent required by RSMo. 354.621.4 for at least 5 years. RSMo. 354.612.4. HMO and DIFP Payors will have access to all documents that relate to compliance with RSMo. Sections 354-600 to 354.636 in accordance with RSMo. 354.621.5.
MONTANA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, managed care community networks, multiple employer welfare arrangements, insurers, or carriers under Montana law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. MedImpact shall not prohibit or interfere with medical communications, as defined by section 33-1-801, Mont. Code Ann, made by Member Pharmacy to an Eligible Person. This prohibition does not apply to: (i) an oral or written contract, direction, requirement or financial inducement or penalty prohibiting Member Pharmacy from disclosing a trade secret, to the same extent as other employees or contractors of MedImpact are prohibited from disclosing the trade secret; (ii) an oral or written contract, direction, requirement or financial inducement or penalty prohibiting Member Pharmacy from referring an Eligible Person to a health plan in which Member Pharmacy has a direct financial interest; and (iii) terms of an oral or written contract mutually agreed upon by MedImpact and Member Pharmacy requiring Member Pharmacy to participate in and cooperate with all programs, policies, and procedures implemented by MedImpact and/or Payor to ensure, review or improve the quality of health care. Mont. Code Ann. §33-1-802.

2. MedImpact shall not take any of the following actions (to the extent applicable) because Member Pharmacy makes a medical communication to an Eligible Person or their guardian or legal representative: (a) terminate the Agreement with Member Pharmacy; (b) reduce compensation to Member Pharmacy; (c) demote Member Pharmacy in regard to relative seniority; or (d) take any other action against Member Pharmacy in retaliation for a medical communication made by Member Pharmacy to an Eligible Person. Mont. Code Ann. §33-1-803.

3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health carrier offering a managed care plan under Montana law, Member Pharmacy agrees:

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

b. If MedImpact or Payor becomes insolvent or otherwise ceases operations, Prescription Drug Benefits to Eligible Persons will continue through the end of the period for which a premium has been paid to Payor on behalf of the Eligible Person, but not to exceed thirty (30) days, or until the Eligible Person's discharge from an acute care inpatient facility, whichever occurs last. Prescription Drug Benefits to an Eligible Person confined in an acute care inpatient facility on the date of insolvency or other cessation of operations must be continued by Member Pharmacy until the confinement in an inpatient facility is no longer medically necessary. Mont. Code Ann. § 33-36-202(2).

c. The provisions of paragraphs (1)(a) and (b) above must be construed in favor of the Eligible Person, survive the termination of this Agreement regardless of the reason for termination, including the insolvency of MedImpact or Payor, and supersede an oral or written contrary agreement between Member Pharmacy and an Eligible Person or the representative of an Eligible Person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by paragraphs (1)(a) and (b) above. Mont. Code Ann. § 33-36-202(3).

d. To the extent permitted by law, MedImpact and Member Pharmacy shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Mont. Code Ann. § 33-36-204(5).

e. Member Pharmacy has responsibilities and obligations under administrative policies and programs of MedImpact and Payor as set forth in the Agreement, including payment terms, utilization reviews, the quality assurance program, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and applicable federal and state. Mont. Code Ann. § 33-36-204(1), (12). Member Pharmacy acknowledges that documents attached to or incorporated by reference in the Agreement have been made available to Member Pharmacy prior to execution of the Agreement. Mont. Code Ann. § 33-36-204(12).

f. Nothing in the Agreement shall be construed to offer an inducement to Member Pharmacy to provide less than medically necessary services to an Eligible Person. Mont. Code Ann. § 33-36-204(2).
g. Nothing in the Agreement shall be construed to prohibit Member Pharmacy from discussing a treatment option with an Eligible Person or from advocating on behalf of an Eligible Person within the utilization review or grievance process established by MedImpact or Payor. Mont. Code Ann. § 33-36-202(3).

h. Member Pharmacy shall make its health records available to appropriate state and federal authorities, in accordance with applicable state and federal laws related to confidentiality of medical or health records, when such authorities are involved in assessing the quality of care or investigating a grievance or complaint of an Eligible Person. Mont. Code Ann. § 33-36-202(4).

i. Member Pharmacy shall furnish Prescription Drug Benefits to Eligible Persons without regard to the Eligible Person’s enrollment in the Plan as a private purchaser or as a participant in a publicly financed program of health services. This paragraph does not apply to circumstances in which Member Pharmacy should not render services because of Member Pharmacy’s lack of training, experience, or skill or because of a restriction on Member Pharmacy’s license. Mont. Code Ann. § 33-36-204(6).

j. Member Pharmacy shall be required to collect applicable coinsurance, copayments, or deductibles from Eligible Persons as set forth in the Agreement. Mont. Code Ann. § 33-36-204(7).

k. MedImpact shall not penalize Member Pharmacy because Member Pharmacy, in good faith, reports to state or federal authorities an act or practice by Payor or MedImpact that may adversely affect patient health or welfare. Mont. Code Ann. § 33-36-204(8).

l. Member Pharmacy may determine in a timely manner whether or not a person is an Eligible Person of a Payor entitled to coverage for Prescription Drug Benefits by utilizing the mechanisms described in the Agreement (e.g., On-Line System). Mont. Code Ann. § 33-36-204(9).

m. The procedures for resolution of administrative, payment, or other disputes between MedImpact and Member Pharmacy are set forth in the Agreement. Mont. Code Ann. § 33-36-204(10).

n. To the extent any of the definitions or provisions contained in the Agreement conflict with definitions or provisions of Plans or with Title 33, Chapter 36, Part 2, Mont. Code Ann., the definitions and provisions of the Agreement shall not control. Mont. Code Ann. § 33-36-204(11).

o. Member Pharmacy agrees that Payor has the right to approve Member Pharmacy’s participation in a network to provide Prescription Drug Benefits to Payor’s Eligible Persons. Mont. Code Ann. § 33-36-209(2).

p. Member Pharmacy agrees that, in the event of MedImpact’s insolvency, Payor may require assignment to Payor of the provisions of the Agreement addressing Member Pharmacy’s obligation to furnish Prescription Drug Benefits. Mont. Code Ann. § 33-36-209(7).
q. Notwithstanding anything to the contrary, Member Pharmacy shall not be required to indemnify Payor or MedImpact for the acts or conduct of Payor and/or MedImpact. Mont. Code Ann. § 33-37-104(2).

r. To the extent prohibited by law, this Agreement may not be terminated by MedImpact or Member Pharmacy prior to the expiration of its term except for just cause, which means reasonable grounds for termination based on a failure to satisfactorily perform contract obligations or other legitimate business reasons. Mont. Code Ann. § 33-37-104(3).
NEBRASKA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of hospital service corporations, health maintenance organizations, preferred provider organizations, prepaid limited health service organizations, managed care organizations, insurers, or carriers under Nebraska law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Nebraska law, Member Pharmacy agrees:
   a. If MedImpact or Payor fails to pay for Prescription Drug Benefits as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed to Member Pharmacy by MedImpact or Payor. Member Pharmacy and its agent, trustee, or assignee may not maintain an action at law or attempt to collect from an Eligible Person sums owed to Member Pharmacy by MedImpact or Payor. Neb. Rev. Stat. § 44-32,141.
   b. If Member Pharmacy terminates this Agreement, Member Pharmacy must provide MedImpact with at least sixty (60) days’ notice of termination. Neb. Rev. Stat. § 44-32,142.
   c. In the event of insolvency of Payor or MedImpact, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons for the remainder of the period for which premiums have been paid on their behalf or until the Eligible Person’s discharge from an inpatient facility, whichever is longer. Neb. Rev. Stat. § 44-32,143.

2. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a Plan with a preferred provider arrangement, Member Pharmacy agrees:
   a. If MedImpact or Payor fails to retain Member Pharmacy under the Agreement, Member Pharmacy shall be permitted to appeal the adverse decision in a process consistent with Section 44-4109.01(6), Nebraska Revised Statutes. Neb. Rev. Stat. § 44-4109.01 (7).
   b. Before initiating a proceeding to terminate Member Pharmacy’s participation, Member Pharmacy shall be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud, imminent harm to patient health, or when Member Pharmacy’s ability to provide services has been restricted by government action. Neb. Rev. Stat. § 44-4109.01 (8).
c. MedImpact shall not exclude Member Pharmacy on the basis of Member Pharmacy's practice having a substantial number of patients with severe or expensive medical conditions. This provision shall not prohibit MedImpact from excluding Member Pharmacy for failure to meet criteria for quality, accessibility, or economic considerations. Neb. Rev. Stat. § 44-4109.01(9).

d. No terms of the Agreement shall have the effect of discriminating against Member Pharmacy. Differences in prices among providers based on individual negotiations, market conditions, patient mix, method of payment, or price differences among providers in different geographic areas shall not be deemed discrimination. Neb. Rev. Stat. § 44-4111.

3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a prepaid limited health service organization under Nebraska law, Member Pharmacy agrees:

   a. If MedImpact or Payor fails to pay for Prescription Drug Benefits as set forth in the Agreement for any reason whatsoever, including, but not limited to, insolvency or breach of contract, Eligible Persons shall not be liable to Member Pharmacy for any sums owed to Member Pharmacy under this Agreement. Neb. Rev. Stat. § 44-4717(1).

   b. Member Pharmacy and its agent, trustee, or assignee may not maintain an action at law or attempt to collect from Eligible Persons sums owed to Member Pharmacy by MedImpact or Payor. Neb. Rev. Stat. § 44-4717(2).

   c. Paragraphs (3)(a) and (b) shall not prohibit Member Pharmacy from collecting copayments from Eligible Persons. Neb. Rev. Stat. § 44-4717(3).

   d. The provisions in paragraphs (3)(a), (b), and (c) shall survive the termination of the Agreement, regardless of the reason giving rise to the termination. Neb. Rev. Stat. § 44-4717(4).

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

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

4. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a managed care plan under Nebraska law, Member Pharmacy agrees:

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

b. If Payor offers a closed plan or combination plan having a closed component and a participating provider, in the event of the insolvency, or other cessation of operations, of the Payor or MedImpact, Prescription Drug Benefits to Eligible Persons will continue through the period for which a premium has been paid on behalf of the Eligible Person or until the Eligible Person’s discharge from an inpatient facility, whichever time is greater. Prescription Drug Benefits to Eligible Persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. Neb. Rev. Stat. § 44-7106(2)(c).

c. The provisions set forth in paragraphs 4(a) and (b) above shall be construed in favor of the Eligible Person, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of the Payor or MedImpact, and shall supersede any oral or written contrary agreement between Member Pharmacy and an Eligible Person or the representative of an Eligible Person if the contrary agreement is inconsistent with paragraphs 4(a) and (b) above. Neb. Rev. Stat. § 44-7106(2)(d).

d. Notwithstanding anything to the contrary in the Agreement, MedImpact and Member Pharmacy shall provide each other at least sixty (60) days written notice if either party terminates the Agreement without cause. Neb. Rev. Stat. § 44-7106(2)(k).

e. Member Pharmacy shall not delegate or assign the rights and responsibilities under the Agreement without MedImpact’s prior written consent. Neb. Rev. Stat. § 44-7106(2)(k).

f. In the event there is a contradiction between the provisions and definitions in the Agreement and Payor’s managed care plan, the

g. Payor has the right to disapprove Member Pharmacy’s participation in its Plans. Neb. Rev. Stat. § 44-7107(2)(c).

h. In the event of MedImpact’s insolvency, Payor has the right to require the assignment to it of the provisions of the Agreement addressing Member Pharmacy’s obligation to furnish Prescription Drug Benefits. Nev. Rev. Stat. § 44-1707(2)(h).

5. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a discount medical plan organization under Nebraska law, Member Pharmacy agrees:

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

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

NEVADA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, carriers, health maintenance organizations, prepaid limited health service organizations, or managed care organizations under Nevada law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. If the Agreement is terminated by MedImpact or Payor for reasons other than medical incompetence or professional misconduct of Member Pharmacy, Member Pharmacy agrees to continue to provide services to Eligible Persons who are undergoing a medically necessary course of treatment until the later of the 120th day after the Agreement is terminated or, with respect to Eligible Persons who are pregnant, until the 45th day after delivery or the date the pregnancy otherwise ends. During this continuation period, Member Pharmacy agrees to accept the reimbursement rates and terms of participation in effect under the Agreement before it terminated. Member Pharmacy further agrees not to seek payment from Eligible Persons for any service provided by Member Pharmacy during this continuation period that Member Pharmacy could not have received from the Eligible Persons if the Agreement were still in effect. N.R.S. §§ 689A.04036, 689B.0303, 695C.1691, 695G.164.

2. MedImpact shall approve or deny a claim for services within thirty (30) days after it receives the claim. If the claim is approved, Payor or MedImpact shall pay the claim within thirty (30) days after it is approved. If MedImpact requires additional information to determine whether to approve or deny the claim, it shall notify Member Pharmacy of its request for additional information with twenty (20) days after it receives the claim. MedImpact shall notify Member Pharmacy of all specific reasons for any delay in approving or denying the claim. MedImpact shall approve or deny the claim within thirty (30) days after receiving the additional information requested. If the claim is approved, Payor or MedImpact shall pay the claim within thirty (30) days after it receives the additional information. MedImpact shall not ask Member Pharmacy to resubmit information that Member Pharmacy has already provided, unless MedImpact provides a legitimate reason for the request and the purpose of the request is not to delay payment of the claim, harass Member Pharmacy or discourage the filing of claims. Payor or MedImpact shall not pay only part of a claim that has been approved and is fully payable. If any approved claim is not paid as set forth in this provision, Payor shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus six (6) percent. The interest shall be calculated from thirty (30) days after
the date on which the claim is approved until the date on which the claim is paid. N.R.S. §§ 689A.410, 689B.255, 689C.485, 695A.188, 695B.2505, 695C.185, 695C.187,

3. If Payor or MedImpact fails to pay a claim within the time period set forth in the Agreement for an Eligible Person of a Payor contracted to provide managed care to recipients of Medicaid under the Nevada state plan or contracted to provide insurance pursuant to the Children’s Health Insurance Program, Payor shall pay Member Pharmacy interest at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus six (6) percent. The interest shall be calculated from thirty (30) days after the date on which the claim is approved until the date on which the claim is paid. N.R.S. § 695C.128.

4. Member Pharmacy releases Eligible Persons from liability for the cost of Prescription Drug Benefits rendered pursuant to the Agreement. If Payor or MedImpact fails to pay for Prescription Drug Benefits for any reason, including, but not limited to insolvency or breach of the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any money owed to Member Pharmacy pursuant to the Agreement. Neither Member Pharmacy nor its agent, trustee, nor assignee may maintain an action at law or attempt to collect from an Eligible Person any money that Payor or MedImpact owes to Member Pharmacy. This provision does not prohibit the collection of any uncovered charges which an Eligible Person agreed to pay or the collection of any copayment from an Eligible Person. This provision survives termination of the Agreement, regardless of the reason for termination. N.R.S. § 695F.220(1)-(4); Nev. Admin. Code §§ 695C.190(2), 695C.530(2), 695F.300(2).

5. Termination of the Agreement shall not release Member Pharmacy from its obligation to complete any procedure on an Eligible Person who is receiving treatment for a specific condition for a period not to exceed sixty (60) days, at the same schedule of copayment or any other applicable charge in effect when the Agreement is terminated. N.R.S. § 695F.220(5).

6. Any amendment to the Agreement must be submitted to the Nevada Commissioner of Insurance for approval before the amendment is effective. N.R.S. § 695F.220(5).

7. Neither Payor nor MedImpact shall restrict or interfere with any communication between Member Pharmacy and its patients regarding any information that Member Pharmacy determines is relevant to the health care of its patients. N.R.S. § 695G.400.

8. Neither Payor nor MedImpact shall terminate the Agreement with, demote, or refuse to contract with or refuse to compensate Member Pharmacy solely because Member Pharmacy in good faith: (a) advocates in private or in public on behalf of a patient; (b) assists a patient in seeking reconsideration of a decision by Payor or MedImpact to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority. N.R.S. § 695G.410.
9. Neither Payor nor MedImpact shall offer or pay any type of material inducement, bonus or other financial incentive to Member Pharmacy to deny, reduce, withhold, limit or delay specific medically necessary health care services to an Eligible Person. N.R.S. § 695G.420.

10. Any party wishing to terminate this Agreement must give the other party at least ninety (90) days’ advance written notice. Nev. Admin. Code § 689B.160.

11. The Agreement shall be effective for at least one (1) year, subject to any right of termination stated in the Agreement and this Regulatory Addendum. Nev. Admin. Code §§ 689B.160, 695C.190(3), 695C.530(5), 695F.300(3).


13. Member Pharmacy shall provide all medically necessary Prescription Drug Benefits to each Eligible Person for the period for which a premium has been paid to Payor. Nev. Admin. Code § § 689B.160, 695C.190(5), 695C.530(4), 695F.300(5).

14. Member Pharmacy must provide proof of insurance against loss resulting from injuries to third parties from Member Pharmacy’s practice of Pharmacy or a reasonable substitute for it as determined by MedImpact or Payor. Member Pharmacy shall indemnify MedImpact and Payor for any liability resulting from the health care services rendered by Member Pharmacy. Nev. Admin. Code §§ 689B.160, 695C.190(6), 695C.530(6), 695F.300(6).


16. Member Pharmacy shall transfer or arrange for the maintenance of the records of Eligible Persons who are its patients if the Member Pharmacy terminates its contract with MedImpact. Nev. Admin. Code § 695C.190, 695C.530(7), 695F.300(7).

17. Beginning, October 1, 2013, notwithstanding anything to the contrary in the Agreement (including this Manual):

   a. After a patient provides to Member Pharmacy, and Member Pharmacy accepts from the patient, any information regarding a health care plan for the purpose of paying for a service which has been or may be rendered to the patient: (i) Member Pharmacy shall maintain a record of the information provided by the patient; and (ii) if Member Pharmacy fails to submit any claim for payment of any portion of any charge pursuant to this Agreement, Member Pharmacy shall not request or require payment from the patient or any portion of the charge beyond the portion of the charge which the patient would have been required to pay pursuant to the terms of this Agreement if
Member Pharmacy had submitted the claim for payment pursuant to the terms of this Agreement.
b. The provisions of paragraph 17(a) above do not apply to a claim if the patient provides information to Member Pharmacy that is inaccurate, outdated or otherwise causes Member Pharmacy to submit the claim in a manner which violates the terms of this Agreement. NRS 629.
NEW HAMPSHIRE ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides
Prescription Drug Benefits to Eligible Persons of an accident or health insurer, health
service corporation, health maintenance organization, and organizations entering
into preferred provider agreements under New Hampshire law.

In the event of a direct conflict between this Addendum and the Agreement, the
applicable provisions of this Regulatory Addendum shall control if required. This
Regulatory 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, Member Pharmacy agrees as follows:

1. In no event, including but not limited to nonpayment by Payor or
MedImpact insolvency of Payor or MedImpact or breach of the Agreement,
shall Member Pharmacy bill, charge, collect a deposit from, seek payment
or reimbursement from, or have recourse against an Eligible Person or a
person acting on behalf of an Eligible Person (other than Payor or
MedImpact) for Prescription Drug Benefits provided pursuant to the
Agreement. This provision does not prohibit Member Pharmacy from
collecting coinsurance, deductibles, or copayments, as specifically
provided in the evidence of coverage, or fees for non-covered services
delivered on a fee-for-service basis to Eligible Persons. Nor does this
provision prohibit Member Pharmacy and an Eligible Person from agreeing
to continue services solely at the expense of the Eligible Person, as long
as Member Pharmacy has clearly informed the Eligible Person that Payor
may not cover or continue to cover a specific service or services. Except
as otherwise provided in the Agreement, this provision does not prohibit
Member Pharmacy from pursuing any available legal remedy. Member
Pharmacy agrees that this provision shall survive termination of the
Agreement regardless of the cause giving rise to termination and shall be
construed to be for the benefit of Eligible Persons. This provision
supersedes any oral or written contrary agreement now existing or
hereafter entered into between Member Pharmacy and Eligible Persons or
persons acting on their behalf. Any modifications, additions or deletions
to this provision shall become effective on a date no earlier than fifteen
(15) business days after the New Hampshire Insurance Commissioner has
received written notice of such proposed changes. N.H. Rev. Stat. §420-
J:8(I).

2. The Agreement shall not be construed to limit information Member
Pharmacy may disclose to patients or to prospective patients regarding
the provisions, terms, or requirements of Payor’s products as they relate
to the needs of Member Pharmacy’s patients except for trade secrets of

3. Member Pharmacy shall have sixty (60) days from the postmarked date to
review any proposed contract with MedImpact and any modifications to
the Agreement, excluding those modifications that are expressly permitted
4. No reimbursement or payment terms under the Agreement shall be
offered as an inducement for Member Pharmacy to not provide medically

5. Member Pharmacy acknowledges receipt, prior to execution of the
Agreement, of a complete copy of the Agreement including all
attachments and exhibits thereto and acknowledges that MedImpact has
made available to Member Pharmacy the most current provider manual.

6. MedImpact shall give Member Pharmacy notice of material changes to the
applicable reimbursement at least sixty (60) days in advance of the

7. Neither MedImpact nor Payor shall remove Member Pharmacy from the
Network or refuse to renew Member Pharmacy’s enrollment in the
Network due to Member Pharmacy’s participation in an Eligible Person’s
internal grievance procedure or external review. N.H. Rev. Stat. §420-
J:8(X).

8. In the event the Agreement is terminated for a reason other than
unprofessional behavior by Member Pharmacy, Member Pharmacy agrees
to continue to provide Prescription Drug Benefits to Eligible Persons for
sixty (60) days from the date of termination. Member Pharmacy agrees to
provide Prescription Drug Benefits during this period in accordance with
the terms and conditions imposed by the Agreement and agrees to accept
as full payment the reimbursement amount that would have applied had
the Agreement not terminated. Within five (5) business days of
termination of the Agreement, Payor or MedImpact shall provide written
notice to affected Eligible Persons explaining their continued access rights.

9. Notwithstanding anything to the contrary, Member Pharmacy shall not be
obligated to give MedImpact the benefit of any lower fee schedules or
charges for services which Member Pharmacy may subsequently agree to

10. In no event shall Member Pharmacy charge an Eligible Person more than
the lower of the Member Pharmacy’s usual and customary charge or the

11. Notwithstanding anything to the contrary in the Agreement regarding
claim submissions, Member Pharmacy may not submit a claim that was
previously denied by another insurer due to the Eligible Person’s transfer
or termination of coverage. N.H. Rev. Stat §§ 415:6-i(III), 415:18m(III),

12. Member Pharmacy agrees to participate in pharmacy audits as set forth in
the Agreement. To the extent of a direct conflict between the terms of
38, effective 1/1/2014), relating to pharmacy audits, the terms of N.H.
control.
NEW JERSEY ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, carriers, and health maintenance organizations ("HMOs") under New Jersey law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:


2. Nothing in the Agreement shall be construed to prohibit, directly or indirectly, Member Pharmacy from charging Eligible Persons for services rendered by Member Pharmacy that are in addition to charges for the drug, for dispensing the drug, for prescription counseling, and those services required by law, provided that the services rendered shall be subject to the approval of the Board of Pharmacy and provided that Member Pharmacy disclose to Eligible Persons the charges for the additional services and their out-of-pocket costs for those services before dispensing the drug. N.J. Stat. Ann. §§ 17B:26-2li; 17B:27-46-li; 17:48A-7i; 17:48E-35.7.

3. Nothing in the Agreement shall operate to prohibit Member Pharmacy, on behalf of an Eligible Person, from discussing or exercising the right to an appeal available under New Jersey law. N.J.A.C. § 11:24-8.4.

4. Neither MedImpact nor Payor shall terminate the Agreement or penalize Member Pharmacy solely because Member Pharmacy filed a complaint or an appeal as permitted by New Jersey law. N.J.A.C. §§ 11:24-15, 11:24A-4.15., 11:24B-5.2.2.

5. Neither MedImpact nor Payor shall penalize Member Pharmacy or terminate the Agreement because Member Pharmacy acts as an advocate for an Eligible Person in seeking appropriate, medically necessary health care services. N.J.S.A. § 26:2S-9; N.J.A.C. §§ 11:24-15.2, 11:24A-4.15, 11:24B-5.2.

6. Nothing in the Agreement shall be construed to provide a financial incentive to Member Pharmacy for withholding Prescription Drug Benefits that are medically necessary as determined under New Jersey law. N.J.S.A. § 26:2S-9; N.J.A.C. §§ 11:24-15.2., 11:24A-4-15, 11:24B-5.2.
7. Member Pharmacy agrees that in the event that MedImpact or Payor fails to pay for Prescription Drug Benefits for any reason whatsoever, including, but not limited to, insolvency of MedImpact or Payor, or breach of contract, Eligible Persons shall not be liable to Member Pharmacy for any sums owed Member Pharmacy under the Agreement. Member Pharmacy shall hold Eligible Persons harmless for the cost of Prescription Drug Benefits, whether or not Member Pharmacy believes its compensation for the Prescription Drug Benefits is made in accordance with the reimbursement provision of the Agreement, or is otherwise inadequate. Member Pharmacy shall not balance bill Eligible Persons who have obtained Prescription Drug Benefits through the Network in accordance with the Plan. Member Pharmacy shall not bill, charge or collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or a person (other than MedImpact or Payor) acting on behalf of an Eligible Person for Prescription Drug Benefits provided pursuant to the Agreement. Neither Member Pharmacy nor its trustee or assignee may maintain an action at law or attempt to collect from Eligible Persons sums owed to Member Pharmacy by MedImpact or Payor. This provision shall not be construed to prohibit collection of required copayments, deductibles or coinsurance, if any, or uncovered charges consented to and lawfully owed to Member Pharmacy by Eligible Persons provided Member Pharmacy informed the Eligible Person that Payor may not cover or continue to cover the services. N.J.S.A. §§ 17:48F-13, 17:48H-18; N.J.A.C. §§ 11:4-37.4, 11:24-15.2, 11:24B-5.2.


9. Nothing in the Agreement shall be construed to impose obligations or responsibilities on Member Pharmacy which would require Member Pharmacy to violate the statutes or rules governing Member Pharmacy’s licensure. N.J.A.C. §§ 11:24-15.2, 11:24A-4.15, 11:24B-5.2.

10. Payor is a third party beneficiary of the Agreement and shall have privity of contract with Member Pharmacy such that Payor shall have standing to enforce the Agreement with Member Pharmacy. N.J.A.C. 11:24-15.2, 11:24B-5.7.


12. Member Pharmacy shall comply with MedImpact and Payors’ quality assurance and utilization review programs in accordance with the Agreement. Member Pharmacy’s activities and records relevant to the provision of Prescription Drug Benefits may be monitored from time to time by MedImpact, Payor, or a contractor acting on either’s behalf in order to perform quality assurance and continuous quality improvement functions. N.J.A.C. §§ 11:24-15.2, 11:24A-4.15, 11:24B-5.2.

13. Member Pharmacy shall maintain licensure, certification and adequate malpractice covered in an amount determined sufficient for its anticipated
risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate year. N.J.A.C. §§ 11:24-15.2, 11:24B-5.2.

14. Eligible Persons’ information shall be kept confidential by Member Pharmacy, subject to the requirements of state and federal law. However, MedImpact, Payor, and Member Pharmacy shall have mutual rights to Eligible Persons’ medical records, as well as timely and appropriate communication of patient information, so that each may perform their respective duties efficiently and effectively. N.J.A.C. §§ 11:24-15.2, 11:24A-4.15, 11:24B-5.2.

15. Unless otherwise provided by law, this Agreement is not subject to prior approval by the Commissioner. In the case of HMOs, only the proposed form of the provider agreement submitted to the Department with the HMO’s initial application for a certificate of authority shall be subject to prior approval by the Commissioner. N.J.A.C. 11:24C-4.3(a). Where required by law, the Agreement and amendments thereto shall be effective upon filing with and approval (where approval is required by law) by the New Jersey Departments of Health and Senior Services and Banking and Insurance. N.J.S.A. § 17B:27A-54; N.J.A.C. §§ 11:24-15.2, 11:24A-4.15, 11:24B-5.2. The following types of amendments do not require prior approval of the Departments: (i) amendments that are clerical in nature; (ii) amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived; and (iii) amendments that involve the substitution of one set of variable text for another set of variable text, if both sets of variable text were previously approved by the Department for the provider agreement form. N.J.A.C. 11:24B-5.2.

16. Nothing herein exempts MedImpact or Payor from liability for MedImpact’s or Payor’s negligent acts or conduct in the provision of its duties under this Agreement. N.J.S.A. § 2A:53A-33.

17. Clean Claim shall have the meaning set forth in N.J.A.C. § 11:22-1.2.

18. Subject to the exceptions recognized by New Jersey law, MedImpact shall render payment for Clean Claims submitted by Member Pharmacy once sufficient funds have been made available by Payor for payment of such Clean Claims, but in no event later than thirty (30) calendar days after MedImpact’s receipt of a Clean Claim or the time established for Medicare claims by 42 U.S.C. Section 1395u( c), whichever is earlier, if the claim is submitted electronically, and no later than forty (40) calendar days after receipt of a Clean Claim submitted by other than electronic means. In the event MedImpact fails to pay such a Clean Claim within these time limits, MedImpact shall include simple interest on the Claim amount at the rate required by law, which shall accrue beginning thirty (30) or forty (40) calendar days, as applicable, from the date all information and documentation required to process the Claim is received by MedImpact. MedImpact shall add interest amounts payable in accordance with this Section to the Claim amount. N.J. Stat. Ann. §§ 17B-26-9.1, 17:48E-10.1; 17F-13.1, 17:48H-33.1; 26:2J-8.1; N.J.A.C. §§ 11:22-1.5, 11:22-1.6.

19. This Agreement shall be construed in accordance with New Jersey Law. N.J.A.C. § 11:24B-5.2
20. MedImpact and Member Pharmacy agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Member Pharmacy may initiate a formal internal review of any complaint or grievance brought by Member Pharmacy, including compensation and claims issues, by submitting the complaint or grievance to MedImpact in writing. MedImpact will review the complaint or grievance and communicate a written response to Member Pharmacy in accordance with the requirements of New Jersey Law (which shall not exceed 30 days following receipt of the complaint or grievance). Complaints or grievances brought by Member Pharmacy relating to payment of Claims will be reviewed at no cost to the Member Pharmacy by employees of MedImpact who are not responsible for Claims payment on a day to day basis, and a written response shall be communicated to Member Pharmacy within ten (10) business days after receipt of such complaint or grievance, or as otherwise required under New Jersey Law. The written response shall include: (a) the names, titles and qualifying credentials of the persons participating in the internal review; (a) a statement of Member Pharmacy’s grievance; and (c) the decision of the reviewers’ along with a detailed explanation of the contractual basis for the decision; (d) a description of the evidence or documentation which supports the decision; and (e) if the decision is adverse to Member Pharmacy, a description of the method to obtain an external review of the decision. Member Pharmacy shall have the right to submit complaints and grievances to DOBI or DHS, depending upon the issue involved, if not satisfied with the resolution of the complaint or grievance through the internal provider compliant mechanism described herein.

If any dispute, or complaint or grievance arising under this Agreement is not satisfactorily resolved by the parties themselves, MedImpact and Member Pharmacy agree to submit such dispute, complaint or grievance to binding arbitration. The party wishing to initiate arbitration must notify the other party by written demand. Any such arbitration shall be held in New Jersey. Such arbitration shall be conducted in accordance with the commercial rules of the American Arbitration Association. The costs of the arbitration under this paragraph shall be borne equally by the parities, and the results of the arbitration shall be issued no later than thirty (30) business days from the receipt by the arbitrator of all documentation necessary to complete its review. N.J.A.C. §§ 11:22-1.8, 11:24-3.7, 11:24:15.2.

21. In the event that any provision of this Agreement is determined to be in conflict with state or federal Law, such provision will be deemed modified to the extent necessary to make it conform to the requirements of such Law. N.J.A.C. §11:24B-5.2.

22. Notwithstanding anything to the contrary, the time period within which Member Pharmacy may bring suit under the Agreement shall not be less than that set forth under the statute of limitation established by law. N.J.A.C. § 11:24B-5.2(c)(1).

23. Notwithstanding anything to the contrary, the prior notice required for an Organized Delivery System to provide notice of an amendment to Member Pharmacy shall not be less than thirty (30) calendar days, except where
more immediate changes are required by State or Federal law. N.J.A.C. § 11:24B-5.2.

24. Notwithstanding anything to the contrary, MedImpact shall not have a unilateral right, acting in its own accord, or at the request of Payor, to amend the Agreement or to require Member Pharmacy to abide by amended terms of the Agreement during either a notice of termination period or a continuity of care period in the event Member Pharmacy elects to terminate the Agreement rather than accept the amendment. This paragraph shall not apply in the event the amendment is required by state of federal law. N.J.A.C. § 11:24B-5.2(c)(2). Notwithstanding the foregoing, to the extent that the Agreement permits unilateral changes, “adverse changes” may only be made with sufficient advance notice to permit termination in advance of the effective date of the change. For purposes of this provision, “adverse change” means any action taken that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to Member Pharmacy or the administrative expenses incurred by Member Pharmacy in complying with the change. N.J.A.C. 11:24C-4.3(c)(3) and 11:24C-4.2. With respect to the terms of the Agreement that were the subject to negotiation, no changes will be made unilaterally to the administration of the Agreement materially impacting those terms. N.J.A.C. 11:24C-4.3(c)(4). Any adverse change during the term of the Agreement may be made in accordance with the terms of the Agreement (but not upon automatic renewal) upon ninety (90) days notice prior to the effective date of the change. If Member Pharmacy declines to accept the amendment, Member Pharmacy may terminate the Agreement as set forth in N.J.A.C. § 11:24C-4.3(c)(3). N.J.A.C. §11.24C-43(d) and (e).

25. Nothing in the Agreement shall be construed to provide that Member Pharmacy may not appeal a utilization management determination on behalf of an Eligible Person with the Eligible Person’s specific consent, or otherwise limit Member Pharmacy’s right to dispute a utilization management determination, except that Member Pharmacy shall comply with reasonable procedural standards specified by MedImpact or Payor, including a time frame during which an appeal may be submitted. N.J.A.C. § 11:24B-5.2(c)(3).

26. Nothing in the Agreement shall be construed to limit Member Pharmacy’s ability to look to Payor for payment for Prescription Drug Benefits rendered to a Payor’s Eligible Person in the event of Payor’s or MedImpact’s default or bankruptcy, provided that Member Pharmacy shall follow procedures for subrogation or assignment of its claims as may be set forth in the Agreement. N.J.A.C. § 11:24B-5.2(c)(4).

27. Nothing in the Agreement shall be construed to prohibit Member Pharmacy from disputing a reassignment or bundling of codes on a claim, or to accept any or all adjustments to a claim as payment if full when adjustment is made as a result of the quality assurance, continuous quality improvement, utilization management, provider incentive, or similar program. N.J.A.C. § 11:24B-5.2(c)(5).

28. Nothing in the Agreement shall be construed to provide that Member Pharmacy will be denied payment with respect to a medically necessary
health care service or supply if the service was not pre-certified or pre-authorized to the extent such denial is not permitted by law. Payment to Member Pharmacy may be reduced by up to 50% percent of the amount that otherwise would have been paid had pre-certification or pre-authorization been obtained. N.J.A.C. § 11:24B-5.2(c)(6).

29. Nothing in the Agreement shall be construed to mean that an Eligible Person lacks the ability to dispute whether a service is covered or whether the person was an Eligible Person at the time Member Pharmacy rendered the service. N.J.A.C. § 11:24B-5.2(c)(7).

30. Notwithstanding anything to the contrary, Member Pharmacy shall not be required to agree that it will not charge MedImpact or Payor an amount that is greater than the least amount charged to another entity with which Member Pharmacy contracts. Any type of “most-favored-nation” claim shall be unenforceable. N.J.A.C. § 11:24B-5.2(c)(8); N.J.A.C. § 11:24C-4.3(c)(2).

31. Nothing in the Agreement shall require Member Pharmacy to be responsible for the actions of a non-participating provider. N.J.A.C. § 11:24B-5.2(c)(9).

32. The compensation methodology is set forth elsewhere in the Agreement. Notwithstanding anything to the contrary, capitation shall not be the sole method of reimbursement to provider that primarily provide supplies (e.g., prescription drugs) rather than services. N.J.A.C. § 11:24B-5.2.

33. This Agreement shall become effective as of the Effective Date appearing on the signature page hereof, subject to prior approval by the New Jersey Departments of Health and Senior Services and Banking and Insurance, and shall continue in effect from year to year unless terminated as provided in the Agreement.

a. Notwithstanding the foregoing, either party may terminate the Agreement without cause by giving to the other party at least ninety (90) days prior written notice of the date of termination.

b. MedImpact may immediately terminate this Agreement without notice at any time if Member Pharmacy (i) commits fraud, (ii) fails to meet its obligations or otherwise breaches this Agreement, or (iii) in the sole discretion of the medical director of MedImpact or Payor, represents an imminent danger to an Eligible Person or the public health, safety and welfare.

c. Either party may, subject to applicable state Law, terminate this Agreement at any time if the other party is adjudged bankrupt; voluntarily files a petition in or for bankruptcy, reorganization or an arrangement with creditors; or makes a general assignment for the benefit of creditors by giving to the other party at least ninety (90) days prior written notice of the date of termination.

d. If MedImpact terminates this Agreement prior to the renewal date, other than pursuant to b) hereof, MedImpact shall provide Member Pharmacy with ninety (90) days prior written notice setting forth the reasons for termination (“Termination Notice”), setting forth Member Pharmacy’s right to a hearing any exception thereto, and
the procedures for exercising that right. Within ten (10) days of receipt of the Termination Notice, Member Pharmacy shall be entitled to request a hearing in writing with respect to the termination (“Hearing Request”). Within thirty (30) days of receipt of a Hearing Request, MedImpact shall hold a hearing before a panel appointed by MedImpact in accordance with N.J.A.C. §§ 11:24-3-6(b), 11:24A-4.9. The panel shall consist of no less than 3 people, at least one person on the panel shall be a clinical peer in the same or substantially similar discipline and specialty as Member Pharmacy, and MedImpact shall not preclude Member Pharmacy from being present at the hearing or represented by counsel. The panel shall render a decision in writing within thirty (30) days of the close of the hearing, unless within such thirty (30) day period the panel provides notice to both Member Pharmacy and MedImpact of the need for an extension for rendering the decision.

The panel’s decision shall set forth the relevant provision of the Agreement and the facts upon which MedImpact or Payor and Member Pharmacy relied at the hearing. The panel shall recommend that Member Pharmacy be terminated, reinstated or provisionally reinstated. The panel shall specify the reasons for its recommendations, including the reasons for any conditions for provisional reinstatement. The panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences for failure to meet the conditions. In the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of the Agreement. In the event that panel recommends that Member Pharmacy be terminated, MedImpact or Payor shall provide notice of the termination to Eligible Persons in accordance with N.J.A.C. §§ 11:24-3.5, 11:24A-4.8.

e. In the event the Agreement terminates, Member Pharmacy agrees to continue to provide Prescription Drug Benefits under the terms of the Agreement, and at the contracted rates under the Agreement, to Eligible Persons for up to four (4) months following the date of termination when it is medically necessary for the Eligible Person to continue such services, except as follows:

1) In the case of pregnancy of an Eligible Person, Medical Necessity shall be deemed to have been demonstrated and coverage of services under the Agreement by the terminated Member Pharmacy shall continue to postpartum evaluation of the Eligible Person, up to six (6) weeks after delivery;
2) In the case of post-operative care, coverage of services under the Agreement by the terminated Member Pharmacy shall continue for a period up to six (6) months;
3) In the case of oncological treatment, coverage of services under the Agreement by the terminated Member Pharmacy shall continue for a period up to one (1) year;
4) In the case of psychiatric treatment, coverage of services under the Agreement by the terminated Member Pharmacy shall continue for a period of up to one (1) year; and
5) In the event that the Member Pharmacy terminates the Agreement, coverage of services under the Agreement by the terminated Member Pharmacy shall continue for Eligible Persons who received services from the Member Pharmacy immediately prior to the date of termination for thirty (30) days following the date of termination, but for the remainder of the four (4) month period under e) only in cases where it is medically necessary to continue treatment with the terminated Member Pharmacy or in accordance with Items 1) through 4) above as they may apply. The determination as to the medical necessity of an Eligible Person’s treatment with Member Pharmacy shall be subject to the appeal procedures provided by New Jersey law.

Notwithstanding the forgoing under e), terminated Member Pharmacy shall not be required to continue to provide Prescription Drug Benefits under the Agreement in the event the Agreement terminates because i) MedImpact determines that Member Pharmacy is an imminent danger to one or more Eligible Persons or the public health, safety and welfare, ii) MedImpact determines that Member Pharmacy committed fraud, iii) MedImpact determines that Member Pharmacy breached the Agreement, or iv) Member Pharmacy is the subject of disciplinary action by any regulatory agency or board of the State of New Jersey.

f. Member Pharmacy’s participation in the hearing process will not be deemed an abrogation of the Member Pharmacy’s legal rights.

g. Member Pharmacy shall not be terminated or penalized solely for (i) acting as an advocate for an Eligible Person seeking appropriate medically necessary health services, or (ii) for exercising his or her right to file a complaint, grievance or appeal, in accordance with procedures set forth in this Agreement.

h. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.


34. Member Pharmacy acknowledges and agrees that the Agreement discloses in plain language the terms and conditions of the agreement between the parties, including but not limited to, the following: (i) compensation terms, including amount and timing of compensation; (ii) if the Agreement applies to products with different compensation or other terms, the specifics applicable to each; (iii) the term or duration of the Agreement; (iv) the method(s) by which the contract may be amended, renewed, and terminated; (v) Member’s Pharmacy’s obligation to participate in preauthorization programs; (vi) Member Pharmacy’s obligation to maintain liability insurance; and (vii) a description of the internal dispute resolution mechanism under the Agreement. N.J.A.C. § 11:24C-4.3(c)(1).

35. MedImpact will not make the terms of the Agreement available to any third party to lease the network unless: (i) the agreement specifically states that MedImpact may enter into an agreement with third parties.
allowing the third parties to obtain the contracting entity’s rights and responsibilities as if the third party were the contracting entity; (ii) every third party accessing the Agreement is contractually obligated to comply with all of its terms; (iii) all such third parties in existence as of the date the Agreement is entered into are identified; (iv) MedImpact includes on its website a listing, updated no less frequently than every 90 days, identifying all such third parties; (v) each third party is required to identify the source of the discount on all remittance advices and/or explanation of payment under which a discount is taken; (vi) the third party is notified of the termination of a provider contract upon issuance of the termination by MedImpact or upon receipt of notice by Member Pharmacy; (vii) the third party ceases its right to Member Pharmacy’s discounted rate upon termination of the Agreement between Member Pharmacy and MedImpact; and (viii) MedImpact delivers to Member Pharmacy a copy of any agreement relied on in the adjudication of a claim within thirty (30) days after the date of a request from Member Pharmacy. For purposes of this provision, “third party” does not include any employer or other group for whom MedImpact provides administrative services, including at least eh payment of claims. N.J.A.C. § 11:24C-4.3(c)(5).
NEW MEXICO ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, multiple employer welfare arrangements, managed health care plans, preferred provider arrangements, nonprofit health care plans, insurers, or carriers under New Mexico law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees to participate in pharmacy audits as set forth in the Agreement. To the extent of a direct conflict between the terms of the Agreement and section 61-11-18.2, New Mexico Statutes, relating to pharmacy audits, the terms of section 61-11-18.2 shall control. N.M. Stat. Ann. § 61-11-18.2.


3. Member Pharmacy shall be responsible for providing Prescription Drug Benefits to Eligible Persons subject to the limitations and conditions set forth in the Agreement. N.M. Admin. Code § 13.10.22.12(B).

4. Member Pharmacy agrees that in no event, including but limited to nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, an Eligible Person, or person acting on behalf of the Eligible Person, for Prescription Drug Benefits provided pursuant to the Agreement. This does not prohibit Member Pharmacy from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to Eligible Persons referenced above, nor from any recourse against Payor, MedImpact, or their successors. N.N. Stat. Ann. § 59A-46-13(E); N.M. Admin. Code § 13.10.22.12(C). The hold harmless provisions of this paragraph shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of Payor or MedImpact. N.M. Admin. Code § 13.10.22.12(L).

5. Member Pharmacy and MedImpact have rights and responsibilities with respect to administractive policies and programs as set forth in the Agreement, including but not limited to, payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs. N.M. Admin. Code § 13.10.22.12(D).
6. Member Pharmacy shall maintain health records necessary to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity or appropriateness of health care services provided to Eligible Persons. Member Pharmacy shall make such health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Eligible Persons, and shall comply with all applicable state and federal laws related to the confidentiality of such records. N.M. Admin. Code § 13.10.22.12(E).

7. Member Pharmacy may not assign or delegate its contractual rights or responsibilities under the Agreement without MedImpact’s prior written consent. N.M. Admin. Code § 13.10.22.12(F).

8. Member Pharmacy shall maintain adequate professional liability and malpractice insurance and shall notify MedImpact not more than ten days after Member Pharmacy’s receipt of notice of any reduction or cancellation of such coverage. N.M. Admin. Code § 13.10.22.12(G).


10. Member Pharmacy shall provide Prescription Drug Benefits to Eligible Persons without discrimination on the basis of a patient’s participation in the Plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when Member Pharmacy appropriately does not render services due to limitations arising from its lack of training, experience, or skill, or due to licensing restrictions. To the extent required by law, Member Pharmacy is entitled to receive from Payor, at no cost to Member Pharmacy, interpreters for limited English proficient individuals and interpretive services for patients who qualify under the American with Disabilities Act (ADA). N.M. Admin. Code § 13.10.22.12(I).

11. Member Pharmacy shall be responsible for providing Prescription Drug Services to Eligible Persons during the days and hours as set forth in the Agreement and credentialing forms provided hereunder. N.M. Admin. Code § 13.10.22.12(J).


13. Terms used in the Agreement that are defined by New Mexico statutes and Insurance Division regulations shall be construed in the Agreement in a manner consistent with the definitions contained in such laws and regulations. N.M. Admin. Code § 13.10.22.12(M).

14. Nothing in the Agreement shall be construed to:
   a. Offer an inducement, financial or otherwise, to provide less than medically necessary services to an Eligible Person;
b. Penalize Member Pharmacy for assisting an Eligible Person to seek reconsideration of Payor’s or MedImpact’s decision to deny or limit benefits to the Eligible Person;

c. Prohibit Member Pharmacy from discussing treatment options with Eligible Persons irrespective of Payor’s or MedImpact’s position on treatment options, or from advocating on behalf of an Eligible Person within the utilization review or grievance processes established by Payor or MedImpact; or

d. Prohibit Member Pharmacy from using disparaging language or making disparaging comments when referring to Payor or MedImpact.

e. Require Member Pharmacy to violate any recognized fiduciary duty of its profession or place its license in jeopardy. N.M. Stat. § 59A-57-6(A); N.M. Admin. Code § 13.10.22.12(N).

15. The parties acknowledge that a Payor failing to pay Member Pharmacy or Eligible Person for out of pocket covered expenses within 45 days after a clean claim has been received by MedImpact on Payor’s behalf shall be liable for the amount due and unpaid with interest on that amount at the rate at one and one half times the rate established by a bulletin entered by the Superintendent of the New Mexico Division of Insurance in January of each calendar year. For purposes of this paragraph, “clean claim” means a manually or electronically submitted claim that contains all the required data elements for accurate adjudication without the need for additional information from outside of MedImpact’s system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by Payor or MedImpact, or particular circumstances requiring special treatment that prevents timely payment from being made by Payor. N.M. Admin. Code § 13.10.22.12(O).

16. In the event Member Pharmacy’s participation under the Agreement terminates, Member Pharmacy agrees to continue providing Prescription Drug Benefits to Eligible Persons, upon request, for a transition period measured by: (1) the amount of time sufficient to permit coordinated transition planning consistent with the Eligible Person’s condition and needs relating to continuity of care, and in any event, not less than 30 days; or (2) for Eligible Persons who have entered the third trimester of pregnancy at the time of Member Pharmacy’s disaffiliation, until the completion of post-partum care directly related to the delivery. During this transition period, Member Pharmacy agrees to accept reimbursement rates as set forth in the Agreement, adhere to Payor’s and MedImpact’s quality assurance requirements, to provide to Payor and/or MedImpact necessary medical information related to Eligible Person’s care; and to otherwise adhere to Payor’s and MedImpact’s policies and procedures, including but limited to procedures regarding referrals, pre-authorization and treatment planning approved by Payor and/or MedImpact. N.M. Admin. Code § 13.10.23.14(A)-(B).

17. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under New Mexico law, Member Pharmacy agrees:
a. Member Pharmacy shall provide MedImpact at least sixty (60) days prior written notice of its intent to terminate the Agreement. NM Stat. Ann. § 59A-46-13(G).

b. In the event of MedImpact’s or Payor’s insolvency, Member Pharmacy shall provide all medically necessary Prescription Drug Benefits to each Eligible Person for the period for which a premium has been paid to Payor, and until Eligible Person’s discharge from an inpatient facility. NM Stat. Ann. § 59A-46-13(F)(2).

18. Member Pharmacy acknowledges that it is not required to participate in one contract with MedImpact in order to participate in another contract with MedImpact. 2014 NM HB 126.

19. Member Pharmacy acknowledges that it has at least thirty (30) days prior to being required to execute this Agreement or any amendment hereto to review the Agreement and/or amendment. 2014 NM HB 126.

20. The time limits for payments to Member Pharmacy are set forth in the base Agreement. 2014 NM HB 126.

21. Beginning May 2014, to the extent applicable and required by New Mexico law (2014 NM HB 126), the following shall apply with respect to MedImpact’s Maximum Allowable Cost Lists:

   a. Before MedImpact places or continues a particular drug on MedImpact Maximum Allowable Cost Lists, the drug: (i) shall be listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration’s approved drug products with therapeutic equivalence evaluations, also known as the "Orange Book"; (ii) shall have an NR or NA rating by Medispan or a similar rating by a nationally recognized reference; (iii) shall be generally available for purchase by pharmacies from national or regional wholesalers; and (iii) shall not be obsolete.

   b. MedImpact’s Maximum Allowable Cost Lists, including identification of the sources used to determine the maximum allowable cost pricing, are available to those New Mexico Member Pharmacies that are subject to such Maximum Allowable Cost Lists. New Mexico Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s Maximum Allowable Cost Lists.

   c. Pricing on MedImpact’s Maximum Allowable Cost Lists may be updated daily, but in all cases at least once every seven (7) business days to reflect modifications of maximum allowable cost pricing. The most current MedImpact Maximum Allowable Costs Lists are available to New Mexico Member Pharmacies online 24/7, 365 days a year (except for scheduled maintenance) through the Pharmacy Verification Network (PVN) at www.pharmacyverification.com (as noted above, New Mexico Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s Maximum Allowable Cost Lists through PVN).

   d. New Mexico Member Pharmacies subject to the Maximum Allowable Cost Lists may challenge a maximum allowable cost for a drug on 4/16/2014
MedImpact’s Maximum Allowable Cost Lists within three (3) business days after the applicable fill date by submitting an email to mac@medimpact.com, detailing the challenge to the MedImpact maximum allowable cost, along with supporting information and/or documentation. MedImpact will respond to any such challenge within fifteen (15) days after receipt of the challenge:

1. If the challenge is successful, MedImpact will make the change in the maximum allowable cost and Member Pharmacy can then reverse and rebill the claim in question (in which case, MedImpact will make the change effective for similarly situated pharmacies as defined by the MedImpact or the applicable Payor); or

2. If the challenge is denied, MedImpact will provide Member Pharmacy the reason for the denial.

e. This Section 21 applies only with respect to MAC lists owned and/or controlled by MedImpact.

f. MedImpact’s Maximum Allowable Cost Lists are CONFIDENTIAL AND PROPRIETARY to MedImpact and contain material MedImpact may consider Trade Secrets. By providing New Mexico Member Pharmacies access to the MedImpact Maximum Allowable Cost Lists hereunder, they are being provided for specified use by the New Mexico Member Pharmacy and may not otherwise be used, reproduced, transmitted, published, or disclosed to others without prior written authorization from MedImpact. MedImpact maintains the sole and exclusive ownership, right, title, and interest in and to its Maximum Allowable Cost Lists. Without limiting the generality of the foregoing, New Mexico Member Pharmacies shall not attempt to replicate the information contained in the MedImpact Maximum Allowable Cost Lists and shall not use the information contained therein in a manner that places MedImpact at a commercial disadvantage. New Mexico Member Pharmacies shall allow only designated individuals who agree to the confidentiality protections herein to have access to the information in the MedImpact Maximum Allowable Cost Lists.

MedImpact NM Addendum 3/10/14
NEW YORK ADDENDUM – INSURERS/CARRIERS TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of an Insurer or Carrier licensed under New York law (collectively and/or individually, “plan”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Subject to the terms and conditions of the Agreement, payment shall be made to Member Pharmacy for covered items rendered to Eligible Persons within the time required by State law, which currently requires payment not later than the 30th day a claim for payment is transmitted via the internet or electronic mail or the 45th day after the date a claim for payment is submitted by other means, such as paper or facsimile, except in cases where the obligation to make payment is not reasonably clear or where there is evidence that the claim may be fraudulent. NY CLS Ins. § 3224-a(a).

If a good faith dispute exists regarding the eligibility of a person for coverage, the liability of another insurer, corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, Member Pharmacy shall be paid any undisputed portion of the claim subject to the terms and conditions of the Agreement and notified by MedImpact in writing within thirty (30) days of the receipt of the claim that there is no obligation to pay the claim, stating the specific reasons why there is no liability or to request all additional information needed to determine liability to pay the claim. NY CLS Ins. § 3224-a(b).

2. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall submit claims for reimbursement to MedImpact no later than 120 days from the date of service. MedImpact shall permit Member Pharmacy to request reconsideration of a claim that is denied exclusively because it was untimely submitted. If Member Pharmacy demonstrates that Member Pharmacy’s non-compliance was a result of an unusual occurrence and that Member Pharmacy has a pattern or practice of timely submitting claims, Member Pharmacy shall be entitled to payment of such claims subject to all other conditions of payment set forth in the Agreement. Payor or MedImpact may, however, reduce the amount of payment on any such untimely claims by 25% of the amount that would have been paid had the claim been timely submitted. The provisions of this paragraph shall not apply to any claim submitted by Member Pharmacy 365 days after the date of service, in which case, the claim shall be denied in full. NY CLS Ins. § 3224-a(g) –(h).

3. Nothing in the Agreement shall be construed as a waiver of Member Pharmacy’s rights as they relate to payment for services for which Member Pharmacy received pre-authorization as provided by New York law. NY CLS Ins. § 3238.
4. If the Agreement is terminated before the termination date, MedImpact shall provide Member Pharmacy a written explanation of the reasons for the proposed termination; and in the event of such a termination, Member Pharmacy has a right to request a hearing within thirty (30) days following such notice. The hearing date must be held within thirty (30) days after the date of receipt of a request for a hearing. NY CLS Ins. § 4803(b)(1-2). The hearing panel shall render a written decision on the proposed action in a timely manner, and the decision shall include reinstatement of Member Pharmacy, provisional reinstatement subject to conditions set forth by MedImpact, or termination of Member Pharmacy. NY CLS Ins. § 4803(3-4).

The hearing panel shall be comprised of three persons appointed by MedImpact. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as Member Pharmacy. The hearing panel may consist of more than three persons, provided, however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel. NY CLS Ins. § 4803(3).

The hearing panel’s decision shall be effective not less than thirty (30) days after the receipt by Member Pharmacy of the hearing panel’s decision, and a termination shall not be effective earlier than sixty (60) days from the receipt of the notice of termination; provided, however, that the provisions of paragraph 14 of the Addendum shall apply to such terminations. NY CLS Ins. § 4803(5-6).

These requirements shall not apply in cases involving imminent harm to patient care, a determination of fraud, or final disciplinary action by state licensing board or other governmental agency that impairs Member Pharmacy’s ability to practice. NY CLS Ins. § 4803(b)(1).

5. MedImpact shall not terminate the Agreement or refuse to renew a contract for participation in the in-network benefits portion of an insurer’s network for a managed care product solely because Member Pharmacy has: (a) advocated on behalf of an Eligible Person; (b) filed a complaint against MedImpact and/or plan; (c) appealed a decision of MedImpact and/or plan; (d) provided information or filed a report pursuant to NY CLS Pub. Health § 4406-c; or (e) requested a hearing or review pursuant to NY CLS Ins. § 4803. NY CLS Ins. § 4803(e).

6. The parties may exercise a right of non-renewal at the expiration of the Agreement, or for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty (60) days’ notice to the other party; provided, however, that any nonrenewal shall not constitute a termination for purposes of paragraphs 4 and 5 of this Addendum. NY CLS Ins. § 4803(6)(c).

7. MedImpact shall not prohibit or restrict Member Pharmacy from disclosing to Eligible Person or Eligible Person’s designated representative, any information that Member Pharmacy deems appropriate regarding: (a) a condition or course of treatment, including the availability of other therapies, consultations, or test; or (b) the provision, terms, or requirements of MedImpact’s or plan’s products as they relate to Eligible Person, where applicable. NY CLS Ins. §§ 3217-b(a)(1-2); 4325(a)(1-2).
8. MedImpact shall not prohibit or restrict Member Pharmacy from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of MedImpact or plan, which the Member Pharmacy believes may negatively impact upon the quality of, or access to, patient care. NY CLS Ins. §§ 3217-b(b); 4325(b).

9. MedImpact shall not prohibit or restrict Member Pharmacy from advocating to MedImpact and/or plan on behalf of Eligible Person for approval of coverage of a particular course of treatment or for the provision of health care services. NY CLS Ins. §§ 3217-b(c); 4325(c).

10. Notwithstanding anything to the contrary in the Agreement, liability for the activities, actions, or omissions of MedImpact or plan shall not by indemnification or otherwise be transferred to Member Pharmacy. Member Pharmacy shall be responsible for any liabilities arising from Member Pharmacy’s own activities, actions, and omissions. NY CLS Ins. §§ 3217-b(d); 4325(d; 4905.

11. The following are addressed elsewhere in the Agreement: (1) method by which payments, including prospective and retrospective adjustments shall be calculated; (2) time periods within which calculations will be completed, dates upon which payments/adjustments shall be due, and rates upon which they will be made; (3) description of information relied upon to calculate any such payments/adjustments and a description of how Member Pharmacy can access a summary of calculations; (4) process to resolve disputed incorrect/incomplete records and adjust payments; and (5) the right of either party to seek arbitration over payment dispute. NY CLS Ins. §§ 3217-b(e) and 4325(e).

12. Member Pharmacy acknowledges and agrees that the terms of the Agreement do not transfer to Member Pharmacy any of a Payor’s financial risk for providing health care to Eligible Persons. NY CLS Ins. §§ 3217-b(f); 4325(f).

13. MedImpact shall notify Member Pharmacy in writing 90 days prior to implementing a change to reimbursement under the Agreement that could reasonably be expected to have a material adverse impact on the aggregate level of payment to Member Pharmacy (“adverse reimbursement change”). If Member Pharmacy objects to the change, Member Pharmacy may, within 30 days of the date of notice, notify MedImpact in writing to terminate its contract with MedImpact effective upon the implementation date of the adverse reimbursement change. The notice provisions of this paragraph shall not apply where: (a) such change is required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or (b) such change is expressly provided for under the terms of the Agreement by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism. NY CLS Ins. §§ 3217-b(g); 4325(g).

14. Member Pharmacy agrees that if its usual and customary or retail price for a prescription drug is less than an Eligible Person’s copayment, Member Pharmacy shall charge such Eligible Person no more than Member Pharmacy’s...
usual and customary or retail price. NY CLS Ins. §§4325 (h); NY CLS Education Law § 6826-a.

15. If Member Pharmacy leaves plan’s in-network benefits portion of its network of pharmacies for a managed care product for reasons other than those for which Member Pharmacy would not be eligible to receive a hearing pursuant to NY Pub. Health § 4803(b)(1), Eligible Persons may continue an ongoing course of treatment with Member Pharmacy during a transitional period of: (a) up to ninety (90) days from the date of the notice to Eligible Person of Member Pharmacy’s disaffiliation from plan’s network; or (b) if the Eligible Person has entered the second trimester of pregnancy at the time of the Member Pharmacy’s disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery provided that Member Pharmacy agrees: (a) to continue to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full; (b) to adhere to plan’s and MedImpact’s quality assurance requirements and to provide plan and MedImpact necessary medical information related to such care; and (c) to otherwise adhere to plan’s and MedImpact’s policies and procedures, including, but not limited, to procedures regarding referrals and obtaining pre-authorization and a treatment plan. NY CLS Ins. § 4804(e)(1)-(2).

16. In the event of plan’s or MedImpact’s insolvency, Member Pharmacy may not: (a) collect or attempt to collect from Eligible Persons sums owed by plan or MedImpact, or (b) maintain any action at law against Eligible Persons to collect sums owed to Member Pharmacy by plan or MedImpact. NY CLS Ins. § 4307(d).

17. In the event Member Pharmacy requests an external appeal of a concurrent adverse determination, Member Pharmacy shall not pursue reimbursement from Eligible Persons for services determined not medically necessary by the external appeal agent, except to collect a copayment, co-insurance or deductible. NY CLS Ins. § 4917.

18. For pharmacies who provide services to members of the Department of Social services medical assistance program,

   a. Member Pharmacy shall prepare and maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six (6) years from the date services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, Member Pharmacy. Member Pharmacy further agrees to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health. 18 NYCRR § 504.3(a).

   b. Member Pharmacy shall comply with the disclosure requirements of Part 502 of Title 18 of the New York Codes, Rules and Regulations, with respect to ownership and control interests, significant business transactions, and involvement with convicted persons. 18 NYCRR § 504.3(b)
c. Member Pharmacy shall accept payment from the medical assistance program as payment in full for all care, services and supplies billed under the program, except where specifically provided in law to the contrary. 18 NYCRR § 504.3(c).

d. Member Pharmacy shall not discriminate on the basis of handicap race, color, religion, national origin, sex, or age. 18 NYCRR § 504.3(d).

e. Member Pharmacy shall submit claims for payment only for medically necessary services actually furnished to Eligible Persons or otherwise authorized under the social services laws. Member Pharmacy shall submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission. Any information provided in relation to any claim for payment shall be true, accurate, and complete. 18 NYCRR § 504.3(e), (f), (h).

f. Member Pharmacy shall permit audits, by the persons and agencies denominated in subparagraph (a) of the section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program, including patient histories, case files, and patient-specific data. 18 NYCRR § 504.3(g).

19. Member Pharmacy acknowledges and agrees that to the extent MedImpact and or plans incur penalties that result from Member Pharmacy’s actions, inactions, or other failure to comply with these and other regulations and requirements, Member Pharmacy shall immediately owe and pay any such penalties imposed upon MedImpact and/or plans, including but not limited to fees, interest, damages, judgments, financial obligations, or other charges. Member Pharmacy acknowledges that MedImpact may deduct the amount of such charges, overpayments, and penalties from disbursements or other remittances to Member Pharmacy.
NEW YORK ADDENDUM - HMO
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Addendum is entered into between MedImpact HealthCare Systems, Inc. ("MedImpact"), Island Health Network IPA, LLC ("IPA"), and the undersigned pharmacy ("Member Pharmacy").

Whereas, MedImpact and Member Pharmacy have entered into that certain MedCare Agreement, under which Member Pharmacy has agreed to provide pharmacy services (the “Agreement”).

Whereas, New York law requires that entities arranging for the provision of pharmacy services for Health Maintenance Organizations or other Managed Care Organizations authorized under Article 44 of the New York Public Health Law (collectively, "HMO") be a company organized under the laws of New York to operate as an independent practice association or otherwise exempt from such requirement.

Whereas, IPA is a New York limited liability company, organized under the laws of New York to operate as an independent practice association, and is a wholly-owned subsidiary of MedImpact.

Whereas, MedImpact, Member Pharmacy, and IPA desire to amend the Agreement to add IPA as a party to the Agreement and to clarify IPA’s role in providing and maintaining the network of pharmacies, in which Member Pharmacy participates, that provide Prescription Drug Benefits to Eligible Persons of HMOs and to otherwise amend the Agreement as set forth in this Addendum.

Now, therefore, for purposes of Member Pharmacy’s participation in the pharmacy networks that provide Prescription Drug Benefits to Eligible Persons of HMOs, MedImpact, Member Pharmacy, and IPA agree as follows:

1. In the event any provision in this Addendum conflicts with the terms of the Agreement, the terms of this Addendum shall govern.

2. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy understands and agrees that the pharmacy networks providing Prescription Drug Benefits to Eligible Persons of HMOs in which Member Pharmacy participates are provided and maintained by IPA.

3. Member Pharmacy agrees that it will participate in all IPA pharmacy networks in which (i) Member Pharmacy participates in as of the date of the acceptance of this Agreement by IPA; (ii) Member Pharmacy executes a Network Participation Addendum accepted by IPA for such pharmacy network(s); and/or (iii) Member Pharmacy agrees to participate as evidenced by its provision of Prescription Drug Benefits to Eligible Persons of an HMOs utilizing such pharmacy network(s).

4. In addition to the entities listed in the indemnification provision of the Agreement, Member Pharmacy’s indemnification obligations under such provision shall extend to IPA and HMOs. Neither IPA nor MedImpact is responsible or liable for Member Pharmacy’s professional judgment in its provision of prescription drugs and services.
5. Member Pharmacy must provide to IPA or MedImpact, upon request, evidence of all such licenses, certifications, and insurance policies referenced in the Agreement.

6. Member Pharmacy, IPA, and MedImpact are independent entities. Member Pharmacy shall perform all services under the Agreement and this Addendum as an independent contractor, and shall exercise its own professional judgment in providing such services. Except for the indemnity provisions of the Agreement, no provision of the Agreement is for the benefit of any person or entity who is not a party hereto, and no such party will have any right or cause of action hereunder. Neither the Agreement nor this Addendum shall be assigned, sub-contracted, delegated, or transferred by Member Pharmacy without the prior written consent of IPA and MedImpact.

7. This Addendum shall be in effect from the date of acceptance by IPA.

8. IPA will act as representative for Member Pharmacy with regard to the payment of claims by an HMO or its delegatee, and in IPA's capacity as representative will assist Member Pharmacy in resolving any claims adjudication issues, complaints or concerns that Member Pharmacy may have with an HMO or its delegatee. To the extent that Member Pharmacy has any complaints with respect to receipt of payments from an HMO or its delegatee for services rendered pursuant to this Agreement, those complaints should be directed to IPA and not to the HMO.

9. To the extent that Member Pharmacy shall provide pharmacy services to Eligible Persons enrolled with an HMO, Member Pharmacy agrees to comply with any requirements for participation as a pharmacy in New York. Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement or this Addendum to the contrary, Member Pharmacy agrees as follows:

The New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contract ("Standard Clauses"), attached hereto as Appendix A, are expressly incorporated into the Agreement by reference and are binding upon IPA, MCO, and Member Pharmacy and set forth the Standard Clause requirements applicable to IPA, HMO, and Member Pharmacy. IPA and Member Pharmacy shall comply with all provisions set forth in Appendix A. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses set forth in Appendix A shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.
New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

Appendix A
(Revised 3/1/11)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

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

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

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

B. General Terms and Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program,
the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or State Insurance Department (SID) guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:
   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO’s or IPA’s own acts or omissions, by indemnification or otherwise, to a provider.


9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between
the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider’s or IPA’s performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider’s or IPA’s performance; and

c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

d. The MCO and the Provider or IPA agree that a woman’s enrollment in the MCO’s Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother’s county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the “Certification Regarding Lobbying”, Appendix A-1 attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the
Provider or IPA shall complete and submit Standard Form-LLL “Disclosure Form to Report Lobbying,” in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person’s involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs).

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA’s providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee’s liability therefor prior to providing the service. Where the Provider
has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member’s inpatient hospital discharge, consistent with Public Health Law §4903.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee’s medical records and other personally identifiable
information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance (including Quality Assurance Reporting Requirements (QARR)), payment processing and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed a consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination
shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days’ notice provided the MCO demonstrates to DOH’s satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days’ notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA’s provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA’s providers agree, that the IPA providers shall continue to provide care to the MCO’s enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA and the IPA’s contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

**F. Arbitration**

To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the
Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA’s analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: ______________

TITLE: ________________________________________

ORGANIZATION: ________________________________________

NAME: (Please Print) ________________________________________

SIGNATURE: ________________________________________

MedImpact NY Addendum 05/30/13
NORTH CAROLINA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This is an Addendum to the MedCare Pharmacy Network Agreement ("Agreement") entered into between the undersigned Member Pharmacy and MedImpact Healthcare Systems, Inc. to incorporate the following provisions. This Addendum shall become effective upon execution by the parties.

To the extent that Member Pharmacy provides pharmacy services to Members of a health benefit plan preferred provider benefit plan, health maintenance organization ("HMO"), or insurer licensed under North Carolina law (collectively and/or individually, "Payor"), Member Pharmacy agrees to comply with any requirements for participation as a Member Pharmacy in North Carolina as required by applicable law.

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. The following definitions shall apply to the following terms used in the Agreement:
   a. "Eligible Persons" and "Eligible Members" mean those individuals who are entitled to Prescription Drug Services through a Plan.
   b. "Payor" means the entity liable for paying benefits under the applicable Plan through a contract with MedImpact.
   c. "Plan" means a health benefits program under which Eligible Persons receive Prescription Drug Benefits.
   d. "Prescription Drug Benefits" means those outpatient prescription drug services or supplies provided as a benefit to Eligible Members as set forth in a Plan.

2. The following definitions apply to the terms used in this Addendum:
   a. "Coinsurance" means the percentage amount required to be collected by Participating Pharmacies from Eligible Members, pursuant to the Plan.
   b. "Copayment" shall mean such dollar amounts as are required to be collected by Participating Pharmacies from Eligible Members, pursuant to the Plan.
   d. "Deductibles" means the amount of expenses for Covered Services which must be paid by Eligible Members before the Payor will provide benefits. 11 N.C.A.C. 0202(2).
   e. "Fee Amendment" means any change to the terms of a contract with Member Pharmacy, including terms incorporated by reference, that modifies fee schedules. A change required by federal or state law, rule, regulation, administrative hearing, or court order is not an amendment. N.C. Gen. Stat. Ann. § 58-50-270.
3. In the event of termination of this Agreement or the insolvency of Payor or MedImpact, Member Pharmacy agrees to continue to provide Prescription Drug Benefits: (1) to Eligible Persons receiving inpatient care until the Eligible Persons are ready for discharge; and (2) to Eligible Persons for the duration of the period after the Payor’s insolvency for which the Eligible Person’s premium payment has been made. 11 N.C.A.C.20.0202; N.C. Gen. Stat. §58-67-120(2).

4. In the event of termination of this Agreement or the insolvency of Payor or MedImpact, Member Pharmacy agrees to cooperate in the transition of administrative duties and records. 11 N.C.A.C. 20.0202.

5. In the event of termination of this Agreement for reasons unrelated to quality of care or fraud, Member Pharmacy agrees, upon request, to continue to provide Prescription Drug Services to an HMO Payor’s Eligible Persons with an “ongoing special condition” for a “transitional period” as those terms are defined in N.C. Gen. Stat. § 58-67-88. During the transitional period, Member Pharmacy agrees: (1) to accept reimbursement at the rates applicable under the Agreement before the start of the transitional period as payment in full for covered services; (2) to provide necessary medical information to MedImpact and Payor and to comply with MedImpact’s and Payor’s quality assurance programs, which shall not override Member Pharmacy’s professional or ethical responsibilities or interfere with Member Pharmacy’s ability to provide information or assistance to patients; (3) to adhere to MedImpact’s and Payor’s policies and procedures for participating pharmacies; and (4) to discontinue providing services at the end of the transition period and assist in the orderly transition to a network provider. N.C. Gen. Stat. Ann. § 58-67-88.

6. Member Pharmacy shall maintain licensure, accreditation, and credentials sufficient to meet MedImpact’s and Payor’s credential verification program requirements and shall notify MedImpact of subsequent changes in status of any information relating to Member Pharmacy’s professional credentials. 11 N.C.A.C. 20.0202.

7. Member Pharmacy shall maintain professional liability insurance coverage in an amount acceptable to MedImpact and notify MedImpact of subsequent changes in status of professional liability insurance on a timely basis. 11 N.C.A.C. 20.0202.

8. Member Pharmacy shall not bill any Eligible Person for Covered Services, except for specified Coinsurance, Copayments, and applicable Deductibles. This provision does not prohibit Member Pharmacy and an Eligible Person from agreeing to continue non-Covered Services at the Eligible Person’s expense, as long as Member Pharmacy has notified the Eligible Person in advance that Payor may not cover or continue to cover specific services and that the Eligible Person chooses to receive the service. 11 N.C.A.C. 20.0202.

9. Member Pharmacy agrees to arrange for call coverage or other backup to provide service in accordance with MedImpact’s and Payor’s standards for Member Pharmacy accessibility. 11 N.C.A.C. 20.0202.
10. MedImpact or Payor shall provide mechanisms to allow Member Pharmacy to verify, before rendering services, that the patient for which the prescription has been claimed is an Eligible Person and is entitled to Prescription Drug Services based on current information possessed by MedImpact and Payor. 11 N.C.A.C. 20.0202.

11. Member Pharmacy shall: (1) maintain confidentiality of Eligible Persons’ medical records and personal information as required by N.C. Gen. Stat. 58, Art. 39 and other health records as required by law; (2) maintain adequate medical and other health records according to industry and Plan standards; (3) make copies of such records available to MedImpact, Payor, and the North Carolina Department of Insurance (“Department”) in conjunction with its regulation of Payor. 11 N.C.A.C. 20.0202.

12. Member Pharmacy shall cooperate fully and timely in the investigation and resolution of any complaint or grievance filed by an Eligible Person or their authorized representative. 11 N.C.A.C. 20.0202.

13. Member Pharmacy shall not discriminate against Eligible Persons on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. 11 N.C.A.C. 20.0202.

14. MedImpact or Payor shall provide advance notice of and Member Pharmacy shall comply with MedImpact’s and Payor’s policies on benefit exclusions, administrative and utilization management programs, credentialing and quality assessment programs, and provider sanction programs provided, however, that none of these programs shall override the professional or ethical responsibility of Member Pharmacy or interfere with Member Pharmacy’s ability to provide information or assistance to Eligible Persons. MedImpact or Payor shall provide notice of changes to such policies and provide Member Pharmacy with sufficient time to comply with such changes. 11 N.C.A.C. 20.0202.

15. MedImpact or Payor shall provide Member Pharmacy with performance feedback reports if Member Pharmacy’s compensation is related to efficiency criteria. 11 N.C.A.C. 20.0202.

16. Member Pharmacy authorizes and MedImpact agrees to include Member Pharmacy’s name (or that of its parent company) in the provider directory distributed to Payor’s Eligible Persons, if applicable to pharmacies. 11 N.C.A.C. 20.0202.

17. Payor or MedImpact shall process claims for Prescription Drug Benefits in compliance with the “prompt pay” statute, as set forth in N.C. Gen. Stat. § 58-3-225.

18. Member Pharmacy shall not assign, delegate, or transfer its duties and obligations under this Agreement without MedImpact’s prior written consent. MedImpact or Payor shall notify Member Pharmacy, in writing, of any duties or obligations that are to be delegated or transferred, before such delegation or transfer. 11 N.C.A.C. 20.0202.

19. This form of Agreement shall be filed with and approved by the Department prior to usage and any material changes to the approved contract form shall
also be filed with the Department for approval before use. A material change requiring prior approval includes a change in the means of calculating payment to Member Pharmacy (e.g. change from fee-for-service to capitation), a change in the distribution of risk between parties, or a change in the delegation of clinical or administrative responsibilities. 11 N.C.A.C. 20.0201 and 20.0203.

20. In the event that MedImpact or Payor fails to pay for Prescription Drug Benefits as set forth in this Agreement, the Eligible Person shall not be liable to Member Pharmacy for any sums owed by MedImpact or Payor. No other provision of this Agreement shall, under any circumstances, change the effect of this section. Member Pharmacy, its agent, trustee, or assignee, may not maintain any action at law against an Eligible Person to collect any sums owed by MedImpact or Payor. N.C. Gen. Stat. § 58-67-115.

21. MedImpact and Payor shall not limit either of the following: (1) Member Pharmacy's ability to discuss with an Eligible Person the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment; or (2) Member Pharmacy’s professional obligations to Eligible Persons or other patients as specified under Member Pharmacy’s professional license. N. C. Gen. Stat. § 58-3-176.

22. Member Pharmacy acknowledges and agrees that Payor retains the right and ability to approve or disapprove Member Pharmacy’s participation as well as the ability to monitor and oversee Member Pharmacy’s offering of services to Eligible Members. 11 N.C.A.C. 20.0204.

23. Member Pharmacy acknowledges that MedImpact or Payor have made available to Member Pharmacy and will continue to make available information regarding fee schedules, claim submission policies, and reimbursement policies as required by law.

24. Nothing in the Agreement shall be construed as or having the effect of restricting Member Pharmacy’s right to enter into provider contracts with other persons.

25. MedImpact or Payor shall provide Member Pharmacy with information about Payor’s benefit designs and incentives that are used to encourage Eligible Persons to use preferred providers.

26. The reimbursement methodology under the Agreement is fee-for-service. 11 N.C.A.C. 20.0202(14).

27. The parties acknowledge that subrogation is not permitted. 11 N.C.A.C. 12.0319.

28. To the extent definitions within the Agreement conflict with those set forth in the Plan, the Plan documents shall control. 11 N.C.A.C. 20.0202.

29. To the extent this Agreement is applicable to Eligible Persons enrolled on a fully insured basis in any health benefit plan for which a license or registration is required by Chapter 58 of the North Carolina General Statutes, this Agreement is governed by all the laws of the State of North Carolina.
30. Member Pharmacy agrees to participate in pharmacy audits as provided in the Agreement. To the extent of a direct conflict between the Agreement and Article 4C of Chapter 90 of the General Statutes of North Carolina as it relates to pharmacy audits, Article 4C shall control. N.C. Gen Stat. Ann. §§ 90-85.50 to 90-85.53.

31. Section XI is amended to include the following additional paragraphs:

- Notices of Fee Amendment required to be given to Member Pharmacy pursuant to the Agreement shall be in writing and addressed to Member Pharmacy with the name, title and address listed below or on the credentialing application and shall be deemed received: (i) five (5) business days following the date the notices were placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery.

32. MedImpact shall provide a copy of its policies and procedures to Member Pharmacy prior to execution of a new or amended contract and annually; such policies and procedures may be provided to Member Pharmacy in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on MedImpact’s or Payor’s website. In this regard, a copy of MedImpact's MedCare Pharmacy Networks Policies and Procedures Manual is available to Member pharmacy at all times on MedImpact's website.

33. In the event any provision of this Addendum conflicts with the terms of the Agreement (including documents incorporated by reference therein), the terms of this Addendum shall control. Pursuant to NCGS 58-50-285(b), the policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

34. MedImpact shall provide Member Pharmacy with at least sixty (60) days prior notice of any Fee Amendment. The proposed Fee Amendment shall be dated, labeled “Amendment”, signed by MedImpact, and include an effective date for the proposed Fee Amendment. The proposed Fee Amendment shall be effective upon the Member Pharmacy failing, within sixty (60) days, to send MedImpact notice that Member Pharmacy objects in writing to the Fee Amendment. If Member Pharmacy objects to the proposed Fee Amendment, the proposed Fee Amendment is not effective and MedImpact shall be entitled to terminate the Agreement upon sixty (60) days written notice to the Member Pharmacy. Nothing in this paragraph prohibits Member Pharmacy and MedImpact from negotiating contract terms that provide for mutual consent to a Fee Amendment or a process for reaching mutual consent.

35. Beginning October 1, 2013, Article V (Price Non-Discrimination) of the Agreement is deleted in its entirety and also, notwithstanding anything to the contrary in the Agreement (including this Manual), nothing in this Agreement shall:

   a. Prohibit, or grant MedImpact an option to prohibit, Member Pharmacy from contracting with another health insurance carrier to provide
health care services at a rate that is equal to or lower than the payment specified in the contract.

b. Require Member Pharmacy to accept a lower payment rate in the event that the Member Pharmacy agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract.

c. Require, or grant MedImpact an option to require, termination or renegotiation of an existing health care contract in the event that Member Pharmacy agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract.

d. Require, or grant MedImpact an option to require, Member Pharmacy to disclose, directly or indirectly, Member Pharmacy’s contractual rates with another health insurance carrier.

e. Require, or grant MedImpact an option to require, the non-negotiated adjustment by the issuer of Member Pharmacy’s contractual rate to equal the lowest rate Member Pharmacy has agreed to charge any other health insurance carrier.

f. Require, or grant MedImpact an option to require, Member Pharmacy to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in the contract. N.C. Gen Stat. Ann. §§58-50-295.
NORTH DAKOTA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under North Dakota law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees to participate in pharmacy audits as set forth in the Agreement. To the extent of a direct conflict between the Agreement and Title 19, Chapter 19-03.6, North Dakota Century Code as it relates to pharmacy audits, Chapter 19-03.6 shall control. N.D. Cent. Code §§ 19-03.6-01 to 19-03.6-04.

2. Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payor, MedImpact or any Payor’s insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Member Pharmacy shall not add additional charges to the Copayment for the provision of Prescription Drug Benefits under this Agreement. If MedImpact determines that Member Pharmacy has overcharged an Eligible Person, Member Pharmacy will promptly pay such overpayment to MedImpact or such Eligible Person as directed upon notification by MedImpact. N.D. Cent. Code §§ 26.1-17.1-16; 26.1-18.1-12.

3. Nothing in the Agreement shall be construed as restricting or interfering with Member Pharmacy’s medical communications as defined in Section 26.1-04-03(15), North Dakota Century Code. MedImpact shall not take any of the following actions based solely on the basis of a medical communication by Member Pharmacy: (a) refusal to contract with Member Pharmacy; (b) termination or refusal to renew the Agreement with Member Pharmacy; (c) refusal to refer patients to or allow others to refer patients to Member Pharmacy; or (d) refusal to compensate Member Pharmacy for covered services that are medically necessary. Nothing in this paragraph prohibits MedImpact from enforcing mutually agreed-upon terms and conditions under the Agreement, including those requiring Member Pharmacy to participate in and cooperate with all programs, policies, and procedures developed or operated by MedImpact and/or Payor to assure, review, or improve the quality and effective utilization of health care services, if the guidelines or
protocols are based on clinical or scientific evidence and do not prohibit or restrict medical communications between Member Pharmacy and its patients. N.D. Cent. Code § 26.1-04-03.

4. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be required to indemnify MedImpact or Payor for negligence, willful misconduct, or breach of contract committed by MedImpact or Payor, and Member Pharmacy shall not be deemed to have waived any right to seek legal redress against MedImpact or Payor. N.D. Cent. Code § 26.1-04-03(16).

5. Nothing in the Agreement shall be construed as offering or providing a specific payment made to, or withheld from, Member Pharmacy as an inducement to deny, reduce, limit or delay medically necessary care, as defined by Section 26.1-0403, North Dakota Century Code, covered by Payor and provided with respect to an Eligible Person. N.D. Cent. Code § 26.1-0403.

6. MedImpact shall not take any of the following actions against Member Pharmacy solely because Member Pharmacy, in good faith, reports to state or federal authorities an act or practice by MedImpact or Payor that jeopardizes patient health or welfare, or advocates on behalf of a patient in a utilization review program or grievance procedure: (a) refusal to contract with Member Pharmacy; (b) termination or refusal to renew the Agreement with Member Pharmacy; (c) refusal to refer patients to or allow others to refer patients to Member Pharmacy; or (d) refusal to compensate Member Pharmacy for covered services that are medically necessary. N.D. Cent. Code § 26.1-04-03(18).

7. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy is not required to accept as reimbursement the lowest payment for services and items furnished under the Agreement that Member Pharmacy charges or receives from any other entity. N.D. Cent. Code § 26.1-04-03(19).

8. Member Pharmacy’s participation under the Agreement shall not be conditioned on Member Pharmacy’s agreement to participate in any other contracts offered by MedImpact. N.D. Cent. Code § 26.1-27.1-04(2).

9. To the extent Provider services Eligible Persons of an HMO under North Dakota Law, Member Pharmacy agrees:


   b. In the event of Payor’s insolvency, Member Pharmacy agrees to continue to provide Prescription Drug Benefits to Eligible Persons after Payor’s insolvency during the period for which premium payment has been made and until Eligible Persons’ discharge from inpatient facilities. N.D. Cent. Code § 26.1-18.1-12(5)

10. To the extent applicable and required by N.D. Cent. Code § 19-02.1, the following shall apply with respect to MedImpact’s MAC lists:
a. Before MedImpact places or continues a drug on a MedImpact MAC list, the drug will: (i) have at least two nationally available, therapeutically equivalent, multiple source drugs or a generic drug is available only from one manufacturer; (ii) be listed as therapeutically equivalent and pharmaceutically equivalent or "A" or "B" rated in the United States food and drug administration's most recent version of the "Orange Book" or the drug is "Z" rated; and (iii) be generally available for purchase by pharmacies in the state from national or regional wholesalers and not obsolete.

b. MedImpact’s MAC lists are available to North Dakota Member Pharmacies subject to the MAC lists. North Dakota Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s MAC lists) through the Pharmacy Verification Network (PVN) at www.pharmacyverification.com or to inquire about obtaining the MAC list in a different format.

c. MedImpact MAC lists may be updated daily, but in all cases are updated at least every seven (7) business days. Because MedImpact’s MAC lists may be updated daily, MedImpact hereby provides notice that the most current MedImpact MAC lists are available to North Dakota Pharmacies online 24/7, 365 days a year (except for scheduled maintenance) through PVN.

d. The sources utilized by MedImpact to determine the maximum allowable cost pricing are identified on the MedImpact MAC lists, which are available to North Dakota Member Pharmacies at the beginning of each Member Pharmacy contract (or August 1, 2013, whichever is later), and upon contract renewal, via PVN.

e. The pricing set forth on the MedImpact MAC lists will not be set below the sources utilized by MedImpact and will not include the dispensing fee in the calculation of the MAC price.

f. North Dakota Member Pharmacies subject to the MedImpact MAC lists may contest a MAC price by submitting an email to mac@medimpact.com, detailing the reason the pharmacy is contesting the MAC price, along with supporting information and/or documentation. MedImpact will provide a determination to a contested MAC price hereunder within seven (7) business days after receipt of the contest.

i. If an update to the MAC price for an appealed drug is warranted, MedImpact will make the change based on the date of the determination and make the adjustment effective for all similarly situated pharmacy providers in the state of North Dakota within the network.

g. This Section 10: (i) applies only with respect to MAC lists owned and/or controlled by MedImpact; and (ii) does not apply with respect to North Dakota Medicaid programs.

11. MedImpact’s MAC Lists are CONFIDENTIAL AND PROPRIETARY to MedImpact and contain material MedImpact may consider Trade Secrets. By providing
North Dakota Member Pharmacies access to the MedImpact MAC lists hereunder, they are being provided for specified use by the North Dakota Member Pharmacy and may not otherwise be used, reproduced, transmitted, published, or disclosed to others without prior written authorization from MedImpact. MedImpact maintains the sole and exclusive ownership, right, title, and interest in and to its MAC lists. Without limiting the generality of the foregoing, North Dakota Member Pharmacies shall not attempt to replicate the information contained in the MedImpact MAC lists and shall not use the information contained therein in a manner that places MedImpact at a commercial disadvantage. North Dakota Member Pharmacies shall allow only designated individuals who agree to the confidentiality protections herein to have access to the information in the MedImpact MAC lists.
OHIO ADDENDUM  
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, health insuring corporations, health maintenance organizations, and health benefit plans under Ohio law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees to provide services to Eligible Persons as further set forth in the Agreement. Ohio Rev. Code § 1751.13(C)(1).

2. Member Pharmacy agrees that in no event, including but not limited to nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against an Eligible Person to whom health care services have been provided, or person acting on behalf of the Eligible Person, for health care services provided pursuant to the Agreement. This does not prohibit Member Pharmacy from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Payor or its successor. This provision shall survive termination of the Agreement with respect to Prescription Drug Benefits provided during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of MedImpact or Payor. Ohio Rev. Code §§ 1751.13(C)(2), (12), 1751.60(C).

3. In the event of MedImpact or Payor’s insolvency or discontinuance of operations, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons as needed to complete any medically necessary procedures commenced but unfinished at the time of the insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all Prescription Drug Benefits that constitute medically necessary follow-up care for that procedure. If an Eligible Person is receiving necessary inpatient care at a hospital, Member Pharmacy shall continue to provide services until the earliest of the following: (a) the Eligible Person’s discharge from the hospital; (b) the determination by the Eligible Person’s attending physician that inpatient care is no longer medically indicated; (c) the Eligible Person’s reaching the limit for contractual benefits; or (d) the effective date of any new coverage. This provision shall not require Member Pharmacy to continue to provide Prescription Drug Benefits after the occurrence of any of the following:
a. The end of the thirty-day period following the entry of a liquidation order under Chapter 3909 of the Ohio Revised Code;

b. The end of the Eligible Person’s period of coverage for a contractual prepayment or premium;

c. The Eligible Person obtains equivalent coverage with another health insuring corporation or insurer, or the Eligible Person’s employer obtains such coverage for the Eligible Person;

d. The Eligible Person or the Eligible Person’s employer terminates coverage under the Plan; or

e. A liquidator affects a transfer of the Payor’s obligations under the Plan pursuant to Ohio law. Ohio Rev. Code § 1751.13(C)(3).

4. Member Pharmacy shall abide by MedImpact and Payor’s administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs as further set forth in the Agreement. Ohio Rev. Code § 1751.13(C)(4).

5. Member Pharmacy agrees to make available its records to MedImpact and Payor to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Eligible Persons as set forth in the Agreement. Member Pharmacy agrees to make its health records available to state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Eligible Persons. Member Pharmacy further agrees to comply with applicable state and federal laws related to the confidentiality of medical or health records. Ohio Rev. Code § 1751.13(C)(5).

6. Member Pharmacy shall not assign or delegate the contractual rights and responsibilities under the Agreement without the prior written consent of MedImpact. Ohio Rev. Code § 1751.13(C)(6).

7. Member Pharmacy shall maintain adequate professional liability and malpractice insurance as set forth in the Agreement. Member Pharmacy shall notify MedImpact not more than ten (10) days after Member Pharmacy’s receipt of notice of any reduction or cancellation of such coverage. Ohio Rev. Code § 1751.13(C)(7).

8. Member Pharmacy shall observe, protect, and promote the rights of Eligible Persons as patients. Ohio Rev. Code § 1751.13(C)(8).

9. Member Pharmacy shall provide health care services without discrimination on the basis of the Eligible Person’s participation in the Plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for service rendered to Eligible Persons. This requirement shall not apply to circumstances when Member Pharmacy does not render services due to limitations arising from Member Pharmacy’s lack of training, experience, or skill, or due to licensing restrictions. Ohio Rev. Code § 1751.13(C)(9).

11. Terms used in the Agreement that are defined by Title XVII [17], Chapter 1751, Ohio Revised Code, shall be construed in a manner consistent with those statutory definitions. Ohio Rev. Code § 1751.13(C)(13).

12. Neither MedImpact nor Payor shall directly or indirectly offer an inducement to Member Pharmacy to reduce or limit medically necessary health care services to an Eligible Person. Ohio Rev. Code § 1751.13(D)(1)(a).

13. Neither MedImpact nor Payor shall penalize Member Pharmacy for assisting an Eligible Person to seek a reconsideration of MedImpact’s or Payor’s decision to deny or limit benefits to the Eligible Person. Ohio Rev. Code § 1751.13(D)(1)(b).

14. Nothing in the Agreement shall be construed to limit or otherwise restrict Member Pharmacy’s ethical and legal responsibility to fully advise Eligible Persons about their medical condition and about medically appropriate treatment options. Ohio Rev. Code § 1751.13(D)(1)(c).


16. Neither MedImpact nor Payor shall penalize Member Pharmacy for providing information or testimony to a legislative or regulatory body or agency provided that the information or testimony is not libelous or slanderous or constitute trade secrets which Member Pharmacy has no privilege to disclose. Ohio Rev. Code § 1751.13(D)(1)(e).

17. Payor retains the right to approve or disapprove Member Pharmacy’s participation under the Agreement. Ohio Rev. Code § 1751.13(E), (F)(3).

18. Member Pharmacy acknowledges that Payor is a third-party beneficiary of the Agreement. Ohio Rev. Code § 1751.13(F)(2).

19. Member Pharmacy acknowledges that Payor retains statutory responsibility to monitor and oversee the offering of Prescription Drug Benefits to its Eligible Persons. Ohio Rev. Code § 1751.13(G).

20. MedImpact shall notify Member Pharmacy prior to the effective date of an amendment to the Agreement, and prior to the effective date of an amendment to any document incorporated by reference into the Agreement if the amendment directly and materially affects Member Pharmacy. Such amendments shall not be effective with regard to Member Pharmacy until Member Pharmacy has had reasonable time as defined in the Agreement to exercise Member Pharmacy’s right to terminate its participation status in accordance with the terms of the Agreement. This provision does not apply, however, if the delay caused by compliance with this provision could result in imminent harm to an
Eligible Person or if the amendment is required by state or federal law, rule, or regulation. Ohio Rev. Code § 1753.08.
OKLAHOMA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides
Prescription Drug Benefits to Eligible Persons of health maintenance organizations,
preferred provider organizations, health services corporations, multiple employer
welfare arrangements, health insurance service organizations, and insurers under
Oklahoma law.

In the event of a direct conflict between this Addendum and the Agreement, the
applicable provisions of this Regulatory Addendum shall control if required. This
Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy agrees that it shall be subject to the audit procedures
   and associated prescription claim documentation and record-keeping
   requirements set forth in the Agreement. To the extent that any such
   procedures are in direct conflict with the Oklahoma Pharmacy Audit
   Integrity Act, the provisions of the Pharmacy Audit Integrity Act shall
   control. 59 Okla. Stat. § 356 et. seq.

2. To the extent Member Pharmacy provides Prescription Drug Benefits to
   Eligible Persons of a health maintenance organization under Oklahoma
   law, Member Pharmacy agrees:

   a. In the event that Payor or MedImpact fails to pay for Prescription Drug
      Benefits as set forth in the Agreement, Eligible Person shall not be
      liable to Member Pharmacy for any sums owed by Payor or

   b. Member Pharmacy shall provide Prescription Drug Benefits for the
      duration of the period after Payor’s insolvency for which premium
      payment has been made and until the Eligible Person’s discharge from

   c. If Member Pharmacy terminates the Agreement, Member Pharmacy
      shall provide MedImpact at least ninety (90) days advance written
      notice. 36 Okla. Stat. § 6913(F).
OREGON ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, carriers, health maintenance organizations, health care service contractors, and discount medical plan organizations under Oregon law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payor, MedImpact or any Payor’s insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Member Pharmacy shall not add additional charges to the Copayment for the provision of Prescription Drug Benefits under this Agreement. If MedImpact determines that Member Pharmacy has overcharged an Eligible Person, Member Pharmacy will promptly pay such overpayment to MedImpact or such Eligible Person as directed upon notification by MedImpact. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Person or someone acting on Eligible Person’s behalf. Or. Rev. Stat. § 743.821; Or. Rev. Stat. § 750.095(2).

2. Member Pharmacy shall be entitled to request an annual accounting from MedImpact, which will be comprised of a report showing the record of all claims submitted, processed, and paid in each processing cycle and which will accurately summarize the financial transactions between MedImpact and Member Pharmacy for the year. Or. Rev. Stat. § 743.803(2)(c).

3. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy may withdraw from the care of an Eligible Member if, in Member Pharmacy’s professional judgment, it is in the best interest of the individual to do so. Or. Rev. Stat. § 743.803(2)(d).

5. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy does not agree to indemnify MedImpact for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional acts of Member Pharmacy or Member Pharmacy’s employees, agents or representatives. Or. Rev. Stat. § 743.803(1)(a).

6. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy does not agree to charge MedImpact or Payor no greater than the lowest rate that Member Pharmacy charges for the same service to any other person. Or. Rev. Stat. § 743.803(1)(b).

7. To the extent Member Pharmacy services eligible persons of a discount medical plan organization under Oregon law, Member Pharmacy agrees:

   a. MedImpact’s Pharmacy Network Authorization to Participate Form for MedImpact’s Consumer Discount Card Network contains the discounts offered under that network may be used for Eligible Members, their dependents, and/or their pets and may be applicable to all products dispensed by prescription including but not limited: OTC products, compounds, supplements, or other medical products or devices. Or. Rev. Stat. § 742.424(2)(a).


   c. MedImpact will communicate to Member Pharmacy via the online claims adjudication system the discounted amount to collect from the Eligible Member (“Member Discount”). Member Pharmacy agrees to collect from the Eligible Member at the point of sale the full Member Discount amount indicated by the online claims adjudication system. Member Discount will not exceed Member Pharmacy’s Usual and Customary Charge. In no event will Member Pharmacy charge an Eligible Member more than the lower of the Member Pharmacy’s Usual and Customary Charge or the Member Discount. Or. Rev. Stat. § 742.424(2)(c).

8. Member Pharmacy acknowledges and agrees that, in order to participate in the network for the NW Prescription Drug Consortium, it is required to enroll and comply with the expectations outlined in the Oregon Patient Safety Commission’s adverse reporting program. Information about enrollment in this program is available at http://www.oregon.gov/OPSC/index.shtml.

9. Member Pharmacy agrees to participate in pharmacy audits in the manner detailed in the Agreement. To the extent of a direct conflict between the terms of the Agreement and 2013 Oregon H.B. No. 2123 (effective 1/1/2014) (“Oregon Audit Law”), the provisions of the Oregon Audit Law shall control. 2013 Oregon H.B. No. 2123.
10. Beginning January 1, 2014, to the extent applicable and required by 2013 Oregon H.B. 2123, the following shall apply with respect to MedImpact's Maximum Allowable Cost Lists (as defined by 2013 Oregon H.B. 2123):

a. Before MedImpact places or continues to place a drug on a maximum allowable cost list, with respect to such drug: (i) there will be at least two therapeutically equivalent, multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers; (ii) the drug will be generally available for purchase from national or regional wholesalers; and (iii) the drug will not be obsolete.

b. MedImpact maximum allowable costs lists are available to Oregon Member Pharmacies subject to such maximum allowable costs list. Oregon Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s maximum allowable cost lists. The maximum allowable cost lists identify the sources utilized to determine the maximum allowable cost pricing of MedImpact.

c. Pricing on MedImpact’s maximum allowable cost lists may be updated daily, but in all cases every seven (7) business days. Because MedImpact’s maximum allowable costs lists may be updated daily, MedImpact hereby provides notice that the most current MedImpact maximum allowable costs lists are available to Oregon Member Pharmacies online 24/7, 365 days a year (except for scheduled maintenance) through the Pharmacy Verification Network (PVN) at www.pharmacyverification.com (as noted above, Oregon Member Pharmacies can contact mac@medimpact.com for instructions on accessing MedImpact’s maximum allowable cost list through PVN).

d. Dispensing fees will not be included in the calculation of maximum allowable cost.

e. Oregon Member Pharmacies subject to the maximum allowable costs lists may appeal reimbursement for a drug subject to maximum allowable cost pricing if the reimbursement for the drug is less than the net amount that Member Pharmacy paid to the supplier of the drug. Oregon Member Pharmacies can initiate an appeal within thirty (30) calendar days of the pharmacy submitting the claim for which the appeal is being requested by submitting an email to mac@medimpact.com, detailing the challenge to the MedImpact maximum allowable cost, along with supporting information and/or documentation. Member Pharmacy may obtain the phone number of the individual who is responsible for processing appeals by submitting a request for such via email to mac@medimpact.com. MedImpact will respond to any such appeal within seven (7) business days.

i. If the appeal is denied, MedImpact will provide the challenging Member Pharmacy with the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.
ii. If the appeal is upheld, MedImpact will make the change in the maximum allowable cost and Member Pharmacy can then reverse and rebill the claim in question (in which case, MedImpact will make the change effective for all similarly situated pharmacies in Oregon that are within the network). If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment under this section shall apply only to critical access pharmacies.

f. This Section 10: (i) applies only with respect to maximum allowable cost lists owned and/or controlled by MedImpact; and (ii) does not apply to maximum allowable cost lists utilized by the state medical assistance program.

g. MedImpact’s maximum allowable cost lists are CONFIDENTIAL AND PROPRIETARY to MedImpact and contain material MedImpact may consider Trade Secrets. By providing Oregon Member Pharmacies access to the MedImpact maximum allowable cost lists hereunder, they are being provided for specified use by the Oregon Member Pharmacy and may not otherwise be used, reproduced, transmitted, published, or disclosed to others without prior written authorization from MedImpact. MedImpact maintains the sole and exclusive ownership, right, title, and interest in and to its maximum allowable cost lists. Without limiting the generality of the foregoing, Oregon Member Pharmacies shall not attempt to replicate the information contained in the MedImpact maximum allowable cost lists and shall not use the information contained therein in a manner that places MedImpact at a commercial disadvantage. Oregon Member Pharmacies shall allow only designated individuals who agree to the confidentiality protections herein to have access to the information in the MedImpact maximum allowable cost lists.

11. In the event Member Pharmacy is a Tribal Health Provider, as defined by the state of Oregon, for services to be offered through a health benefit plan certified by the Exchange as a Qualified Health Plan (QHP), Member Pharmacy shall so notify MedImpact in writing of such status, in which case the parties shall use the QHP Addendum for Indian Health Care Providers to supplement and amend the Agreement. Member Pharmacy acknowledges and agrees that the Exchange may amend the QHP Addendum for Indian Health Care Providers, in which case the parties will be required to amend the Agreement to reflect such change(s) within ninety (90) days of adoption of the change. Member Pharmacy acknowledges that the Exchange may be notified of Tribal Health Provider contractual relationships hereunder. OAR 945-020-0040.
PENNSYLVANIA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of medical service corporations, managed care insurance plans, health maintenance organizations, and insurers under Pennsylvania law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Pennsylvania law, Member Pharmacy agrees:

   a. If Member Pharmacy terminates the Agreement, it must give MedImpact at least sixty (60) days advance notice. 31 Pa. Admin. Code § 301.124.

   b. Member Pharmacy hereby agrees that in no event, including, but not limited to non-payment by MedImpact or Payor, insolvency of MedImpact or Payor, or breach of this Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons or persons other than Payor acting on behalf of the Eligible Person for Prescription Drug Benefits as set forth in this Agreement. This provision shall not prohibit collecting supplemental charges or copayments in accordance with the terms of the applicable agreement between Payor and the Eligible Person. 31 Pa. Admin. Code § 301.122; 28 Pa. Admin. Code § 9.725(4).

   c. Member Pharmacy further agrees that (i) the hold harmless provisions in paragraph 1(b) above shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Eligible Person and that (ii) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on their behalf. 31 Pa. Admin. Code § 301.122; 28 Pa. Admin. Code § 9.725(4).

   d. Any modification, addition, or deletion to the provisions in paragraphs 1(a), (b) or (c) above shall become effective on a date no earlier than fifteen (15) days after the Pennsylvania Secretary of Health has received written notice of such proposed changes. 31 Pa. Admin. Code § 301.122.

   e. In the event of the insolvency of MedImpact or Payor, Member Pharmacy shall continue to provide Prescription Drug Benefits for the duration of the period after the insolvency for which premium payment
has been made or until the Eligible Person’s discharge from an inpatient facility or expiration of benefits (limited to Prescription Drug Benefits directly related to the condition which occasioned the admission), whichever is longer. 31 Pa. Admin. Code § 301.123.

f. Member Pharmacy acknowledges and agrees that nothing in the Agreement limits the following:

(i) The authority of Payor to ensure Member Pharmacy’s participation in and compliance with Payor’s quality assurance, utilization management, enrollee complaint and grievance systems and procedures or limits.

(ii) The Department of Health’s authority to monitor the effectiveness of Payor’s systems and procedures or the extent to which Payors adequately monitor any function delegated to MedImpact, or to require Payor to take prompt corrective action regarding quality of care or consumer grievances and complaints.

(iii) Payor’s authority to sanction or terminate a Member Pharmacy found to be providing inadequate or poor quality care or failing to comply with Payor systems, standards or procedures as agreed to by MedImpact. 28 Pa. Admin. Code § 9.725(1).

g. Member Pharmacy acknowledges and agrees that any delegation by Payor to MedImpact for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to Payor’s oversight and monitoring of MedImpact’s performance. 28 Pa. Admin. Code § 9.725(2).

h. Member Pharmacy acknowledges and agrees that Payors, upon failure of MedImpact to properly implement and administer the systems, or to take prompt corrective action after identifying quality, enrollee satisfaction or other problems, may terminate their contracts with MedImpact, and that as a result of the termination, Member Pharmacy’s participation in Payor’s plans may also be terminated. 28 Pa. Admin. Code § 9.725(3).

2. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a managed care organization under Pennsylvania law, Member Pharmacy agrees:

a. MedImpact shall not sanction, terminate, fail to renew, or restrict Member Pharmacy or its participation for any of the following reasons:

i. Discussing the process that Payor or MedImpact uses or proposes to use to deny payment for a Prescription Drug Benefit;

ii. Advocating for medically necessary and appropriate health care services with or on behalf of an Eligible Person, including information regarding the nature of treatments, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests;
iii. Protesting a plan decision, policy or practice the Member Pharmacy believes interferes with its ability to provide medically necessary and appropriate health care;

iv. Discussing the decision of Payor or MedImpact to deny payment for a Prescription Drug Benefit;

v. Filing a grievance on behalf of and with the consent of an Eligible Person, or helping an Eligible Person file a grievance;

vi. Discussing any other information Member Pharmacy reasonably believes is necessary to provide an Eligible Person information concerning the health care of the Eligible Person; or


b. In no event including, but not limited to, non-payment by Payor or MedImpact, insolvency of Payor or MedImpact, or a breach of this Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the Eligible Person or persons other than Payor acting on behalf of the Eligible Person for Prescription Drug Benefits set forth in this Agreement. This provision does not prohibit collecting supplemental charges or co-payments in accordance with the terms of the agreement between Payor and the Eligible Person. 28 Pa. Admin. Code § 9.722(e)(1)(iii).

c. Member Pharmacy further agrees that (i) the hold harmless provisions in paragraph 2(b) above shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Eligible Person and that (ii) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on their behalf. 28 Pa. Admin. Code § 9.722(e)(1).

d. Member Pharmacy shall keep confidential records of Eligible Persons in accordance with 40 Pa. Stat. § 991.2131 and all applicable State and Federal regulations. Member Pharmacy agrees to grant access to records to the employees and agents of the Pennsylvania Department of Health, Insurance Department, and Department of Public Welfare with direct responsibility for quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with State law. 28 Pa. Admin. Code § 9.722(e)(2).

e. Member Pharmacy agrees to participate in and abide by the decisions of MedImpact's and Payor's quality assurance, utilization review and Eligible Person complaint and grievance systems. 28 Pa. Admin. Code § 9.722(e)(3).


h. MedImpact shall make payment to Member Pharmacy for Prescription Drug Benefits rendered to Eligible Persons within the time required by State law, which currently requires payment within forty-five (45) days after the date a claim for payment is received with all documentation reasonably necessary for MedImpact to process the claim. 28 Pa. Admin. Code § 9.722(e)(6).

i. Notwithstanding anything to the contrary in the Agreement, MedImpact and Member Pharmacy shall provide each other at least sixty (60) days prior written notice if either party terminates the Agreement without cause. 28 Pa. Admin. Code § 9.722(e)(7).

j. MedImpact shall give Member Pharmacy at least thirty (30) days prior written notice of any changes to contracts, policies or procedures affecting Member Pharmacy or the provision or payment of health care services to Eligible Persons, unless the change is required by Law. 28 Pa. Code § 9.722(e)(8).

k. MedImpact shall offer no financial incentive reimbursement system to Member Pharmacy which shall weigh utilization performance as a single component more highly than quality of care, enrollee services and other factors collectively. 28 Pa. Admin. Code § 9.722(f)(2).

l. MedImpact shall offer no financial incentive that compensates Member Pharmacy for providing less than medically necessary and appropriate care to an Eligible Person. 28 Pa. Admin. Code § 9.722(f)(3).

3. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a preferred provider organization under Pennsylvania Law, Member Pharmacy agrees:

a. Member Pharmacy hereby agrees that in no event, including, but not limited to non-payment by MedImpact or Payor, insolvency of MedImpact or Payor, or breach of this Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons or persons other than MedImpact or Payor acting on behalf the Eligible Person for Prescription Drug Benefits as set forth in this Agreement. This provision shall not prohibit collecting supplemental charges or copayments in accordance with the terms of the applicable agreement between Payor and the Eligible Person. 31 Pa. Admin. Code §§ 152.14, 152.104(a)(3)(i).

b. Member Pharmacy agrees to participate in and abide by the decisions of MedImpact’s and Payor’s quality assurance, utilization review and Eligible Person complaint and grievance systems. 31 Pa. Admin. Code § 152.104(a)(3)(ii), (iii).

c. Member Pharmacy agrees to abide by Payor’s rules and regulations for preferred providers, including those regarding hospital privileges,

d. Member Pharmacy shall keep confidential records of Eligible Persons in accordance with 40 Pa. Stat. § 991.2131 and all applicable State and Federal regulations. Member Pharmacy agrees to grant access to records to the employees and agents of the Pennsylvania Department of Health, Insurance Department, and Department of Public Welfare with direct responsibility for quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with State law. 31 Pa. Admin. Code § 152.104(a)(3)(v).

e. Member Pharmacy agrees that Payor may immediately terminate Member Pharmacy’s participation and preferred status if Member Pharmacy is found to be harming Eligible Persons. 31 Pa. Admin. Code § 152.104(a)(3)(vi).
RHODE ISLAND ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization, health plan, insurer or carrier licensed under Rhode Island law (collectively and/or individually, “Payor”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Notwithstanding anything to the contrary in the Agreement, MedImpact shall not terminate Member Pharmacy “without cause”; provided, however, that “cause” shall include lack of need due to economic considerations. R.I. Gen. Laws § 23-17.13-3(c)(10); 14 000 CRIR 022 § 5.3.

2. MedImpact shall afford Member Pharmacy due process for all adverse decisions resulting in a change of Member Pharmacy’s status as a participating Member Pharmacy. MedImpact shall notify Member Pharmacy of the proposed actions and the reasons for the proposed action. MedImpact shall give Member Pharmacy the opportunity to contest the proposed action and participate in the internal appeals process set forth in the Agreement. R.I. Gen. Laws § 23-17.13-3(c)(11); 14 000 CRIR 022 § 5.12.


4. Member Pharmacy agrees that in the event of the insolvency of Payor or MedImpact, Eligible Persons shall not be liable to Member Pharmacy for charges for Prescription Drug Benefits received before the time of insolvency. R.I. Gen. Laws § 27-41-13(h).

5. In the event of the insolvency of Payor or MedImpact, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons confined in hospitals, skilled nursing facilities, intermediate care facilities, or home health agencies at the time of insolvency until the earlier of discharge or ninety (90) days following the insolvency or, for Eligible Persons of federally qualified health maintenance organizations, for that period of time required by federal standards for confinement coverage. Member Pharmacy shall continue to provide Prescription Drug Benefits to all other Eligible Persons for a period of thirty (30) days following the insolvency. Gen. Laws of R.I. § 27-41-13(h).

6. Member Pharmacy agrees that Eligible Persons shall not be liable to Member Pharmacy for charges for covered health services, except for amounts due for copayments or deductibles billed in accordance with the terms of Payor’s...
SOUTH CAROLINA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, health benefit plans, insurers, or carriers under South Carolina law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Pharmacy shall neither bill Eligible Persons of a health maintenance organization for services rendered nor hold Eligible persons of a health maintenance organization financially responsible for services rendered. S.C. Stat. § 38-33-130(B).

2. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy acknowledges that Member Pharmacy, MedImpact and Payor are each responsible for the legal consequences and costs of their own acts or omissions and shall not be responsible for the acts or omissions, or both, of the other parties. S.C. Stat. § 38-71-1740(A)(1).

3. Nothing in the Agreement shall be construed to limit Member Pharmacy’s ability to discuss with an Eligible Person, the treatment options available to the Eligible Person, risks associated with treatments, utilization management decisions, and recommended course of treatment. S.C. Stat. § 38-71-1740(A)(2).

4. Nothing in the Agreement shall be construed to limit Member Pharmacy’s legal obligations to an Eligible Person as specified under Member Pharmacy’s professional license. S.C. Stat. § 38-71-1740(A)(2).

5. In the event Member Pharmacy terminates its participation under the Agreement, Member Pharmacy shall, if requested, continue to provide Prescription Benefit Services to Eligible persons, subject to the terms of the Agreement, for a period of ninety (90) days or the anniversary date of the plan, whichever occurs first. S.C. Stat. § 38-71-1730(A)(4).

6. In the event Member Pharmacy’s participation under the Agreement is terminated or non-renewed and Member Pharmacy is then providing Prescription Drug Benefits to Eligible Persons with a serious medical condition, Member Pharmacy agrees to continue to provide Prescription Drug Benefits to such Eligible Persons for ninety (90) days or until termination of the Eligible Person’s benefit period, whichever is greater. During this period of continued care, Member Pharmacy shall accept as payment in full the rates set forth in the Agreement and, except for applicable deductibles or copayments, shall not bill or otherwise hold an Eligible Person financially responsible for Prescription Drug Benefits rendered in the continuation of care. For purposes of this paragraph, “serious medical condition” means a health condition or illness, that
requires medical attention, and where failure to provide the current course of treatment through Member Pharmacy would place the person’s health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. The provisions of this paragraph shall not apply in the event Member Pharmacy’s license is suspended or revoked. S. C. Stat. §§ 38-71-243, 38-71-246
SOUTH DAKOTA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under South Dakota law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy services Eligible Persons of a health carrier offering a managed care plan under South Dakota law, Member Pharmacy agrees:

   a. Member Pharmacy agrees that in no event, including but not limited to nonpayment by MedImpact or Payor of amounts due Member Pharmacy under this Agreement, insolvency of MedImpact or Payor or any breach of this Agreement by MedImpact or Payor, shall Member Pharmacy or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Eligible Persons, including Eligible Persons who have a health savings account, persons acting on the Eligible Person’s behalf, other than MedImpact or Payor, except for the payment of applicable co-payment, co-insurance, or deductibles for services covered by the Payor. S.D. Codified Laws § 58-17F-11(2).

   b. Member Pharmacy’s obligations with respect to the services for which Member Pharmacy will be responsible, including any limitations or conditions on services, and with respect to determining whether an individual is an Eligible Person are governed by the Agreement and any related attachments thereto. S.D. Codified Laws § 58-17F-11(1), (9).

   c. MedImpact’s provisions stating the requirements and responsibilities of Member Pharmacy with respect to MedImpact’s applicable administrative policies and programs, including payment terms, copayments and deductibles, utilization review, quality assessment, and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs are set forth in the Agreement and related attachments. S.D. Codified Laws §§ 58-17F-11 (4), (8).

   d. Member Pharmacy shall not be penalized or prohibited from (1) discussing treatment options with Eligible Persons; (2) for advocating on behalf of Eligible Persons within the utilization review or grievance processes established by Payor or MedImpact; or (3) reporting, in good faith, to state or federal authorities any act or practice by Payor.
or MedImpact that jeopardizes patient health or welfare. S.D. Codified Laws § 58-17F-11(5).

d. In accordance with the Agreement, related attachments, and any applicable government program addenda to the Agreement, Member Pharmacy shall make health records available upon request so that MedImpact can process claims, perform necessary quality assurance or quality improvement programs, or comply with any lawful request for information from appropriate state authorities. S.D. Codified Laws § 58-17F-11(6).

e. Notwithstanding anything in the Agreement to the contrary, either party shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. If Member Pharmacy either gives or receives notice of termination without cause, Member Pharmacy agrees, upon MedImpact’s request, to continue to provide Prescription Drug Benefits to Eligible Persons and to follow all applicable requirements of the Agreement for the following time periods, whichever is applicable: (i) for a period of ninety days following the effective date of the termination; or (ii) for Eligible Persons who have entered the second trimester of pregnancy at the time of termination, until the completion of postpartum care directly related to the delivery. S.D. Codified Laws § 58-17F-11(7).

f. Member Pharmacy acknowledges and agrees that Payor retains the right to disapprove Member Pharmacy’s participation status in Payor’s network. S.D. Codified Laws § 58-17F-12(2).

g. Member Pharmacy agrees that in the event of MedImpact’s insolvency Payor may require the assignment to Payor of the provisions of the Agreement addressing Member Pharmacy’s obligation to provide Prescription Drug Benefits. S.D. Codified Laws § 58-17F-12(7).

2. To the extent Member Pharmacy services Eligible Persons of a discount medical plan under South Dakota law, Member Pharmacy agrees:

a. MedImpact’s Pharmacy Network Authorization to Participate Form for MedImpact’s Consumer Discount Card Network contains: (1) MedImpact’s requirements concerning the services and products to be provided by Member Pharmacy at a discount; (2) Member Pharmacy’s applicable discounted rates and (3) the requirement that Member Pharmacy will not charge Eligible Persons more than the discounted rates. S.D. Codified Laws §§ 58-17E-27; 58-17E-28; 58-17E-29.
This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, prepaid limited health service organizations, third-party prescription programs, health maintenance organizations and health care service corporations, under Tennessee law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payor, MedImpact or any Payor’s insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Member Pharmacy shall not add additional charges to the Copayment for the provision of Prescription Drug Benefits under this Agreement. If MedImpact determines that Member Pharmacy has overcharged an Eligible Person, Member Pharmacy will promptly pay such overpayment to MedImpact or such Eligible Person as directed upon notification by MedImpact. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Person or someone acting on Eligible Person’s behalf. Tenn. Code § 56-32-105(c).

2. Member Pharmacy acknowledges that MedImpact operates only as an intermediary between Payors and Member Pharmacy with respect to payment. Payors have agreed with MedImpact to pay sufficient funds for claims submitted by Member Pharmacy. Provided that sufficient payment has been received by MedImpact from Payor and provided the applicable Copayment has been collected by Member Pharmacy, MedImpact will pay Member Pharmacy for Prescription Drug Benefits provided to Eligible Persons in accordance with the payment rate information communicated to Member Pharmacy through the electronic claims system, less the applicable Copayment. Such payments will be made within thirty (30) days of receipt of such a clean claim. Any overpayments made to Member Pharmacy or amounts owed by Member Pharmacy to MedImpact (including but not limited to POS charges, administrative charges, claim overpayments and reversals) may be deducted from amounts otherwise payable to Member Pharmacy.
Member Pharmacy acknowledges, understands, and agrees that claim payment amounts are the sole and absolute responsibility of the Payor. Member Pharmacy further acknowledges, understands, and agrees that MedImpact is not obligated to pay Member Pharmacy for claims of a Payor if a Payor fails to provide MedImpact with sufficient funds for such payment, and MedImpact has no liability to Member Pharmacy for nonpayment or for any delay in payment from a Payor. Accordingly, Member Pharmacy agrees to recover any unpaid balances from Payor only and that Member Pharmacy shall have no claim against MedImpact, and shall not seek payment from MedImpact, above or beyond the amount of payments made to MedImpact by the applicable Payor regardless of the cause of any non-payment or delay in payment by Payor. Member Pharmacy acknowledges, understands, and agrees that MedImpact is not the Payor and that except as otherwise set forth in this Agreement, there are no third party beneficiaries under this Agreement.

In the event that a Payor makes an assignment for the benefit of creditors, files a voluntary or involuntary petition in bankruptcy, is adjudicated insolvent or bankrupt, or a receiver or trustee is appointed, MedImpact shall have the right, but not the obligation, to participate in such proceedings on behalf of Member Pharmacy. MedImpact has the right to deduct from amounts otherwise payable to Member Pharmacy the Member Pharmacy’s pro rata share of any reasonable costs and fees (including attorneys’ fees) incurred by MedImpact in any such proceedings. All such amounts shall become immediately due and owing by Member Pharmacy upon notification by MedImpact. Tenn. Code § 63-10-103.

3. Any and all disputes, controversies or claims (including without limitation tort claims, requests for provisional remedies or other interim relief and issues as to arbitrability of any matter) arising out of, in connection with, or relating to this Agreement, or the breach hereof, that cannot be settled through negotiation shall be settled (a) first, by the parties trying in good faith to settle the dispute by mediation under the Commercial Mediation Rules of the American Health Lawyers Association (“AHLA”) (such mediation session to be held in San Diego, California and to commence within fifteen (15) days of the appointment of the mediator by the AHLA), and (b) if the controversy, claim or dispute cannot be settled by mediation, then by arbitration administered by the AHLA under its Arbitration Rules (such arbitration to be held in San Diego, California before a single arbitrator and to commence within twenty (20) days of the appointment of the arbitrator by the AHLA), and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Any controversy, claim or dispute under $500,000 shall be handled in accordance with the expedited procedures under the AHLA Arbitration Rules. This Agreement shall be construed and enforced in accordance with the laws of the State of California, without regard to conflict of law principles. The arbitrator must follow the rule of Law of California, and may only award remedies provided in the Agreement. The award of the arbitrator will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. The expenses of the arbitration, including reasonable attorney’s fees, will be paid for by the party against whom the award of the arbitrator is rendered. Any damages awarded may not exceed the
amount of payments made under this Agreement (excluding amounts paid by MedImpact on behalf of Payors). The award of the arbitrator will not prohibit MedImpact from exercising any right MedImpact may have pursuant to the Agreement or Law. The mediation and arbitration provisions of this paragraph shall be binding upon all parties and shall be the sole and exclusive method of handling any and all disputes, claims and controversies arising out of or related to this Agreement. Tenn. Code § 63-10-103.

4. Member Pharmacy must comply with the credentialing and quality assurance initiatives required by MedImpact, including any special quality management requirements and programs established by MedImpact or Payors. Member Pharmacy must meet all standards of operation as required by Law. Member Pharmacy must maintain an internal quality assurance program and, upon request, report on such program to MedImpact, along with remedial action plans. Tenn. Admin. Code § 1200-8-33-.06(7).

5. MedImpact, and its authorized agents, have the right to audit compliance with the Agreement during the term of the Agreement and for six (6) years after its expiration, or any longer period as required by applicable law. Upon reasonable notice from MedImpact, during regular business hours, Member Pharmacy must provide auditors with or access to examine and/or copy any and all documents and records that MedImpact deems necessary to determine whether the Member Pharmacy is compliant with the Agreement. Member Pharmacy must promptly comply with all requests for documentation and records. Tenn. Admin. Code § 1200-8-33-.06(7).

6. To the extent Prescription Drug Benefits are provided to Eligible Persons of a prepaid limited health service organization, the Agreement may be canceled upon issuance of an order by the Tennessee Department of Insurance pursuant to Tenn. Code § 56-51-129(c).

7. To the extent Member Pharmacy services Eligible Persons of a discount medical plan organization under Tennessee law, MedImpact’s Pharmacy Network Authorization to Participate Form for MedImpact’s Consumer Discount Card Network contains: (1) the requirements concerning the services and products to be provided by Member Pharmacy at a discount; and (2) Member Pharmacy’s applicable reimbursement rates. Tenn. Code § 47-18-2701.
TEXAS ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, preferred provider plan carriers, exclusive provider benefit plan issuers, health maintenance organizations ("HMOs"), and managed care entities under Texas law (collectively and/or individually, "Payor").

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. Upon request by any reasonable and verifiable means, Member Pharmacy is entitled to all information necessary to determine that Member Pharmacy is being compensated in accordance with the Agreement. Member Pharmacy may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment methodology and fee schedules applicable to payment for specific services that Member Pharmacy will receive under the Agreement. MedImpact may provide the required information by any reasonable method. MedImpact shall provide the information not later than the 30th day after the date MedImpact receives the request. The information shall include a level of detail sufficient to enable a reasonable person with experience and competence in claim processing to determine the payment to be made according to the terms of the Agreement for covered Prescription Drug Benefits that are rendered to Eligible Persons. MedImpact will provide notice of changes to information that will result in a change of payment to Member Pharmacy not later than the 90th day before the date the changes take effect and shall not make retroactive revisions to the coding guidelines and fee schedules. The Agreement may be terminated by Member Pharmacy on or before the 30th day after the date Member Pharmacy receives information requested in this paragraph without penalty or discrimination in participation in other health care products or plans. Upon receipt of information described in this paragraph, Member Pharmacy may only: (1) use or disclose the information for the purpose of practice management, billing activities, and other business operations and (2) disclose the information to a governmental agency involved in the regulation of health care or insurance. MedImpact shall, on Member Pharmacy’s request, provide the name, edition, and model version of the software that MedImpact uses to determine bundling and unbundling of claims, if applicable. This provision may not be waived, voided, or nullified by contract. Tex. Ins. Code §§ 843.321, 1301.136; 28 Tex. Admin. Code §§ 3.3703(20), 11.901(a)(11).

2. If Member Pharmacy voluntarily terminates its participation under the Agreement, Member Pharmacy shall provide reasonable advance notice to each Eligible Person under Member Pharmacy’s care. MedImpact shall provide assistance to Member Pharmacy in ensuring that the notice requirements are met. Tex. Ins. Code §§ 843.309, 1301.160; 28 Tex.

3. Neither MedImpact nor Payor shall reduce or limit payment to Member Pharmacy, or otherwise penalize Member Pharmacy, because Member Pharmacy provides an outpatient contraceptive service. Tex. Ins. Code § 1369.107.

4. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be required to hold harmless Payor or otherwise assume tort liability resulting from Payor’s acts or omissions. Tex. Ins. Code §§ 843.310, 1301.065; 28 Tex. Admin. Code §§ 3.3703(9), 3.9204(h), 11.901(a)(7).

5. Neither MedImpact nor Payor shall engage in any retaliatory action against Member Pharmacy, including terminating Member Pharmacy’s participation under the Agreement or refusing to renew the Agreement, because Member Pharmacy has reasonably filed a complaint against Payor on behalf of an Eligible Person or appealed a decision by Payor. Tex. Ins. Code §§ 843.281, 1301.066; 28 Tex. Admin. Code § 11.901(a)(2).

6. Neither MedImpact nor Payor shall prohibit, attempt to prohibit, or discourage Member Pharmacy from discussing or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient regarding: (1) information or an opinion about the patient’s health care, including the patient’s medical condition or treatment options; (2) the provisions, terms, requirements, or services of the Plan as they relate to the patient’s medical needs; (3) the fact that the Agreement has terminated or that Member Pharmacy will otherwise no longer be providing services under the Plan; or (4) the fact that Payor must allow referral to a non-network provider within no more than five business days of Member Pharmacy’s request if medically necessary covered Prescription Drug Benefits are not available in network. Neither MedImpact nor Payor shall in any way penalize, terminate the participation of, or refuse to compensate Member Pharmacy for covered Prescription Drug Benefits because Member Pharmacy discussed or communicated with a current, prospective, or former patient, or a person designated by a patient regarding such matters. Tex. Ins. Code §§ 843.363, 1301.067; 28 Tex. Admin. Code §§ 3.3703(13), 3.9204(l)-(m), 11.903, 11.2604(b)(7).

7. Neither MedImpact nor Payor shall use any financial incentive or make payment to Member Pharmacy that acts directly or indirectly as an inducement to limit medically necessary services. Tex. Ins. Code §§ 843.314, 1301.068; 28 Tex. Admin. Code § 3.3703(7).


10. Neither MedImpact nor Member Pharmacy shall sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the Agreement without the express authority of and prior adequate notification to the other. Tex. Ins. Code § 1301.056.

11. MedImpact shall provide Member Pharmacy written reasons for the termination of the Agreement at least ninety (90) days prior to the effective date of the termination. Within thirty (30) days following receipt of the written termination notice, Member Pharmacy may request a review by MedImpact or Payor’s advisory review panel. Within sixty (60) days of Member Pharmacy’s request and before the effective date of the termination, Member Pharmacy shall be entitled to a review of the proposed termination by the advisory review panel, except in a case in which there is imminent harm to patient health or an action by a state pharmacy board, or other licensing board or governmental agency, that effectively impairs Member Pharmacy’s ability to practice, or in a case of fraud or malfeasance. The advisory review panel shall be composed of physicians and providers, including at least one representative in Member Pharmacy’s specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Payor or MedImpact, as applicable. Within that same 60-day period, the advisory review panel must make its formal recommendation and MedImpact shall communicate the decision regarding termination to Member Pharmacy. The decision of the advisory panel must be considered but is not binding on Payor or MedImpact. MedImpact or Payor, as applicable, shall provide Member Pharmacy, on request, a copy of the recommendation of the advisory review panel and the determination of Payor or MedImpact. On Member Pharmacy’s request, Member Pharmacy is entitled to an expedited review process. Tex. Ins. Code §§ 843.306, 843.307, 1301.057; 28 Tex. Admin. Code §§ 3.3703(19), 3.3706, 3.9204(e), (g), 11.901(a)(5).


13. Neither MedImpact nor Payor shall refuse to process or pay an electronically submitted clean claim as defined by Tex. Ins. Code Title 8, Subtitle D, Chapter 1301, Subchapter C, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. Tex. Ins. Code §§ 843.323, 1301.0641; 28 Tex. Admin. Code §§ 3.3703(22), 11.901(c).

14. Member Pharmacy agrees that in no event, including, but not limited to non-payment by Payor or MedImpact, insolvency of Payor or MedImpact,
or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Eligible Person or a person, other than Payor or MedImpact, acting on their behalf for covered Prescription Drug Benefits provided pursuant to the Agreement. This provision shall not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Plan. Member Pharmacy further agrees that this provision shall survive termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Eligible Persons. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the Texas Insurance Commissioner has received written notice of such proposed changes. Tex. Ins. Code §§ 843.361, 1272.055; 28 Tex. Admin. Code § 3.9204(i), 11.901(1).

15. In the event of termination of this Agreement, Member Pharmacy shall provide reasonable advance notice of the impending termination to Eligible Persons who are current patients of Member Pharmacy. Termination of the Agreement, unless based on medical competence or professional behavior, does not release Payor from the obligation to continue reimbursing Member Pharmacy for providing medically necessary covered Prescription Drug Benefits at the time of termination to Eligible Persons who have special circumstances in accordance with the dictates of medical prudence. Examples of Eligible Persons who may have special circumstances include an Eligible Person with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy. Payor shall provide continued reimbursement at rates no less than the rates set forth in the Agreement for the Eligible Persons’ care in exchange for continuity of ongoing treatment. For purposes of this provision, “special circumstance” means a condition such that Member Pharmacy reasonably believes that discontinuing care by Member Pharmacy could cause harm to the Eligible Persons. Member Pharmacy shall identify in writing a special circumstance warranting continued service and must request that an Eligible Person be permitted to continue treatment under Member Pharmacy’s care and agree not to seek payment from the Eligible Person of any amount for which the Eligible Person would not be responsible if the Member Pharmacy continued to participate under the Agreement. Disputes regarding the necessity for continued treatment by Member Pharmacy shall be resolved directly between Member Pharmacy and MedImpact and/or Payor, as applicable. This provision does not extend the obligation of Payor or MedImpact to reimburse Member Pharmacy for ongoing treatment of an Eligible Person after: (1) the 90th day following the effective date of termination or (2) if the Eligible Person has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination. However, the obligation of Payor to reimburse Member Pharmacy for services provided to an Eligible Person who is past the 24th week of pregnancy at the time of termination, extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery. Tex. Ins. Code §§ 843.362, 1272.302; 28 Tex. Admin. Code §§ 3.3703(12), 3.9204(f), 11.901(a)(3).
16. MedImpact shall not directly or indirectly charge Member Pharmacy a fee for electronically accessing information about an Eligible Person’s eligibility status, benefit level, or financial information such as copayment and deductible requirements. Tex. Ins. Code § 1274.003.

17. Nothing in the Agreement shall be construed to restrict Member Pharmacy from contracting with other insurers, preferred provider plans, preferred provider organizations, or HMOs. 28 Tex. Admin. Code § 3.3703(1).

18. If MedImpact or Payor uses economic profiling to admit or terminate Member Pharmacy from participation under the Agreement, MedImpact shall make available to Member Pharmacy upon request the economic profile of Member Pharmacy, including the written criteria by which Member Pharmacy’s performance is to be measured. MedImpact shall adjust the economic profile to recognize the characteristics of Member Pharmacy’s practice that may account for variations from expected costs. Tex. Ins. Code § 1301.058; 28 Tex. Admin. Code §§ 3.3703(14), 3.9204(j).

19. Nothing in the Agreement shall be construed to condition the administration of an immunization or vaccination by Member Pharmacy upon the issuance of an immunization or vaccination protocol by a physician. 28 Tex. Admin. Code §§ 3.3703(16), 11.904.

20. Nothing in the Agreement shall be construed to prohibit Member Pharmacy from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act. §§ 3.3703(17), 11.904.

21. Notwithstanding anything to the contrary in the Agreement, Member Pharmacy shall not be required to provide financial statements or make a deposit with MedImpact as a condition of applying to participate or continuing to participate under the Agreement. 28 Tex. Admin. Code § 3.4204.

22. Member Pharmacy shall be entitled to a waiver of the requirement that claims be electronically submitted under the Agreement in any of the following circumstances:

   a. No method is available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C.R.F., Parts 160 and 162) do not support all of the information necessary to process the claim.

   b. The operation of small provider practices. This exception applies to those providers with fewer than ten full-time-equivalent employees, consistent with 42 C.F.R. § 424.32(d)(1)(vii).

   c. Demonstrable undue hardship, including fiscal or operational hardship.

   d. Any other special circumstances that would justify a waiver.
Member Pharmacy’s request for a waiver must be in writing and must include documentation supporting the issuance of a waiver. Upon receipt of a request for a waiver, MedImpact shall, within fourteen (14) calendar days, issue or deny a waiver in writing to Member Pharmacy. A written denial shall include the reasons therefore and provide notice of Member Pharmacy’s right to appeal the determination to the Texas Department of Insurance within fourteen (14) calendar days of receipt. MedImpact shall not refuse to contract or renew the Agreement with Member Pharmacy because Member Pharmacy has requested a waiver or appealed a waiver determination.

Notwithstanding anything to the contrary in the Agreement, MedImpact shall not limit the mode of electronic transmission that Member Pharmacy may use to submit information to MedImpact electronically. Notwithstanding anything to the contrary in the Agreement, MedImpact shall not directly or indirectly charge or hold Member Pharmacy responsible for a fee for the adjudication of a claim. MedImpact shall provide Member Pharmacy ninety (90) calendar day’s written notice before requiring Member Pharmacy to electronically submit claims or equivalent encounter information, referral certifications, or any authorization or eligibility transactions. Tex. Ins. Code § 1213.005; 28 Tex. Admin. Code § 11.901(a)(13), 21.3701.

23. MedImpact shall provide at least sixty (60) calendar day’s prior written notice of any changes of address for submission of claims and of any changes of delegation of claims payment functions to Member Pharmacy. 28 Tex. Admin. Code § 21.2811.

24. Nothing in the Agreement shall be construed to extend statutory or regulatory time frames set forth by Texas law or to waive Member Pharmacy’s right to recover reasonable attorney’s fees and court costs where provided for by statute. 28 Tex. Admin. Code § 21.2817.

25. To the extent Member Pharmacy services Eligible Persons of a discount health care program under Texas law, Member Pharmacy agrees:

a. MedImpact’s Pharmacy Network Authorization to Participate Form for MedImpact’s Consumer Discount Card Network contains: (1) MedImpact’s requirements concerning the services and products to be provided by Member Pharmacy at a discount; (2) Member Pharmacy’s applicable discounted rates; and (3) the requirement that Member Pharmacy will not charge Eligible Persons more than the discounted rates. Tex. Health & Safety Code § 76.056(a).

b. Member Pharmacy shall notify MedImpact in the event Member Pharmacy loses the authority to provide such services or products, including by suspension or revocation of Member Pharmacy’s license. Tex. Health & Safety Code § 76.056(a).

Member Pharmacy agrees to participate in pharmacy audits as set forth in the Agreement. Notwithstanding anything to the contrary in the Agreement, MedImpact shall provide Member Pharmacy with written notice of an audit via certified mail no later than 15 days before an on-site audit is scheduled to occur. MedImpact shall not use extrapolation to
complete an audit of Member Pharmacy, and nothing in the Agreement shall be construed as requiring Member Pharmacy to agree to extrapolation audits as a condition of participation under the Agreement. Tex. Ins. Code §§ 843.3401, 1301.1041.

26. Member Pharmacy agrees to comply with all applicable requirements of Insurance Code § 1661.005 and refund any overpayment received from an Eligible Person within 30 days after Member Pharmacy determines that an overpayment has been made. Tex. Ins. Code § 1661.005; 28 Tex. Admin. Code § 3.3703(25).
UTAH ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, managed care organizations, insurers, or carriers under Utah law.

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. During the first two (2) years of the Agreement, MedImpact may terminate the Agreement with or without cause upon providing Member Pharmacy with the requisite amount of notice provided in the Agreement, but in no case shall it be less than sixty (60) days. Utah Code Ann. § 31A-22-617.1(2)(a).

2. MedImpact may terminate Member Pharmacy for cause as provided in the Agreement provided that prior to terminating for cause, MedImpact shall:
   a. Inform Member Pharmacy of its intent to terminate and the grounds for doing so; and
   b. Upon Member Pharmacy’s request, MedImpact shall meet with Member Pharmacy to discuss the reasons for termination.


3. Notwithstanding the above, if MedImpact has a reasonable basis to believe that Member Pharmacy has engaged in fraudulent conduct or poses a significant risk to patient care or safety, MedImpact may immediately suspend Member Pharmacy from further performance under the Agreement, provided that Member Pharmacy shall be made aware of and allowed to access MedImpact’s internal appeals process before termination may become final. Utah Code Ann. § 31A-22-617.1(c)-(d).

4. MedImpact and Member Pharmacy agree to resolve all disputes, controversies and claims in the manner set forth in the Agreement and any related attachments, with the exception that, if arbitration is initiated, the arbitrator shall be jointly selected by the parties, the cost of which shall be jointly shared, and each party shall bear its own additional expenses. Utah Code §§ 31A-22-617.1(2)(d); 31A-22-617(1)(a)(iii); 31A-8-407.

5. If Payor or MedImpact fails to pay for Prescription Benefit Services as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by Payor or MedImpact. Utah Code §§ 31A-8-407(1)(a)(i); 31A-22-617(1)(a)(i).

6. Member Pharmacy acknowledges and agrees that if Payor or MedImpact becomes insolvent, the rehabilitator or liquidator may require Member Pharmacy to:

4/16/2014
a. Continue to provide Prescription Drug Benefits until the earlier of (a) ninety (90) days after the date of the filing of a petition for rehabilitation or liquidation or (b) the date the term of the Agreement ends; and

b. Reduce the fees that Member Pharmacy is otherwise entitled to receive from Payor or MedImpact under the Agreement during the time period described in the paragraph immediately above, provided that the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the Agreement and provided that Eligible Persons shall continue to pay the same copayments, deductibles, and other payments for services as before the petition for reorganization or liquidation. Member Pharmacy shall accept the reduced payment as payment in full and relinquish the right to collect additional amounts from Eligible Persons. Utah Code §§ 31A-8-407; 31A-22-617(1)(c).

7. Notwithstanding anything to the contrary in the Agreement, audits of Member Pharmacy shall be conducted in accordance with the processes set forth in Section 58-17b-622 of the Utah Code. Utah Code § 58-17b-622.
VERMONT ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of discount medical plans, health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Vermont law.

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides services to Eligible Persons of a managed care organization under Vermont Law, Member Pharmacy agrees:

   a. Nothing in the Agreement shall be construed to prohibit Member Pharmacy from disclosing to Eligible Persons or potential Eligible Persons information about the Agreement or the Eligible Person’s Plan that may affect their health or any decision regarding health. 18 Vt. Stat. Ann. § 9414(a)(3); Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(B).

   b. MedImpact shall not establish selection standards for Member Pharmacy’s initial or renewed participation under the Agreement in a manner that would exclude Member Pharmacy because it treats or specializes in treating populations presenting a risk of higher-than-average claims, losses or health services utilization or provides a higher-than-average level of uncompensated care. Copies of the selection standards will be made available to Member Pharmacy on request. This paragraph shall not be construed to prohibit MedImpact from declining to select Member Pharmacy if Member Pharmacy fails to meet other legitimate selection criteria of MedImpact, or requiring MedImpact to employ any specific providers or types of providers who may meet its selection criteria, or as requiring MedImpact to contract with or retain more providers than are necessary to maintain an adequate network unless otherwise prohibited by law. Nothing in this paragraph or this Addendum shall be construed to prohibit MedImpact for declining to select or from not renewing the Agreement with Member Pharmacy based on Member Pharmacy’s failure to conform to MedImpact’s and/or Payor’s quality of care standards and quality management program. Code of Vt. Regs. 21 040 010, Rule H-2009-03, §§ 5.3(C), (Q).

   c. MedImpact shall maintain an appeal process through which Member Pharmacy may obtain review of MedImpact’s decision to not renew the Agreement with Member Pharmacy based on MedImpact’s selection criteria. The appeal process shall include written notice to Member Pharmacy of MedImpact’s decision against renewal of the Agreement, which shall include a statement of the reasons for MedImpact’s decision not to renew the Agreement. It shall also include reasonable
time limits for taking and resolving the appeals, and a reasonable opportunity for Member Pharmacy to respond to MedImpact’s statement of reasons supporting its decision not to renew the Agreement. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(D).

d. Member Pharmacy shall not be prohibited from or penalized for (i) advocating on behalf of an Eligible Person within the utilization review or grievance processes established by Payor and/or MedImpact; (ii) discussing treatment options with Eligible Persons regardless of Payor’s position on the treatment options; or (iii) in good faith reporting to state or federal authorities any act or practice by MedImpact or Payor that jeopardizes patient health or welfare. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(F).

e. Member Pharmacy’s requirements and responsibilities with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, chronic care programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable provisions required by federal or state law are set forth in the Agreement, the Manual, and any related attachments. Member Pharmacy shall be allowed to participate in MedImpact’s quality management program, dispute resolution process, and utilization management program to the extent required by law. Member Pharmacy shall notify MedImpact of any changes that would impact Member Pharmacy’s credentialing status or ongoing availability to Eligible Persons. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(G).

f. Nothing in the Agreement shall be construed as creating an inducement to Member Pharmacy to forego providing medically necessary services to an Eligible Person or referring an Eligible Person to such services. Code of Vt. Regs. 21 040 010, Rule H-2009-03, §5.3(H).

g. Member Pharmacy agrees to take those steps necessary, as directed by MedImpact, to ensure the availability and confidentiality of the health records necessary to monitor and evaluate the quality of care, and to conduct medical and other health care evaluations and audits to determine, on a concurrent or retrospective basis, the necessity and appropriateness of care provided to Eligible Persons. Member Pharmacy shall make its health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Eligible Persons, and shall comply with the applicable state and federal laws related to the confidentiality of medical or health records. Code of Vt. Regs. 21 040 010, Rule H-2009-03 § 5.3(I).

h. Member Pharmacy agrees that in no event, including nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or a person (other than Payor) acting on behalf of the Eligible Person for Prescription Drug
Benefits provided pursuant to this Agreement. This provision does not prohibit Member Pharmacy from collecting coinsurance, deductibles, and copayments, as specifically provided in Eligible Person’s certificate or coverage, or fees for uncovered services delivered on a fee-for-service basis to Eligible Persons. This provision does prohibit Member Pharmacy from requesting payment from an Eligible Person for any services that have been confirmed by independent external review obtained through the Department of Banking, Insurance, Securities and Health Care Administration pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug. Code of Vt. Regs. 21 040 010, Rule H-2009-03, § 5.3(L).

i. In the event Payor and/or MedImpact becomes insolvent or otherwise ceases operations, Prescription Drug Benefits to Eligible Persons will continue through the period for which a premium has been paid to Payor on behalf of the Eligible Person or until the Eligible Person’s discharge from an inpatient facility, whichever period is greater. Prescription Drug Benefits to an Eligible Person confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Eligible Person’s continued confinement in the facility is no longer medically necessary. Code of Vt. Regs, Rule H-2009-03 § 5.3(M).

j. The provisions of paragraphs “h” and “i” above shall be construed in favor of the Eligible Person; shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of Payor and/or MedImpact, and shall supersede any oral or written contrary agreement between Member Pharmacy and an Eligible Person or an Eligible Person’s representative if the contrary agreement is inconsistent with the “hold harmless” and continuation of covered services provisions required in those paragraphs. Code of Vt. Regs. Rule H-2009-03 § 5.3(N).

k. Notwithstanding anything in the Agreement to the contrary, either party shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Such notices shall not issue unless and until negotiations have concluded and a final decision on termination has been reached. Within five (5) working days of the date that Member Pharmacy either gives or receives final notice of termination, either for or without cause, Member Pharmacy shall supply MedImpact with a list of its patients that are Eligible Persons of affected Payors. Code of Vt. Regs. 21 040 010, Rule H-2009-03 § 5.3(O).

l. Notwithstanding anything to the contrary, no clause in the Agreement shall operate to transfer to Member Pharmacy, by indemnification or otherwise, any liability relating to activities, actions or omissions of MedImpact or Payor as opposed to those of Member Pharmacy. Code of Vt. Regs. 21 040 010, Rule H-2009-03 § 5.3(R).

m. In the event the Agreement is terminated without cause by either party or MedImpact elects not to renew the Agreement without cause, Member Pharmacy agrees to continue to provide Prescription Drug
Benefits and abide by the payment rates, quality-of-care standards and protocols under the Agreement, and to provide the necessary clinical information to MedImpact and/or Payor, as follows:

i. For Eligible Persons with life-threatening, disabling or degenerative conditions, Member Pharmacy shall continue to provide Prescription Drug Benefits for sixty (60) days from the date of termination or non-renewal or until accepted by a contracted provider, whichever is shorter; and

ii. For Eligible Persons in their second or third trimester of pregnancy, Member Pharmacy shall continue to provide Prescription Drug Benefits until the completion of postpartum care.


2. To the extent Member Pharmacy services Eligible Persons of an HMO under Vermont Law, Member Pharmacy agrees:

a. Member Pharmacy agrees that in no event, including nonpayment by Payor or MedImpact, insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or a person (other than Payor) acting on behalf of the Eligible Person for Prescription Drug Benefits provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles, and coinsurances on MedImpact’s or Payor’s behalf made in accordance with the terms of the Plan between Payor and Eligible Persons. 8 Vt. Stat. Ann. § 5102b(d).

b. In the event of Payor’s insolvency, Member Pharmacy shall continue to provide Prescription Drug Benefits to Eligible Persons after Payor’s insolvency during the period for which premium payment has been made and until Eligible Persons’ discharge from inpatient facilities. 8 Vt. Stat. Ann. § 5102b(f).
VIRGINIA ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization, health plan, or carrier licensed under Virginia law (collectively and/or individually, “Payor”).

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. In the processing of any payment of claims for Prescription Drug Benefits rendered by Member Pharmacy under the Agreement and in performing under the Agreement, the parties shall adhere to and comply with the minimum fair business standards required under Va. Code Ann. § 38.2-3407.15(B), (see also Va. Code Ann. § 38.2-4319 and 4214) which include the following:

   a. Claims shall be paid within forty (40) days of receipt of the claim, except where the obligation to pay the claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by Member Pharmacy that:

      i. The claim is determined not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

      ii. The claim was submitted fraudulently. Va. Code Ann. § 38.2-3407.15(B)(1).

   b. MedImpact shall maintain a written or electronic record of the date of receipt of a claim. Member Pharmacy shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim. Va. Code Ann. § 38.2-3407.15(B)(1).

   c. MedImpact shall, within thirty (30) days after receipt of a claim, request electronically or in writing from Member Pharmacy the information and documentation that MedImpact believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection, claims shall be paid in compliance with this section. MedImpact shall not refuse to pay a claim for Prescription Drug Benefits rendered pursuant to this Agreement if MedImpact fails timely to notify or attempt to notify
Member Pharmacy of the matters identified above unless such failure was
casted in material part by Member Pharmacy; however, nothing herein
shall preclude MedImpact from imposing a retroactive denial of payment
of such a claim if permitted by the Agreement unless such retroactive
denial of payment of the claim would violate subsection (h) set forth
below. Nothing in this subsection shall require MedImpact to pay a claim
that is not a clean claim. Va. Code Ann. § 38.2-3407.15(B)(2).

d. Any interest owing or accruing on a claim under § 38.2-3407.1 or § 38.2-
4306.1 of Title 38.2 of the Virginia Code, under the Agreement, or under
any other applicable law shall, if not sooner, be paid without necessity of
demand at the time the claim is paid or within sixty (60) days thereafter.

e. MedImpact and/or Payor, as applicable, shall establish and implement
reasonable policies to permit Member Pharmacy (i) to confirm in advan
cing during normal business hours by free telephone or electronic means if
available whether the health care services to be provided are medically
necessary and a covered benefit and (ii) to determine the Payor’s
requirements applicable to Member Pharmacy (or to the type of health
care services which Member Pharmacy has contracted to deliver under
this Agreement) for (a) pre-certification or authorization of coverage
decisions, (b) retroactive reconsideration of a certification or
authorization of coverage decision or retroactive denial of a previously
paid claim, (c) Member Pharmacy-specific payment and reimbursement
methodology, coding levels and methodology, downcoding, and bundling
of claims, and (d) other Member Pharmacy-specific applicable claims
processing and payment matters necessary to meet the terms and
conditions of the Agreement, including determining whether a claim is a
clean claim. MedImpact does not routinely, as a matter of policy, bundle
or downcode claims submitted by Member Pharmacy. If, however,
MedImpact routinely, as a matter of policy, bundles or downcodes claims
submitted by a Member Pharmacy, MedImpact shall clearly disclose that
practice in each Member Pharmacy contract. Further, MedImpact shall
either (i) disclose in its Member Pharmacy contracts or on its website the
specific bundling and downcoding policies that MedImpact reasonably
expects to be applied to Member Pharmacy or Member Pharmacy’s
services on a routine basis as a matter of policy or (ii) disclose in each
Member Pharmacy contract a telephone or facsimile number or e-mail
address that Member Pharmacy can use to request the specific bundling
and downcoding policies that MedImpact reasonably expects to be
applied to that Member Pharmacy or Member Pharmacy’s services on a
routine basis as a matter of policy. If such request is made by or on
behalf of Member Pharmacy, MedImpact shall provide the requesting
Member Pharmacy with such policies within 10 business days following
the date the request is received. Va. Code Ann. § 38.2-
3407.15(B)(4)(a).

f. MedImpact shall make available to Member Pharmacy within ten (10)
business days of receipt of a request, copies of or reasonable electronic
access to all such policies that are applicable to Member Pharmacy or to
the particular health care services identified by Member Pharmacy. In
the event the provision of the entire policy would violate any copyright
law, MedImpact may instead comply with this subsection by timely
delivering to Member Pharmacy a clear explanation of the policy as it applies to Member Pharmacy and to any health care services identified by Member Pharmacy. Va. Code Ann. § 38.2-3407.15(B)(4)(b).

g. MedImpact and/or Payor shall pay a claim if MedImpact and/or Payor has previously authorized the health care service or has advised Member Pharmacy or Eligible Person in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

i. The documentation for the claim clearly fails to support the claim as originally authorized; or

ii. The refusal is because (i) another payor is responsible for the payment, (ii) Member Pharmacy has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to MedImpact or Payor by Member Pharmacy, Eligible Person, or other person not related to MedImpact or Payor, as applicable, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and MedImpact and/or Payor did not know, and with the exercise of reasonable care could not have known, of the person’s eligibility status. Va. Code Ann. § 38.2-3407.15(B)(5).

h. Neither MedImpact nor Payor may impose any retroactive denial of a previously paid claim unless MedImpact or Payor has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because Member Pharmacy was already paid for the services identified on the claim or the health care services identified on the claim were not delivered by Member Pharmacy, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which MedImpact and/or Payor requires under the Agreement that a claim be submitted by Member Pharmacy following the date on which a health care service is provided. MedImpact or Payor shall notify Member Pharmacy at least 30 days in advance of any retroactive denial of a claim. Va. Code Ann. § 38.2-3407.15(B)(6).

i. Neither MedImpact nor Payor may impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless MedImpact or Payor specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and provides a written explanation of why the claim is being retroactively adjusted. Va. Code Ann. § 38.2-3407.15(B)(7).

j. This Agreement shall include, at the time it is presented to Member Pharmacy for execution, (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid which is applicable to Member Pharmacy or to the range of health care services reasonably expected to be delivered by Member Pharmacy on a routine basis and (ii) all material addenda, schedules and exhibits thereto.
and any policies (including those referred to in subsection e above) applicable to Member Pharmacy or to the range of health care services reasonably expected to be delivered by Member Pharmacy under the Agreement. Va. Code Ann. § 38.2-3407.15(8).

k. No amendment to the Agreement or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit or policy) applicable to Member Pharmacy (or to the range of health care services reasonably expected to be delivered by Member Pharmacy) shall be effective as to Member Pharmacy, unless Member Pharmacy has been provided with the applicable portion of the proposed amendment (or the proposed new addenda, schedule, exhibit or policy) at least sixty (60) calendar days before the proposed effective date and Member Pharmacy has failed to notify MedImpact in writing within thirty (30) calendar days of receipt of the documentation of Member Pharmacy’s intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement. Va. Code Ann. § 38.2-3407.15(B)(9).

l. MedImpact and/or Payor shall not be violation of Va. Code Ann. § 38.2-3407.15 if its failure to comply is caused in material part by Member Pharmacy or if MedImpact’s or Payor’s compliance is rendered impossible due to matters beyond such entity’s control (such as an act of God, insurrection, strike, fire, or power outages), which are not caused in material part by MedImpact or Payor, as applicable. Va. Code Ann. § 38.2-3407.15(D).

m. In the event that MedImpact’s or Payor’s provision of a policy required to be provided under subsection j or k above would violate any applicable copyright law, MedImpact or Payor may instead comply with this subsection by providing a clear, written explanation of the policy as it applies to the Member Pharmacy. Va. Code Ann. § 38.2-3407.15(10).

n. MedImpact and/or Payor, as applicable, has established in writing its claim payment dispute mechanism and shall make this information available to Member Pharmacy upon request. Va. Code Ann. § 38.2-3407.15(11).

o. To the extent that the Agreement requires Member Pharmacy to submit claims electronically, Member Pharmacy shall be entitled to electronic payment of clean claims, as defined in subsection A of Section 38.3-3407, Va. Code Ann., if the claims are submitted in the form required by MedImpact, in compliance with 45 CFR Part 142, as amended, if Member Pharmacy agrees to accept claims details for such payments electronically, in compliance with 45 CFR Part 142, as amended, and if Member Pharmacy has provided accurate electronic funds transfer information to MedImpact. Va. Code Ann. § 38.3-3407.9:03.

p. Nothing in the Agreement shall be construed to require Member Pharmacy to deny covered services that Member Pharmacy knows to be medically necessary and appropriate that are provided with respect to a specific Eligible Person or group of Eligible Persons with similar medical conditions. Va. Code Ann. 38.2-4209(F).
2. To the extent Member Pharmacy provides services to members of an HMO, Member Pharmacy agrees to the following:

   a. Member Pharmacy hereby agrees that in no event, including, but not limited to nonpayment by Payor or MedImpact or the insolvency of Payor or MedImpact, or breach of the Agreement, shall Member Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Eligible Person other than the Payor for Prescription Drug Benefits provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of Payor’s subscriber agreement. Member Pharmacy further agrees that (i) this provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Payor’s Eligible Persons and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Member Pharmacy and Eligible Persons or persons acting on such Eligible Person’s behalf. Va. Code Ann. § 38.2-5805(C)(9), (10); Va. Code Ann. § 38.2-4301(C)(2).

   b. If Member Pharmacy terminates this Agreement, Member Pharmacy shall give MedImpact and Payor at least sixty (60) days advance written notice of termination. Va. Code Ann. § 38.2-5805(C)(1), (7).

   c. Neither Member Pharmacy nor its agent, trustee, or assignee thereof, may maintain any action at law against an Eligible Person to collect sums owed by Payor or MedImpact. Va. Code Ann. § 38.2-5805(C)(2), (5).

   d. In the event either Payor or MedImpact fails to pay for Prescription Drug Benefits as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by either MedImpact or Payor. Va. Code Ann. § 38.2-5805(C)(4).

3. To the extent Member Pharmacy provides services to a covered patient of a health insurer and to the extent required by Va. Code Ann. §8.01-27.5, Member Pharmacy agrees as follows:

   a. Member Pharmacy shall submit its claim to MedImpact for the applicable health care services in accordance with the terms of this Agreement, provided that the covered patient provides the Member Pharmacy with information required by the terms of the covered patient's health care policy's plan documents, including the information that is required to verify the individual's coverage under the health care policy, within not fewer than 21 business days before the deadline for the Member Pharmacy to submit its claim as required by the terms of the Agreement.

   b. If a Member Pharmacy does not submit its claim in accordance with the requirements of this Agreement, then (i) the covered patient shall have no obligation to pay for health care services for which the Member Pharmacy was required to submit its claim, (ii) Member Pharmacy shall not have the benefit of the liens provided by §§ 8.01-66.2 and 8.01-66.9 with regard to health care services for which the Member Pharmacy was required to submit its claim, and (iii) the
Member Pharmacy shall be prohibited from recovering payment for any of the health care services for which it was required to submit its claim for medical expense benefits to the covered patient under a policy of motor vehicle liability insurance pursuant to § 38.2-2201, by exercising an assignment of the covered patient's rights to the medical expense benefits, or by other means.

c. If Member Pharmacy submits its claim to MedImpact in accordance with the requirements of this Agreement, the covered patient or MedImpact, as applicable, shall be obligated to pay for the health care services in accordance with the terms of the Agreement or health care policy's plan documents, as applicable. To the extent that self-insured or self-funded plans governed by ERISA provide otherwise, Member Pharmacy shall be permitted to submit claims and coordinate benefits as otherwise provided for in the Agreement.
WASHINGTON ADDENDUM
TO MEDCARE PHARMACY NETWORK AGREEMENT

In the event any provision of this Addendum conflicts with the terms of the Agreement (including documents incorporated by reference therein, the terms of this Addendum shall control to the extent of the conflict with respect to Plans subject to the applicable Washington law or regulation.

To the extent that Member Pharmacy provides Pharmacy Services to Eligible Persons of a health carrier, health carrier service contractor, health maintenance organization (“HMO”), or other insurer licensed under Washington law (collectively and/or individually, “Payer”), Member Pharmacy agrees to comply with any requirements for participation as a Member Pharmacy in Washington as required by applicable law.

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. **Collection from Eligible Persons.** Section II of the Agreement is deleted in its entirety and replaced with the following:

   Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payer, MedImpact or any Payer’s insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf other than Payer, for services provided pursuant to the Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance, and/or non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Eligible Persons in accordance with the terms of the Eligible Person’s Plan. WAC 284-43-320(2)(a).

   Member Pharmacy agrees, in the event of insolvency of MedImpact or a Payer, to continue to provide the services promised in the Agreement to Eligible Persons for the duration of the period for which premiums on behalf of the Eligible Person was paid or until the Eligible Person’s discharge from inpatient facilities (if applicable), whichever time is greater. WAC 284-43-320(2)(b).

   Notwithstanding any other provision of this Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Eligible Person’s Plan. WAC 284-43-320(2)(c).

   Member Pharmacy may not bill the Eligible Person for covered services (except for deductibles, copayments, or coinsurance) where payment is denied because Member Pharmacy has failed to comply with the terms or conditions of the Agreement. WAC 284-43-320(2)(d).
To the extent permitted by the Agreement, if Member Pharmacy contracts with other providers or facilities who agree to provide covered services to Eligible Persons with the expectation of receiving payment directly or indirectly from MedImpact or Payer, such providers or facilities must agree to abide by the provisions of this section. WAC 284-43-320(2)(f).

Member Pharmacies that willfully collect or attempt to collect an amount from an Eligible Person knowing that collection to be in violation of the Member Pharmacy constitutes a Class C felony under WAC 284-43-320(3); RCW 48.80.030(5) and (6).

In the event MedImpact or Payer fails to pay for services as provided in the Agreement, the Eligible Person shall not be liable to the Member Pharmacy for sums owed by MedImpact or Payer. Member Pharmacy and its agents, trustees, or assignees may not maintain any action against an Eligible Person to collect sums owed by MedImpact and/or Payer. RCW 48.44.202(4)(a) and (b); RCW 48.46.243(4).

This Section II will survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Eligible Persons and supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Person or someone acting on Eligible Person’s behalf. WAC 284-43-320(2)(e).

2. Payment. Section IV of the Agreement shall be deleted in its entirety and replaced with the following:

Member Pharmacy acknowledges that MedImpact operates only as an intermediary between Payers and Member Pharmacy with respect to payment. Payers have agreed with MedImpact to pay sufficient funds for claims to MedImpact and submitted by Member Pharmacy. MedImpact will pay Member Pharmacy for Prescription Drug Benefits provided to Eligible Persons in accordance with the payment rate information communicated to Member Pharmacy through the electronic claims system, less the applicable Copayment.

For amounts due Member Pharmacy under the Agreement, Member Pharmacy shall be paid in accordance with the following minimum standards:

i. Ninety-five percent (95%) of monthly volume of a Payer’s clean claims shall be paid within thirty (30) days of receipt by MedImpact; and

ii. Ninety-five percent (95%) of the monthly volume of all of a Payer’s claims shall be paid or denied within sixty (60) days of receipt by MedImpact, except as agreed to in writing by the parties on a claim-by-claim basis.

WAC 284-43-321(a).

The receipt date of a claim is the date MedImpact receives either written or electronic notice of the claim. MedImpact has established a reasonable method for confirming receipt of claims and responding to Member Pharmacy inquires about claims via the online adjudication system and Member Pharmacy Help Desk. WAC 284-43-321(b) and (c).
Payer or MedImpact, as applicable, shall pay interest on undenied and unpaid clean claims more than sixty-one (61) days old until Payer or MedImpact, as applicable, meets the standards established in this section. Interest shall be assessed at the rate of one percent (1%) per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Interest shall be added to the amount of the unpaid claim without the necessity of the Member Pharmacy submitting an additional claim. Any interest paid under this section shall not be applied to an Eligible Person’s deductible, copayment, coinsurance, or any similar obligation of an Eligible Person. WAC 284-43-321(2)(d).

A “clean claim” means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section. WAC 284-43-321(3).

Denial of a claim will be communicated to Member Pharmacy, including the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, MedImpact or Payer, as appropriate, will provide Member Pharmacy with the supporting basis for the decision. WAC 284-43-321(4).

The standards set forth in this section do not apply to claims about which there is a substantial evidence of fraud or misrepresentation by Member Pharmacy or Eligible Persons, or instances where MedImpact has not been granted reasonable access to information under the Member Pharmacy’s control. WAC 284-43-321(6).

Member Pharmacy acknowledges, understands, and agrees that claim payment amounts are the sole and absolute responsibility of the Payer. Member Pharmacy further acknowledges, understands, and agrees that MedImpact is not obligated to pay Member Pharmacy for claims of a Payer if a Payer fails to provide MedImpact with sufficient funds for such payment, and MedImpact has no liability to Member Pharmacy for nonpayment or for any delay in payment from a Payer. Accordingly, Member Pharmacy agrees to recover any unpaid balances from Payer only and that Member Pharmacy shall have no claim against MedImpact, and shall not seek payment from MedImpact, above or beyond the amount of payments made to MedImpact by the applicable Payer regardless of the cause of any non-payment or delay in payment by Payer. Member Pharmacy acknowledges, understands, and agrees that MedImpact is not the Payer and that except as otherwise set forth in this Agreement, there are no third party beneficiaries under this Agreement.

In the event that a Payer makes an assignment for the benefit of creditors, files a voluntary or involuntary petition in bankruptcy, is adjudicated insolvent or bankrupt, or a receiver or trustee is appointed, MedImpact shall have the right, but not the obligation, to participate in such proceedings on behalf of Member Pharmacy. MedImpact has the right to deduct from amounts otherwise payable to Member Pharmacy the Member Pharmacy’s pro rata share of any reasonable costs and fees (including attorneys’ fees) incurred by MedImpact in any such proceedings. All such amounts shall become
3. **Indemnification and Limitation on Liability.** Section VII of the Agreement shall be deleted in its entirety and replaced with the following:

All liability arising from the provision of prescription drugs and services by Member Pharmacy, its employees, agents or representatives, including the professional judgment of Member Pharmacy, its employees, agents or representatives, will be the sole responsibility of Member Pharmacy. Member Pharmacy shall indemnify and hold harmless MedImpact, the Payers, and their respective employees, agents, representatives, members, eligible participants and dependents, against loss, expense, liability, or damage, including, without limitation, any and all claims, causes of action, judgments, awards, settlements, costs, fees, or debts of whatever nature, including without limitation reasonable attorneys’ fees and costs, arising out of or in connection with: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Member Pharmacy, its employees, agents or representatives in the performance or omission of any act assumed by Member Pharmacy; or (b) the provision of pharmacy services, including the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Member Pharmacy, its employees, agents or representatives. Such indemnification shall include the duty to defend any such legal action against MedImpact, the Payers, and their respective employees, agents, members, representatives, eligible participants, and dependents. MedImpact is not responsible or liable for Member Pharmacy’s professional judgment in its provision of prescription drugs and services. This Section VIII will survive the termination of this Agreement.

Notwithstanding any other term of this Agreement, in no event shall either party be liable to the other party for special, indirect, incidental, exemplary, consequential (including but not limited to loss of profits) or punitive damages arising from the relationship of the parties or the conduct of business under this Agreement (even if the other party has been advised of or has foreseen the possibility of such damages).

Member Pharmacy shall not be required to provide indemnification or otherwise assume liability relating to activities, actions, or omissions of Payer in violation of the standard of care provisions set forth in RCW 48.43.545.

4. **Entire Agreement.** Section XI of the Agreement is deleted in its entirety and replaced with the following:

This Agreement, the Pharmacy Network Participation Acceptance Form, any state-specific Pharmacy Network Addendum(s), and the Authorization to Participate forms related to the Networks constitute the entire Agreement between MedImpact and Member Pharmacy, all of which are incorporated herein by reference as if fully set forth herein and are referred to collectively as the “Agreement”. Except as incorporated herein by reference, any prior agreements, promises, negotiations, or representations concerning the subject matter covered by the Agreement are of no force and effect. In the event any provision or part thereof contained in the Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the validity or enforceability of
any other provision or part thereof of the Agreement. In the event of a conflict between any of the documents comprising the Agreement, the terms in the applicable state-specific Pharmacy Network Addendum shall control first, then the Agreement, Policies and Procedures in Section XIV, and the Authorization to Participate forms, in that order.

Unless otherwise required by this Agreement, including but not limited to changes affecting compensation and/or health care delivery which are governed by Subsection 7 of Section XIV, this Agreement may be amended from time to time by MedImpact by providing thirty (30) days prior written notice of such amendment to Member Pharmacy. Member Pharmacy may reject such amendment by providing written notice to MedImpact of its intent not to accept such amendment prior to its taking effect. MedImpact has the right to immediately terminate the Agreement in the event any amendment is rejected by Member Pharmacy. WAC 284-43-320(4).

5. Mediation and Arbitration. Section XIII of the Agreement is deleted in its entirety and replaced with the following:

Any and all disputes, controversies or claims (including without limitation tort claims, requests for provisional remedies or other interim relief and issues as to arbitrability of any matter) arising out of, in connection with, or relating to this Agreement, or the breach hereof, that cannot be settled through informal discussions between the parties or through Member Pharmacy availing itself of MedImpact’s Member Pharmacy grievance resolution process set forth in Subsection 15 of Section XIV shall be settled (a) first, by the parties trying in good faith to settle the dispute by mediation under the Commercial Mediation Rules of the American Health Lawyers Association (“AHLA”) (such mediation session to be held in a location agreed upon by the parties and to commence within 15 days of the appointment of the mediator by the AHLA), and (b) if the controversy, claim or dispute cannot be settled by non-binding mediation, then by non-binding arbitration administered by the AHLA under its Arbitration Rules (such arbitration to be held in a location agreed upon by the parties before a single arbitrator and to commence within 20 days of the appointment of the arbitrator by the AHLA) if agreed upon by the parties. Any controversy, claim or dispute under $500,000 shall be handled in accordance with the expedited procedures under the AHLA Arbitration Rules if agreed upon by the parties. The arbitrator must follow the rule of Law of Washington, and may only award remedies provided in the Agreement. The expenses of the arbitration, including reasonable attorney’s fees, will be paid for by the party against whom the award of the arbitrator is rendered. Any damages awarded may not exceed the amount of payments made under this Agreement (excluding amounts paid by MedImpact on behalf of Payers). In the event the parties cannot resolve the matter through mediation or arbitration, either party may pursue judicial remedy in a court of competent jurisdiction. Any dispute between the parties shall be addressed in a county mutually agreeable to the parties in the State of Washington. RCW 48.43.055; WAC 284-43-320(11); WAC 284-43-322.

6. Administrative Policies. Subsection 4.1 of Section XIV is deleted in its entirety and replaced with the following:

Member Pharmacy shall provide Prescription Drug Benefits to Eligible Persons in accordance with the terms of the Agreement (including these Policies and
Procedures), the prescriber's directions, the applicable Plan, applicable Law, and Member Pharmacy's professional judgment. Member Pharmacy may refuse to provide Pharmacy Services to an Eligible Person based on that professional judgment, which must be documented. Member Pharmacy shall use its best efforts to maintain an adequate supply of medications. The Agreement, and any addenda or attachments thereto, sets forth Member Pharmacy’s responsibilities with respect to applicable administrative policies and programs, including but not limited to: payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and applicable federal and state requirements. RCW 48.43.505; WAC 284-43-320(4).

7. **Verification of Eligible Persons.** Subsection 4.2 of Section XIV is deleted in its entirety and replaced with the following:

MedImpact shall provide eligibility and benefit information as set forth in the Agreement. Coverage for emergency and non-emergency care that had prior authorization under the Agreement and a Plan’s written policies at the time the care was rendered shall not be retrospectively denied. Nothing contained in the Agreement may have the effect of modifying benefits, terms, or conditions contained in a Plan. In the event of any conflict between the Agreement and a Plan, the benefits, terms, and conditions of the Plan shall govern with respect to coverage provided to Eligible Persons. RCW 48.43.525; WAC 284-43-320(1).

8. **Nondiscrimination.** Subsection 4.10 of Section XIV is deleted in its entirety and replaced with the following:

Member Pharmacy must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, religion, disability, medical condition, political convictions, age, sexual orientation, and marital or family status. Unless professional judgment dictates otherwise, Member Pharmacy must provide Prescription Drug Benefits and related services to all Eligible Persons.

Member Pharmacy shall provide services under the Agreement to Eligible Persons without regard to the Eligible Persons’ enrollment in a plan as a private purchaser of a plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the Member Pharmacy should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. WAC 284-43-320(8).

9. **Professional Judgment and Conduct.** Subsection 4.12 of Section XIV is deleted in its entirety and replaced with the following:

Member Pharmacy must comply with all applicable Laws and provide all services and products in a professional manner and in compliance with the highest industry standards, with care, skill, and diligence. Member Pharmacy must at all times exercise professional judgment in providing pharmacy services to an Eligible Person. Member Pharmacy is under no obligation to provide a Prescription Drug Benefit which, in his/her professional judgment, should not be dispensed.
Member Pharmacy shall not be precluded or discouraged from informing an Eligible Person of the care he or she requires, including various treatment options, and whether in Member Pharmacy’s view such care is consistent with medical necessity, medical appropriateness, the health coverage criteria, or otherwise covered by the Eligible Person’s medical coverage agreement with a Payer. Member Pharmacy is not prohibited or discouraged and shall not be penalized for advocating on behalf of an Eligible Person when practicing in compliance with the law. Nothing in this section shall be construed to authorize Member Pharmacy to bind a Payer or MedImpact to pay for any service. Nothing in the Agreement precludes or discourages Eligible Persons or those paying for their coverage from discussing the comparative merits of different carriers with Member Pharmacy. RCW 48.43.510(6) and (7); WAC 284-43-320(5). Member Pharmacy shall not be penalized because it, in good faith, reports to state or federal authorities any act or practice by the Payer or MedImpact that jeopardizes patient health or welfare or that may violate state or federal law. WAC 284-43-320(9).

10. Documentation. Subsection 4.13 of Section XIV is deleted in its entirety and replaced with the following:

Member Pharmacy must maintain accurate, complete, up-to-date, and otherwise in conformance with generally accepted standards and good pharmacy practice, all documents and records related to the provision of Prescription Drug Benefits to Eligible Persons. Such documents and records include, but are not limited to:

- Original prescriptions
- Signature and/or electronic tracking logs
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/doctor orders

Member Pharmacy must maintain such documents and records in a readily obtainable location for a period of six (6) years from the date of service or such longer period as required by Law.

Member Pharmacy shall make records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Eligible Persons subject to applicable state and federal laws related to the confidentiality of medical or health records. WAC 284-43-320(6).

11. Subcontractors. The following provision shall be added to the Agreement as Section XIV, Subsection 4.16, "Subcontractors":

To the extent permitted by the Agreement, in the event Member Pharmacy subcontract with providers in connection with the Agreement, Member Pharmacy shall require that its subcontracts comply with the provisions set forth in this addendum. WAC 284-43-300.
12. **Subrogation.** The following provision shall be added to the Agreement as Section XIV, Subsection 4.17, ”Subrogation“:

MedImpact shall not unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. Subject to the terms of the Agreement, MedImpact shall pay claims in accordance with the payment schedule set forth in the Agreement. WAC 284-51-215.

13. **Utilization Review.** The following provision shall be added to the Agreement as Section XIV, Subsection 4.18, ”Utilization Review“:

Clinical protocols, medical management standards, and other review criteria of a Payer are available to Member Pharmacy upon written request to the extent required by law. RCW 48.43.520; WAC 284-43-410(1).

14. **Contracting Outside Plan.** The following provision shall be added to the Agreement as Section XIV, Subsection 4.19, ”Contracting Outside Plan“:

Member Pharmacy acknowledges and agrees that Payers may not prohibit directly or indirectly Eligible Persons from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the Eligible Persons choose. Nothing in this section shall be construed to bind a Payer or MedImpact for any services delivered outside the Plan. RCW 48.43.085; WAC 284-43-320(10).

15. **Claims Payment.** Subsection 6 of Section XIV is deleted in its entirety and replaced with the following:

15.1 MedImpact will reimburse Member Pharmacy according to the Agreement and will provide Member Pharmacy with a report showing the record of all claims submitted, processed, and paid in each processing cycle. Unless otherwise agreed to in writing by an officer of MedImpact, claims will be paid at the lower of: (1) Member Pharmacy's Usual and Customary price; (2) the applicable AWP discount and dispensing fee; or (3) MAC plus the applicable dispensing fee. In no case shall reimbursement to Member Pharmacy exceed Member Pharmacy's Usual and Customary price.

15.2 Drug classification (e.g., legend vs. over-the-counter, brand vs. generic) will be as published by the First Data Bank Service in its Blue Book and AWP pricing will be the price as published by Medi-Span or such other nationally recognized classification and pricing source which MedImpact may select.

15.3 MedImpact is not obligated to reimburse Member Pharmacy for a claim if Member Pharmacy has breached any of the provisions or terms set forth in the Agreement with respect to that claim.

15.4 For the services MedImpact provides to Member Pharmacy under this Agreement, MedImpact charges Member Pharmacy a fee per transaction. These fees will be immediately due and owing by Member Pharmacy to MedImpact and MedImpact has the right to deduct such amounts from any amounts payable to Member Pharmacy. A transaction means each claim, reversal, reject, resubmission, or other electronic
communication sent to MedImpact through the Online Claim System. Any modifications to this transaction fee requirement must be in writing and signed by an officer of MedImpact.

15.5 Except in cases of fraud or as provided below, MedImpact or Payer may not (i) request a refund from Member Pharmacy of a payment previously made to satisfy a claim unless it does so in writing to Member Pharmacy within twenty-four (24) months after the date the payment was made; or (ii) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request will specify why MedImpact and/or Payer believes Member Pharmacy owes the refund. If Member Pharmacy fails to contest the request in writing to MedImpact within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

MedImpact and/or Payer (as applicable) may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (i) request a refund from Member Pharmacy of a payment previously made to satisfy a claim unless it does so in writing to Member Pharmacy within thirty (30) months after the date the payment was made; or (ii) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request will specify why MedImpact and/or Payer (as applicable) believes Member Pharmacy owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Member Pharmacy fails to contest the request in writing to MedImpact within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

MedImpact may at any time request a refund from Member Pharmacy of a payment previously made to satisfy a claim if: (i) a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (ii) MedImpact and/or Payer (as applicable) is unable to recover directly from the third party because the third party has either already paid or will pay Member Pharmacy for the services covered by the claim.

Nothing in this section prohibits Member Pharmacy from choosing at any time to refund to MedImpact any payment previously made to satisfy a claim.

For purposes of this section, “refund” means the return, either directly or through an offset to a future claim, of some or all of a payment already received by Member Pharmacy.

This section neither permits nor precludes Member Pharmacy from recovering from an Eligible Person any amounts paid to Member Pharmacy for benefits to which Eligible Person was not entitled under the terms and conditions of the Plan or other benefit agreement or policy.

This section does not apply to claims for services provided through dental-only health Payers, health care services provided under Title
XVIII (Medicare) of the Social Security Act, or Medicare supplemental Plans regulated under chapter 48.66 RCW. RCW 48.43.600.

15.6 Except in cases of fraud or as provided below, Member Pharmacy may not (i) request additional payment from MedImpact or Payer (as applicable) to satisfy a claim unless it does so in writing to MedImpact or Payer within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made; or (ii) request that the additional payment be made any sooner than six (6) months after receipt of the request. Any such request must specify why Member Pharmacy believes MedImpact or Payer owes the additional payment.

Member Pharmacy may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (i) Request additional payment from MedImpact or Payer to satisfy a claim unless Member Pharmacy does so in writing to MedImpact or Payer within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made; or (ii) request that the additional payment be made any sooner than six (6) months after receipt of the request. Any such request must specify why Member Pharmacy believes MedImpact or Payer owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

This subsection does not apply to claims for services provided through dental-only health Payers, health care services provided under Title XVIII (Medicare) of the Social Security Act, or Medicare supplemental Plans regulated under chapter 48.66 RCW. RCW 48.43.605.

16. **Pricing Changes.** Subsection 7 of Section XIV shall be deleted in its entirety and replaced with the following:

Notwithstanding anything in the Agreement to the contrary, Member Pharmacy shall have reasonable notice of not less than sixty (60) days of changes that affect Member Pharmacy compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, Member Pharmacy may terminate the Agreement without penalty if Member Pharmacy does not agree with the changes. No change to the Agreement may be made retroactive without the express consent of Member Pharmacy. WAC 284-43-320(4).

17. **Audit.** Subsection 8 of Section XIV shall be deleted in its entirety and replaced with the following:

MedImpact and Member Pharmacy and the authorized agents of each party have the right to audit compliance with the Agreement, including common errors in the submission of claims, during the term of the Agreement and for six (6) years after its expiration, or any longer period as required by applicable Law. Upon reasonable notice from the auditing party, during regular business hours, the audited party must provide auditors with or access to examine and/or copy any and all documents and records that the
auditing party deems necessary to determine whether the audited party is compliant with the Agreement. The audited party must promptly comply with all requests for documentation and records. If the auditing party is denied admission to the audited party’s premises or if audited party does not timely present requested documentation and records, the auditing party may assess a $500.

In addition, where based on a sampling of audited claims, MedImpact determines that Member Pharmacy has engaged in fraud or abuse, MedImpact has the right to extrapolate for purposes of determining the amount due and owing to MedImpact for noncompliant claims, which amount shall become immediately due and owing to MedImpact. Member Pharmacy shall have thirty (30) days to provide documentation to MedImpact to dispute such findings.

The auditing party may report its audit findings to Payers, appropriate governmental entities, and regulatory agencies.

The audit of records by MedImpact shall be limited to Eligible Persons and shall be limited to the extent necessary to perform the audit. To the extent required by law, Member Pharmacy shall have the right to audit denials of claims. WAC 284-43-324.

18. Termination for Default. Section 12.1.2 of Section XIV is deleted in its entirety and replaced with the following:

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 upon ten (10) days' prior written notice, provided, however, that the defaulting party has not cured such default within ten (10) days prior to the end of such ten (10) day period. This paragraph shall not be construed to prevent either party from seeking injunctive relief, including specific performance, against the other prior to the expiration of the cure period. Member Pharmacy’s non-adherence to any of the provisions in the Agreement, including the Pharmacy Network Participation Acceptance Form, the Pharmacy Network Addendum(s), and the Authorization to Participate forms will constitute a material default of this Agreement.

19. Immediate Termination. Section 12.1.3 of Section XIV is deleted in its entirety and replaced with the following:

MedImpact may terminate this Agreement immediately upon written notice to Member Pharmacy in the event of (i) Member Pharmacy’s breach of any representations or warranties set forth in this Agreement; (ii) failure by Member Pharmacy to meet any licensing or credentialing requirements as defined by any state or federal agency or by any nationally recognized accreditation agency program standards or by MedImpact or any applicable Payer; (iii) the right to control the operation of the business of Member Pharmacy is transferred or given to a different person or entity; or (iv) Member Pharmacy’s fraudulent submission of false claim information. Further, MedImpact may terminate Member Pharmacy from participating in any specific Payer’s network without cause upon a 60-day written notice to Member Pharmacy (or such longer period as required by applicable Law). WAC 284-43-320(4).
20. **Rights and Remedies in the Event of Termination or Breach.** Subsection 12.2 of Section XIV is deleted in its entirety and replaced with the following:

In the event of termination of this Agreement for any reason, in addition to all other rights and remedies MedImpact may have at Law, equity, or under this Agreement, MedImpact shall have the right to deduct from any amounts owing to Member Pharmacy any amounts which Member Pharmacy owes to MedImpact.

In the event Member Pharmacy breaches any provision of the Agreement, in addition to all other termination rights, MedImpact shall have the right to (i) suspend any and all obligations of MedImpact under and in connection with this Agreement, (ii) impose reasonable investigation and handling fees, and/or (iii) offset against any amounts owed to Member Pharmacy under this Agreement or under any other agreement between MedImpact and Member Pharmacy, any amounts required to be paid by Member Pharmacy to MedImpact, in accordance with the overpayment provisions set forth in Subsection 6.5 of Section XIV. These rights and remedies are in addition to any and all other rights and remedies that may be available to MedImpact under the Agreement or at Law or equity. RCW 48.43.600.

Termination of the Agreement for any reason shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

21. **No Cause Termination.** Subsection 12 of Section XIV is amended by adding the following new Section 12.4, “No Cause Termination”:

The parties shall provide at least sixty (60) days’ written notice to each other before terminating the contract without cause. WAC 284-43-320(7). In the event of termination of the Agreement without cause, Member Pharmacy shall continue to provide services to Eligible Persons in accordance with the terms and conditions of the Agreement for at least sixty (60) days following notice of termination to the Eligible Persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. RCW 48.43.515(7).

22. **Notices to Member Pharmacy.** Subsection 13.2 of Section XIV is deleted in its entirety and replaced with the following:

All notices by MedImpact to Member Pharmacy pursuant to the Agreement may be given via the claims system, by facsimile, e-mail, or mail at the facsimile number, e-mail address or mailing address as set forth in the Member Pharmacy’s Pharmacy Network Participation Acceptance Form.

All notices will be deemed received when delivered in person, by e-mail, or by facsimile, or, if sent by mail; the notice will be deemed received on the sixth business day after the date such notice was mailed.
23. **Applicable Law.** Subsection 13.4 of Section XIV is deleted in its entirety and replaced with the following:

This Agreement shall be construed and enforced in accordance with the laws of the State of Washington, without regard to conflict of law principles.

24. **MedImpact’s Member Pharmacy Grievance Resolution Process.** Subsection 15 of Section XIV is deleted in its entirety and replaced with the following:

Member Pharmacy is entitled a fair dispute resolution mechanism. In addition to the dispute resolution process set forth in the Agreement, Member Pharmacy shall contact MedImpact at the address listed in the “Notice” provision of the Agreement for the procedures for processing and resolving disputes. WAC 284-43-320(11). In all events, the following shall apply:

   a. Member Pharmacy shall have the opportunity to be heard regarding a complaint after submitting a written request to MedImpact for review. If MedImpact fails to grant or reject a request within thirty (30) days after it is made, Member Pharmacy may proceed as if the complaint had been rejected. A complaint that has been rejected by MedImpact may be submitted to nonbinding mediation in accordance with the mediation and arbitration provisions in Section XIII. This section is solely for resolution of provider complaints. Complaints by, or on behalf of, an Eligible Persons are not subject to these grievance processes. RCW 48.43.055.

   b. With respect to billing disputes, MedImpact shall render a decision within sixty (60) days of receipt of a written complaint from Member Pharmacy. WAC 284-43-322(5).

   c. In all events, Member Pharmacy shall have not less than thirty (30) days after the action giving rise to a dispute for Member Pharmacy to complain and initiate the dispute resolution process. WAC 284-43-322.

25. **Price Non-Discrimination.** For Plans subject to Washington laws and regulations, any language contained in the Agreement pertaining to Price Non-Discrimination shall not apply.

26. **Material Amendments.** MedImpact will provide no less than sixty (60) days notice to Member Pharmacy of any proposed material amendment to the Agreement. Member Pharmacy may choose to reject the terms of the proposed material amendment through written or electronic means at any time during the notice period and such rejection may not affect the terms of the health care provider's existing Agreement.

   a. For purposes of this provision, “material amendment” means an amendment to the Agreement that would result in requiring Member Pharmacy to participate in a health plan, product, or line of business with a lower fee schedule in order to continue to participate in a health plan, product, or line of business with a higher fee schedule. A material amendment does not include any of the following: (i) a decrease in payment or compensation resulting from a change in a fee schedule published by MedImpact upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement, compensation addendum, or fee schedule notice; (ii) a decrease in payment or compensation that was anticipated under the terms of the
contract, if the amount and date of applicability of the decrease is clearly identified in the contract; or (iii) changes unrelated to compensation so long as reasonable notice of not less than sixty (60) days is provided.

2013 Washington SB 5215.

MedImpact WA Addendum 01/21/13 – UPDATED 11/01/13
WEST VIRGINIA ADDENDUM  
TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of insurers, carriers, health maintenance organizations, hospital and medical service corporations, and prepaid limited health service organizations under West Virginia law.

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Regulatory Addendum shall control if required. This Regulatory 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, Member Pharmacy agrees as follows:

1. Member Pharmacy shall render to Eligible Persons any service as it may be entitled to under the terms and conditions of the Plan and shall submit only such charges to MedImpact as are set forth in the fee schedule of the Agreement, and any related attachments.  W.Va. Code §§ 33-24-7.

2. In the event Payor or MedImpact fails to pay fees for services rendered to Eligible Persons by Member Pharmacy, the Eligible Persons shall not be liable to Member Pharmacy. Member Pharmacy shall not collect or attempt to collect from Eligible Persons any money for Prescription Drug Benefits. Neither Member Pharmacy nor its representative may maintain any action at law against Eligible Persons to collect money owed to Member Pharmacy by Payor or MedImpact. This provision shall not be construed to apply to the amount of any deductible or copayment.  W. Va. Code §§ 33-25A-7a, 33-25D-10.

3. Member Pharmacy shall provide sixty (60) days’ advance written notice to MedImpact and the West Virginia Commissioner of Insurance before canceling the Agreement for any reason. Nonpayment for goods or services rendered by Member Pharmacy to Eligible Persons is not a valid reason for avoiding the sixty day advance notice of cancellation.  W. Va. Code § 33-25A-7a, 33-25D-10.

4. MedImpact shall not provide Member Pharmacy an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, or to Member Pharmacy as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to an Eligible Person or a group of Eligible Persons with similar medical conditions.  W. Va. Code § 33-25C-4; W. Va. Admin. Code § 111-53-4.

5. Nothing in the Agreement shall be construed to restrict or limit Member Pharmacy from communicating medical advice or options available to Eligible Persons or in any way limiting the communication between Member Pharmacy and its patients. Nothing in the Agreement shall prevent Member Pharmacy from advising an Eligible Person whether or not a treatment is covered by a Plan. W. Va. Admin. Code § 111-53-4.

7. MedImpact shall adhere to the following standards in the processing and payment of claims:

a. MedImpact shall either deny, pay, or require Payor to pay a clean claim, as defined in W. Va. Code § 33-45-1, within forty (40) days of receipt if submitted manually or within thirty (30) days if submitted electronically, except when: (a) another party is responsible for the claim; (b) MedImpact is coordinating benefits within another payor; (c) Member Pharmacy has already been paid for the claim; (d) the claim was submitted fraudulently; or (d) there was a material misrepresentation in the claim.

b. MedImpact shall maintain a written or electronic record of the date of receipt of a claim. Member Pharmacy shall be entitled to inspect the record on request and to rely on that record or any other relevant evidence as proof of the fact of receipt of the claim. If MedImpact fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by Member Pharmacy.

c. Within thirty (30) days after receipt of a claim, MedImpact shall request electronically or in writing from Member Pharmacy any information or documentation that MedImpact believes will be required to process and pay the claim or to determine if the claim is a clean claim. MedImpact shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen (15) days of receipt of the information from the first request, only seek or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested which MedImpact reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, MedImpact shall either deny, pay, or require Payor to pay the claim within thirty (30) days. MedImpact or Payor may not refuse to pay a claim for Prescription Drug Benefits if MedImpact fails to timely notify Member Pharmacy within thirty (30) days of receipt of the claim of the additional information requested unless such failure was caused in material part by Member Pharmacy. Provided, that nothing herein precludes MedImpact from imposing a retroactive denial of such claim where otherwise permitted by the Agreement unless such retroactive denial would violate subparagraph (h) of this paragraph 6.

d. Interest shall accrue at a rate of ten percent per annum after the claims payment period set forth in subparagraph (a) above. At the time the claim is paid, or within thirty (30) days thereafter, Payor shall pay interest owing, without necessity of demand. The interest
payment shall be accompanied by an explanation of the assessment on each claim of interest paid.

e. MedImpact shall establish and implement reasonable policies to permit Member Pharmacy to promptly confirm in advance during normal business hours whether the health care services to be provided are Prescription Drug Benefits and to determine requirements applicable to Member Pharmacy for: (1) precertification or authorization of coverage decisions; (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (iii) specific payment and reimbursement methodology; and (iv) claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a clean claim.

f. MedImpact shall make available to Member Pharmacy within twenty (20) business days of receipt of a request, reasonable access either electronically or otherwise, to all policies that are applicable to Member Pharmacy.

g. Payor or MedImpact shall pay a clean claim if MedImpact or Payor has previously authorized the services or has advised Member Pharmacy or the Eligible Person in advance of the provision of the services that the services are Prescription Drug Benefits unless the documentation for the claim provided by Member Pharmacy clearly fails to support the claim as originally authorized or unless the refusal is because:

   i. Another party is responsible for the payment;
   ii. Member Pharmacy has already been paid for the services;
   iii. The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to MedImpact or Payor by Member Pharmacy or another person not related to MedImpact or Payor;
   iv. The person receiving the services was not an Eligible Person on the date of service and neither MedImpact nor Payor knew or with the exercise of reasonable care could have known, of the person’s eligibility status;
   v. There is a dispute regarding the amount of charges submitted or;
   vi. The services were not Prescription Drug Benefits and neither MedImpact nor Payor knew or with the exercise of reasonable care could have known, at the time of the certification that the services were not covered.

h. A previously paid claim may be retroactively denied only if:

   i. The claim was submitted fraudulently;
   ii. The claim contained material misrepresentations;
   iii. The claim payment was incorrect because Member Pharmacy was already paid on the claim or the services were not delivered by Member Pharmacy; or
   iv. Member Pharmacy was not entitled to reimbursement;
   v. The service was not a Prescription Drug Benefit; or
vi. The person to whom the service was rendered was not an Eligible Person.

i. Upon receipt of notice of a retroactive denial, Member Pharmacy shall notify MedImpact within forty (40) days of its intent to pay or demand written explanation of the reasons for the denial.

j. Upon receipt of explanation for retroactive denial, Member Pharmacy shall reimburse MedImpact within thirty (30) days for allowing an offset against future payments or provide written notice of dispute.

k. Disputes shall be resolved between the parties within thirty (30) days of receipt of notice of dispute.

l. Upon resolution of dispute, Member Pharmacy shall pay any amount due or provide written authorization for an offset against future payments.

m. MedImpact may retroactively deny a claim for the reasons set forth in section subparagraph (h)(iii)-(vi) above within one year from the date the claim was originally paid. There shall be no time limit for retroactively denying a claim for the reasons set forth in subparagraph (h)(i)-(ii) above.

n. Member Pharmacy acknowledges that at the time the Agreement was presented to Member Pharmacy for execution it included or was accompanied by (i) a fee schedule, reimbursement policy, and statement as to the manner in which claims will be calculated and paid and the range of services reasonably expected to be delivered by Member Pharmacy; and (ii) all referenced addenda, schedules, and exhibits.

o. An amendment to the Agreement that relates to payment or the delivery of care by Member Pharmacy shall not be effective as to Member Pharmacy unless Member Pharmacy has been provided with the proposed amendment and has failed to notify MedImpact within twenty (20) business days of receipt of Member Pharmacy’s intent to terminate the Agreement at the earliest date thereafter permitted under the Agreement.

p. MedImpact shall complete its initial credentialing process and accept or reject Member Pharmacy within four months after submission of Member Pharmacy’s completed application. This time frame may be extended for an additional three months because of delays in primary source verification. MedImpact shall make available to Member Pharmacy a list of all information required to be included in the application. If Member Pharmacy is permitted by MedImpact to provide services during the credentialing period, Member Pharmacy shall be paid for the services pursuant to the terms and conditions of the Agreement if Member Pharmacy’s application is approved.

8. MedImpact shall not terminate the Agreement, fail to renew the Agreement, or penalize Member Pharmacy for invoking its rights under paragraph 7 above or otherwise under the Agreement. W. Va. Code § 33-45-4.


10. Notwithstanding anything to the contrary in the Agreement, to the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a discount medical plan organization under West Virginia law, MedImpact’s Pharmacy Network Authorization to Participate Form for MedImpact’s Consumer Discount Card Network contains: (1) MedImpact’s requirements concerning the services and products to be provided by Member Pharmacy at a discount; (2) Member Pharmacy’s applicable discounted rates and (3) the requirement that Member Pharmacy will not charge Eligible Persons more than the discounted rates. W. Va. Code §§ 33-15E-10; 33-15E-13.
This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a limited service health organization, preferred provider plan, defined network plan, health maintenance organization ("HMO"), or insurer licensed under Wisconsin law (collectively and/or individually, "Payor").

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. Member Pharmacy acknowledges and agrees that disciplinary action taken against Member Pharmacy will be reported to the appropriate credentialing board. Wis. Stat. Ann. § 609.17.

2. If Member Pharmacy’s participation under the Agreement terminates for reasons other than misconduct on the part of Member Pharmacy or Member Pharmacy’s cessation of practice in the applicable geographic service area, Member Pharmacy agrees to continue to provide care to Eligible Persons undergoing a course of treatment for the shorter of the following time periods:
   a. For the remainder of the course of treatment or for ninety (90) days after Member Pharmacy’s participation under the Agreement terminates, whichever is shorter; or
   b. If the Eligible Person is a woman in the 2nd or 3rd trimester of pregnancy when Member Pharmacy’s participation under the Agreement terminates, until the completion of postpartum care for the woman and infant.

Member Pharmacy agrees to accept as reimbursement for services provided under this continuity of care provision the contracted rate set forth in the Agreement.

When providing services under this continuity of care provision, Member Pharmacy shall be subject to the hold harmless requirements of Wis. Stat. Ann. § 609.91.

Member Pharmacy shall post a notification of termination and of Eligible Persons’ rights to continuity of care under Wis. Stat. Ann. § 609.24 in each of its pharmacies subject to the Agreement the greater of 30 days prior to the termination or 15 days following MedImpact’s receipt of Member Pharmacy’s termination notice. Wis. Stat. Ann. § 609.24; Wis. Admin. Code Ins. § 9.35

3. Member Pharmacy acknowledges that attached hereto as “Appendix 1” is a summary notice of the statutory limitations and requirements of the

4. The Agreement shall not be construed to limit Member Pharmacy’s disclosure of information, to or on behalf of an Eligible Person, about the Eligible Person’s medical condition or treatment options. Member Pharmacy may discuss, with or on behalf of an Eligible Person, all treatment options and any other information that Member Pharmacy determines to be in the best interest of the Eligible Person. Neither MedImpact nor any defined network plan Payor may penalize Member Pharmacy or terminate the Agreement because Member Pharmacy makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an Eligible Person. Further, neither MedImpact nor any defined network plan Payor may retaliate against Member Pharmacy for advising an Eligible Person of treatment options that are not covered benefits. Wis. Stat. Ann. § 609.30; Wis. Admin. Code Ins. § 9.36.

5. Member Pharmacy’s participation under the Agreement is not exclusive. The Agreement shall not be construed to prevent or materially inhibit Member Pharmacy’s participation as a provider for other health care plans or insurers. Wis. Stat. Ann. §§ 628.35, 628.36.

6. Claims by Member Pharmacy shall be overdue if not paid within thirty (30) days of written submission of a covered claim. Overdue payments shall bear simple interest at the rate of 12% per year. Wis. Stat. Ann. § 628.46.

7. Member Pharmacy shall promptly respond to complaints and grievances filed with MedImpact or a Payor to facilitate resolution. Member Pharmacy shall provide MedImpact and/or Payor all information necessary to permit Payor to respond to complaints or grievances. Wis. Admin. Code § 18.03.
APPENDIX “1”

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RE COURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat. requires each health maintenance organization insurer (“HMO insurer”), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in § § 609.91 to 609.935, and §609.97 (1), Wis. Stat.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in." An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS.

An enrollee of an HMO insurer is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is
represented, or an affiliate is represented, by one of at least three HMO insurer board members who directly or indirectly represent one or more IPAs or affiliates of IPAs.

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.

3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.

4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.

5. The care is required to be provided under the requirements of s. Ins. 9.35 Wis. Adm. Code.

B. "OPT-OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).

2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.
3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.

5. Failure by the HMO insurer to provide notice to providers of the statutory hold-harmless provisions.

6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) day before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the HMO insurer, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

NOTICES
All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

   P. O. Box 7873, Madison, WI 53707-7873

HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.

Source: WISCONSIN ADMINISTRATIVE CODE
COMMISSIONER OF INSURANCE
CHAPTER INS 9. DEFINED NETWORK PLANS
SUBCHAPTER III. MARKET CONDUCT STANDARDS FOR DEFINED NETWORKPLANS, PREFERRED PROVIDER PLANS AND LIMIITED SERVICE HEALTH ORGANIZATIONS
APPENDIX C NOTICE
2013 WI ADC Ch. Ins. 9, effective 2-28-2013
WYOMING ADDENDUM TO MEDCARE PHARMACY NETWORK AGREEMENT

This Regulatory Addendum applies to the extent that Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of health maintenance organizations, managed care organizations, health service corporations, insurers, or carriers under Wyoming law.

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

Without limiting the generality of the foregoing, Member Pharmacy agrees as follows:

1. To the extent Member Pharmacy provides Prescription Drug Benefits to Eligible Persons of a health maintenance organization under Wyoming law, Member Pharmacy agrees:
   a. In the event Payor fails to pay for Prescription Drug Benefits as set forth in the Agreement, Eligible Persons shall not be liable to Member Pharmacy for any sums owed by Payor. Member Pharmacy shall not collect or attempt to collect from Eligible Persons sums owed by Payor. Member Pharmacy and its agents, trustees, or assignees shall not maintain an action at law against Eligible Persons to collect sums owed by Payor. Wyo. Stat. Ann § 26-34-114(o)-(q).
   b. In the event of Payor’s insolvency, Member Pharmacy agrees to continue to provide Prescription Drug Benefits to Eligible Persons after Payor’s insolvency during the period for which premium payment has been made and until Eligible Persons’ discharge from inpatient facilities. Wyo. Stat. Ann. § 26-34-114(r)(ii).
   c. Notwithstanding anything in the Agreement to the contrary, Member Pharmacy shall give MedImpact at least sixty (60) days advance notice prior to termination of the Agreement. Wyo. Stat. Ann. § 26-34-114(s).
   d. Nothing in the Agreement shall be construed as having or shall have the effect of discriminating against Member Pharmacy based solely on its inability to provide Prescription Drug Benefits in Payor’s entire service area or based solely on the academic degree held by Member Pharmacy’s providers who are acting within the scope of their professional licenses under Wyoming law. Wyo. Stat. Ann. § 26-34-134.

4/16/2014
AUDIT/RECOUPMENT POLICIES AND PROCEDURES:

In the event of a direct conflict between the Audit/Recoupment Policies and Procedures set forth herein and the Agreement, the applicable provisions of this Audit/Recoupment Policies and Procedures shall control if and to the extent required by law. This Audit/Recoupment Policies and Procedures may be modified from time to time by MedImpact.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, the following Audit/Recoupment Policies and Procedures shall apply to the extent required by applicable law:

Alabama:

The following shall apply to audits conducted in Alabama in accordance with Alabama Code Sections 34-23-184 through 34-23-187 –

- Member Pharmacy shall be provided no less than two (2) weeks written notice before conducting an on-site audit. To the extent not otherwise identified herein, the notice will include a checklist of items being audited and the manual, including the name, date, and edition or volume, applicable to the audit and the auditing guidelines.
- With respect to on-site audits, Member Pharmacy shall be provided a list of material copied or removed during the course of an on-site audit (which may be done through a checklist or an audit acknowledgement form).
- Member Pharmacy must produce items during the course of the audit or within thirty (30) days of the on-site audit.
- The auditor will not interfere with the delivery of pharmacy services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process.
- In the event an audit involves clinical and/or professional judgment, the audit will be conducted by or in consult with a licensed pharmacist.
- Clerical and record-keeping errors, such as typographical errors, scrivener’s errors, or computer error regarding a required document or record will not be deemed fraud; however, such errors may be subject to recoupment.
- Member Pharmacy shall have the right to submit amended claims through an online submission to correct clerical or record-keeping errors in lieu of recoupment of a claim where no actual financial harm to the patient or plan has occurred, provided that the prescription was dispensed according to Alabama law and within plan limits.
- Member Pharmacy shall not be subject to recoupment of funds unless MedImpact can provide proof of the intent to commit fraud or such error results in actual financial harm to MedImpact, a Payor, or a consumer. A person shall not be subject to criminal penalties for errors provided for in this subsection without proof of intent to commit fraud, waste, or abuse.
- Documentation will not be required that is not required by state and federal law or Alabama Medicaid.
- The information shall be considered to be valid if documented on the prescription, computerized treatment notes, pharmacy system, or other acceptable medical records.
- Unless superseded by state or federal law, MedImpact shall only have access to previous audit reports on a particular pharmacy conducted by an auditor for MedImpact, Payor, or a Plan. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit
reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan.

- Audit results shall be disclosed in accordance with the Agreement.
- Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- Reasonable costs associated with the audit shall be the responsibility of the auditor with the exception of Alabama Medicaid if the claim sample exceeds 100 unique prescription hard copies.
- Recoupment shall be based on the actual overpayment or underpayment of actual claims.
- Finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- A finding of an overpayment may not include the cost of the drugs that were dispensed in accordance with the prescriber's orders, provided the prescription was dispensed according to state law and plan limits.
- A finding of an overpayment may not include the dispensing fee amount unless a prescription was not actually dispensed; the prescriber denied authorization; the prescription dispensed was a medication error by the pharmacy; or the identified overpayment is solely based on an extra dispensing fee.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact and will be audited under rules applicable to the contractor and time period of the prescription.
- The period covered by an audit may not exceed two (2) years from the date the claim was submitted or adjudicated.
- An audit may not be conducted six (6) months past the date the plan terminated its contract to adjudicate claims with MedImpact.
- An audit will not be initiated or scheduled during the first five (5) days of any month.
- Member Pharmacy shall be provided with a written report of the audit and the parties shall comply with the following requirements:
  o The preliminary audit report shall be delivered to Member Pharmacy within ninety (90) days after the conclusion of the audit, with a reasonable extension to be granted upon request.
  o Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request.
  o A final audit report shall be delivered to Member Pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, whichever is later.
The audit documents shall be signed by the auditor assigned to the audit. The acknowledgement or receipt shall be signed by the auditor and the audit report shall contain contact information of the representative of MedImpact.

Recoupments of any disputed funds or repayment of funds to MedImpact by Member Pharmacy shall occur after final internal disposition of the audit, including any appeals process. If the identified discrepancy for an individual audit exceeds twenty-five thousand dollars ($25,000), future payments in excess of that amount to Member Pharmacy may be withheld pending finalization of the audit.

Interest shall not accrue during the audit period.

After completion of any review process, a copy of the final audit report may (and to the extent required by law, will) be delivered, to the plan sponsor in a manner pursuant to a contract.

Arkansas:

The following shall apply to audits conducted in Arkansas in accordance with Arkansas Code Ann. Sections 17-92-1201 et seq; 23-63-1801 et seq; and 54 Code of Ark. Rules and Regs. 085 –

- Member Pharmacy shall have at least one (1) week notice before the initial on-site audit is conducted for each audit cycle.
- Audits involving clinical or professional judgment shall be conducted by or in consultation with a pharmacist.
- Clerical or recordkeeping errors regarding a required document or record shall not in and of itself constitute fraud, however they may be subject to recoupment and are not subject to criminal penalties without proof of intent to commit fraud.
- Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- A finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Recoupment shall be based settlement on the actual overpayment unless the projection for overpayment or underpayment is part of a by the pharmacy.
- Where an audit is for a specifically identified problem that has been disclosed to Member Pharmacy, the audit shall be limited to claims that are identified by prescription number.
- Audits, not conducted due to an identified problem, shall be limited to twenty-five randomly selected prescriptions and shall not be initiated more than two times in a calendar year.
- If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site.
- Recoupment shall not be based on additional requirements beyond those prescribed by the Arkansas State Board of Pharmacy (inapplicable to cases of Food and Drug Administration regulation or drug manufacturer safety programs).
• Recoupment shall only occur following the correction of a claim and shall be limited to amounts paid in excess of amounts payable under the corrected claim.
• Except for Medicare claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim shall not be reversed unless Member Pharmacy obtained the adjudication by fraud or misrepresentation of claim elements.
• Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
• Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.
• The period covered by an audit may not exceed two (2) years from the date the claim was submitted or adjudicated.
• Unless otherwise consented to by Member Pharmacy, an audit shall not be initiated or schedule an audit during the first seven (7) calendar days of any month due to the high volume of prescriptions filled during that time.
• The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.
• A final audit report shall be delivered to Member Pharmacy within six (6) months after receipt of the preliminary audit report or the final appeal, whichever is later.
• The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits.
• Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process.
• MedImpact shall have an appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report.
• If, following an appeal, MedImpact finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated; it shall dismiss the audit report or the unsubstantiated portion of the audit report without any further proceedings.
• A copy of the final audit report may (and to the extent required by law, will) be provided to the plan sponsor after completion of any review process.
• The full amount of any recoupment on an audit shall be refunded to the responsible party; a charge or assessment for an audit shall not be based, directly or indirectly, on amounts recouped. However, MedImpact may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both the following conditions are met: a contract explicitly states the percentage charge or assessment to the responsible party; and the commission or other payment to the auditor or employee is not based, directly or indirectly, on amounts recouped.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.
Arizona:
The following shall apply to adjustments of payment or denial of claims in Arizona in accordance with ARS Section 20-3102(I) –

- Except in cases of fraud, neither MedImpact nor Member Pharmacy shall adjust or request an adjustment of the payment or denial of a claim more than one (1) year after the health care insurer has paid or denied that claim.

California:
The following shall apply to audits conducted in California in accordance with California Business and Professions Code, Sections 4430-4439 –

- MedImpact, in conducting a pharmacy audit, shall not receive payment or any other consideration on any basis that is tied to the amount claimed or actual amount recovered from Member Pharmacy that is the subject of the audit. However, MedImpact may charge or assess the plan sponsor, directly or indirectly, based on amounts recouped if both of the following conditions are met: a contract explicitly states the percentage charge or assessment to the plan sponsor; and no commission or financial incentive is paid to the auditor or employee based, directly or indirectly, on amounts recouped.
- Member Pharmacy shall not be subject to recoupment of funds for a clerical or recordkeeping error, unless the error resulted in actual financial harm to the pharmacy benefit manager, the carrier, or the beneficiary of a health benefit plan.
- Except as otherwise prohibited by state or federal law, MedImpact shall keep confidential any information collected during the course of the audit and shall not share any information with any person other than the carrier, pharmacy benefit manager, or third-party payer for which the audit is being performed.
- MedImpact shall have access only to previous audit reports relating to a particular pharmacy conducted by or on behalf of MedImpact. Nothing in this manual shall be construed to authorize access to information that is otherwise prohibited by law.
- MedImpact may disclose its general opinions or conclusions regarding the business practices of the pharmacy based on the audit.
- MedImpact shall, prior to conducting the audit, notify Member Pharmacy in writing that an entity other than MedImpact will conduct the pharmacy audit and the carrier or pharmacy benefit manager have executed a business associate agreement or other agreement as required under state and federal privacy laws.
- MedImpact, prior to leaving a pharmacy at the end of an onsite portion of the audit, shall provide the pharmacist in charge with a complete list of records reviewed to allow the pharmacy to account for disclosures as required by state and federal privacy laws.
- MedImpact, when conducting an onsite pharmacy audit, shall not initiate or schedule a pharmacy audit during the first five (5) business days of any calendar month, unless it is expressly agreed to by Member Pharmacy being audited.
- MedImpact, when conducting an onsite pharmacy audit, shall provide Member Pharmacy at least two (2) weeks' prior written notice before conducting an initial audit.
- A pharmacy audit that involves clinical judgment shall be conducted by, or in consultation with, a licensed pharmacist.
• All determinations regarding the legal validity of a prescription or other record shall be made consistent with California state law.
• Paper or electronic signature logs that document the delivery of pharmacy services shall be accepted to the extent permitted by law.
• The period covered by an audit shall not exceed two (2) years from the date the claim was submitted or adjudicated unless state or federal law requires a longer period or unless the originating prescription is required.
• A preliminary audit report shall be delivered to Member Pharmacy no later than sixty (60) days after conclusion of the audit and before issuing a final audit report.
• Member Pharmacy shall be provided at least thirty (30) days following receipt of the preliminary audit report to respond to the findings in the report, including addressing any alleged mistakes or discrepancies and producing documentation to that effect.
• Member Pharmacy may use authentic and verifiable statements or records to validate the pharmacy record. Any legal prescription may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, unless otherwise specifically addressed in the audit policies and procedures and/or the Agreement.
• Extrapolation may be used to calculate penalties or amounts to be recouped. However, Member Pharmacy may present evidence to validate orders for dangerous drugs or devices that are subject to invalidation due to extrapolation.
• Prior to issuing a final audit report, any response by Member Pharmacy to the preliminary audit report shall be taken into consideration.
• The final audit report shall be delivered to the pharmacy no later than one hundred twenty (120) days after receipt of a pharmacy’s response to the preliminary audit report.
• MedImpact maintains a process for appealing the findings in a final audit report that complies with the following requirements:
  o Member Pharmacy shall be provided a time period of at least thirty (30) days following receipt of the final audit report to file an appeal with MedImpact as identified in the appeal process.
  o MedImpact shall provide Member Pharmacy with a written determination of appeal issued, which shall be appended to the final audit report, and a copy of the determination shall be sent to the carrier, health benefit plan sponsor, or other third-party payer.
  o If, following the appeal, either party is not satisfied with the appeal, the party may seek relief under the terms of the Agreement.
  o MedImpact, or any person acting on behalf of those entities, shall not attempt to make chargebacks or seek recoupment from Member Pharmacy, or assess or collect penalties from the pharmacy, until the time period for filing an appeal to a final audit report has passed, or until the appeal process has been exhausted, whichever is later. Should the identified discrepancy for a single audit exceed thirty thousand dollars ($30,000), future payments to the pharmacy in excess of thirty thousand dollars ($30,000) may be withheld pending adjudication of an appeal.
  o Interest shall not accrue during the audit period for either party, beginning with the notice of the audit and ending with the conclusion of the appeal process.
  o If, following final disposition of a pharmacy audit, it is found that an audit report or any portion thereof is unsubstantiated, the audit report shall be amended accordingly.
report or the unsubstantiated portion thereof shall be dismissed without the necessity of any further proceedings.

**Colorado:**

The following shall apply to recovery of overpayments in Colorado in accordance with Colo. Rev. Stat. §§ 10-16-704(4.5) and 10-16-122.5–

- Member Pharmacy shall be given at least seven (7) days’ written notice prior to commencing an audit.
- The audit will be conducted in consultation with a licensed pharmacist to the extent the audit requires the application of clinical or professional judgment.
- Extrapolation or other statistical expansion techniques shall not be used in calculating the amount of a recoupment or penalty resulting from an audit.
- Member Pharmacy shall be permitted to produce additional claims documentation using any commercially reasonably method, including facsimile, mail, or electronic claims submission, if an audit results in the dispute or denial of a claim.
- Member Pharmacy shall be provided a detailed notice with respect to recovery of overpayments.
- Member Pharmacy may dispute preliminary audit results and any resulting recoupment or penalty at the address designated by MedImpact.
- MedImpact will not recoup funds when an audit results in the identification of a clerical error in a required document or record unless the error results in actual financial harm to MedImpact, a plan, or a Member.
- Member Pharmacy may use verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner, to validate the pharmacy record and delivery.
- Any legal prescription may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, electronic prescriptions, or documented telephone calls from the prescriber or the prescriber's agent.
- The time period covered by an audit will not exceed twenty-four (24) months from the date that the prescription was submitted to or adjudicated by MedImpact, unless a longer period is required by state or federal law.
- The time periods specified herein are waived for audits of pharmacy records when fraud or other intentional or willful misrepresentation is indicated through review of claims data, statements, physical review, or other investigative methods. Member Pharmacy shall receive at the time of the audit a written or verbal explanation of the information that led to the conclusion that there is an indication of fraud or other intentional or willful misrepresentation. The explanation is not required if law enforcement has intervened due to the indication of fraud.

**Georgia:**

The following shall apply to audits conducted in Georgia in accordance with O.C.G.A. 26-4-118–

- Member Pharmacy shall be given at least one (1) week notice prior to conducting the initial on-site audit for each audit cycle.
• An audit which involves clinical or professional judgment will be conducted by or in consultation with a pharmacist.

• Clerical and record-keeping errors, including but not limited to typographical errors, scrivener’s errors, or computer error regarding a required document or record will not in and of itself be deemed as fraud. No such claim shall be subject to criminal penalties without proof of intent to commit fraud. No recoupment of the cost of drugs or medicinal supplies properly dispensed shall be allowed if such error has occurred and been resolved in accordance with Law; provided, however, that recoupment shall be allowed to the extent that such error resulted in an overpayment, under payment, or improper dispensing of drugs or medicinal supplies.

• Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.

• A finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

• Recoupment shall be based on the actual overpayment or underpayment unless the projection for overpayment or underpayment is part of a settlement agreed to by the pharmacy.

• Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.

• Member Pharmacy shall be allowed at least thirty (30) days following conclusion of an on-site audit or receipt of the preliminary audit report in which correct a clerical or record-keeping error or produce documentation to address any discrepancy found during an audit, including to secure and remit an appropriate copy of the record from a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication if the lack of such a record or an error in such a record is identified in the course of an on-site audit or noticed within the preliminary audit report.

• The period covered by an audit may not exceed two (2) years from the date the claim was submitted or adjudicated.

• An audit shall not be initiated or scheduled during the first seven (7) calendar days of any month due to the high volume of prescriptions filled during that time unless otherwise consented to by Member Pharmacy.

• The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.

• A final audit report shall be delivered to Member Pharmacy within six (6) months after receipt of the preliminary audit report or final appeal, whichever is later.

• The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits.

• Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process.

• Member Pharmacy shall have at least thirty (30) days from the delivery of the preliminary audit report to appeal an unfavorable preliminary audit report to MedImpact. If, following the appeal, MedImpact finds that an unfavorable audit report or any portion thereof is unsubstantiated, MedImpact shall dismiss the audit report or such portion without the necessity of any further proceedings.
• MedImpact may (and to the extent required by law, will) provide a copy of the final audit report, after completion of any review process, to the plan sponsor.
• The aforementioned limitations do not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

Illinois:
The following shall apply to recoupments in Indiana in accordance with 215 ILCS 5/368d –
• Member Pharmacy shall be provided with a remittance advice or written demand for recoupment with explanation of the recoupment/offset, which will include the name of the patient, the date of service, the service code/description, the recoupment amount, and the reason for recoupment.
• The remittance advice or written demand for recoupment will prominently display a telephone number or mailing address to initiate an appeal of the recoupment along with the deadline for the appeal.
• Any appeal by Member Pharmacy must be made within sixty (60) days of receiving the remittance advice or demand for recoupment.
• No recoupment/offset will be requested or withheld from future payments that are eighteen (18) months or more after the original payment was made unless there is a formal finding of fraud or material misrepresentation, a Payor is the plan administrator for a state comprehensive health insurance plan, or Member Pharmacy has already been paid in full by another payor, third party, or workers’ compensation insurer.

Indiana:
The following shall apply to audits conducted in Indiana in accordance with Ind. Code. §§ 25-26-22-4.2 and §§ 25-26-22-5 et seq. –
• Auditors may conduct an audit for a third party payer not more than one (1) time per calendar year for each their party payer; provided, however, if the audit results in a finding of a particular problem at the pharmacy, the auditor may return within the calendar year to determine ongoing compliance.
• Member Pharmacy shall be provided at least two (2) weeks written notice before an initial onsite audit is performed for each audit cycle.
• Audits may be conducted during normal business hours of the pharmacy.
• The auditor shall not interfere with the delivery of pharmacist services to a patient and shall use every effort to minimize inconvenience and disruption to Member Pharmacy operations during the audit.
• If the audit requires use of clinical or professional judgment, the audit will be conducted by or in consultation with a licensed pharmacist.
• Member Pharmacy shall be allowed to use written or otherwise transmitted hospital, physician, or other health practitioner records to validate a pharmacy record with respect to a prescription for a legend drug.
• Audits shall be performed according to the same standards and parameters that MedImpact uses to audit all other similarly situated pharmacies.
• The period covered by the audit will not exceed twenty-four (24) months after the date on which the claim that is the subject of the audit was submitted to or adjudicated by the third party payer.
• Member Pharmacy is permitted to resubmit electronically any claims disputed by the audit in accordance with the Agreement. This does not, however, limit
the time period for audits under the Medicaid program that are conducted due to a federal requirement.

- Audits shall not be initiated or scheduled during the first seven (7) calendar days of any month without the voluntary consent of the pharmacy. The consent may not be mandated by a contract or any other means.
- Payment for conducting the audit will not be based on a percentage of any amount recovered as a result of the audit to the extent prohibited by law.
- Within twenty-four (24) hours of receiving the notice of an audit, Member Pharmacy may reschedule the audit to a date not more than fourteen (14) days after the date proposed by MedImpact/the auditor. However, if MedImpact/auditor is unable to reschedule within the fourteen (14) day period, MedImpact shall select and reschedule the audit for a date after the fourteen (14) day period.
- If a clerical error is identified by MedImpact during the course of an audit, Member Pharmacy shall be allowed to obtain a prescription that corrects the clerical error from the prescribing physician. However, if the clerical error results in an overpayment to Member Pharmacy, the overpayment may be recouped by the third party payer.
- Following an audit a preliminary audit report shall be delivered to Member Pharmacy no later than ninety (90) days after the audit is concluded.
- With the preliminary audit report, a written appeal procedure shall be provided for Member Pharmacy to follow if the pharmacy desires to appeal a finding contained in the preliminary audit report.
- The written appeal procedure will provide for a period of at least thirty (30) days during which Member Pharmacy may file an appeal after receiving the preliminary audit report.
- The final audit report shall be delivered to Member Pharmacy no later than one hundred twenty (120) days after the preliminary audit report is received by the pharmacy or if an appeal is filed, a final appeal determination is made, whichever is later.
- Each audit report must be signed by the auditor and the pharmacist participating in the audit.
- MedImpact may (and, to the extent required by law, will) provide a copy of the final audit report to the third party payer.
- If requested by Member Pharmacy, the auditor shall provide the audit report to Member Pharmacy by a means that allows signature confirmation, including an electronic signature. If sent by electronic mail, any other verification system may be used, provided that the receipt is acknowledged by the pharmacy.
- Clerical errors regarding a required document does not constitute fraud without proof of intent to commit fraud; however, such errors may be subject to recoulement.
- An audit finding of an overpayment or underpayment of a claim must be based on an actual overpayment or underpayment.
- A finding of an overpayment or underpayment may not be based on a projection of the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs. Audits conducted by the Medicaid, Medicare, or any other federal program are not subject to the same regulations.
- Before recoupment of funds may be made based on an audit finding of overpayment or underpayment a final audit report must be distributed and at
least thirty (30) days must elapse after the date on which the final audit report is distributed before the recoupment of funds exceeding ten thousand dollars ($10,000) except when an audit finds that fraud, willful misrepresentation, or alleged serious abuse has occurred.

- Interest on funds do not accrue during the audit period.
- Extrapolation audit shall not be used as a basis for calculating overpayment or underpayment recoupments or penalties.
- The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or alleged serious abuse has occurred.

**Iowa:**

The following shall apply to audits conducted in Iowa in accordance with Iowa Admin. Code § 191-59.6 –

- Member Pharmacy shall be given at least one (1) week written notice of the initial on-site audit prior to conducting any audit.
- Any audit which involves clinical or professional judgment will be conducted by or in consultation with a pharmacist.
- If MedImpact alleges an overpayment has been made to Member Pharmacy, Member Pharmacy shall be provided sufficient documentation to determine the specific claims included in the alleged overpayment.
- Member Pharmacy may use the records of a hospital, physician or other authorized practitioner of the healing arts for drugs or medicinal supplies, written or transmitted by any means of communication, for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- The period covered by an audit may not exceed two (2) years from the date on which the claim was submitted or adjudicated.
- Unless otherwise consented to by Member Pharmacy, an audit may not be initiated or scheduled during the first seven (7) calendar days of any month due to the high volume of prescriptions filled during that time.
- The preliminary audit report will be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.
- A final written audit report shall be received by Member Pharmacy within six (6) months of the preliminary audit report or final appeal, whichever is later.
- Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.
- The accounting practice of extrapolation shall not be used in calculating the recuperation of contractual penalties for audits.
- Recuperation of any disputed funds shall occur only after final disposition of the audit, including the appeals process.
- MedImpact shall have an appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report. If, following the appeal, MedImpact finds that an unfavorable audit report or any portion thereof is unsubstantiated, MedImpact shall dismiss the audit report or said portion without the necessity of any further proceedings.
- If, following the final appeal, MedImpact finds that an unfavorable audit report or any portion thereof is found to be substantiated, MedImpact shall
already have in place a process for an independent third-party review of the final audit findings.

- As part of the final appeal process of any final adverse decision, MedImpact shall notify Member Pharmacy in writing of its right to request an independent third-party review of the final audit findings and the process used to request such a review.
- After completion of any review process, MedImpact may (and to the extent required by law, will) provide a copy of the final audit report to the plan sponsor.
- The foregoing shall not apply to any investigative audit which involves fraud, willful misrepresentation, abuse, or any other statutory provision which authorizes investigations relating to but not limited to insurance fraud.

**Kansas:**

The following shall apply to audits conducted in Kansas in accordance with Kan. Stat. Ann. §§ 40-2442 and 65-16,121 et seq. –

- The period covered by the audit shall not exceed two (2) years from the date the claim was submitted to or adjudicated or as otherwise provided by state or federal law.
- The preliminary audit report shall be delivered to Member Pharmacy within sixty (60) days after the conclusion of the audit.
- Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.
- The final audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after receipt of the preliminary audit report or final appeal, whichever is later.
- Recoupment of any disputed funds or repayment of funds by Member Pharmacy shall occur, to the extent demonstrated or documented in the pharmacy audit findings, after final internal disposition of the audit including the appeals process.
- If the identified discrepancy for an individual audit exceeds twenty thousand dollars ($20,000), any future payments to Member Pharmacy may be withheld pending finalization of the audit.
- Unless otherwise required by the federal or state law, any audit information may not be shared.
- MedImpact shall only have access to previous audit reports on a particular Member Pharmacy conducted by MedImpact.
- MedImpact, upon request of the plan sponsor, shall provide a copy of the final report, including the disclosure of any money recouped in the audit.
- Member Pharmacy may provide a copy of the report to the commissioner of insurance, provided such report shall not contain any personally identifiable health information in violation of the provisions of the health insurance portability and accountability act of 1996 (Pub. L. No. 104-191).
- The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.
Kentucky:

The following shall apply to audits conducted in Kentucky in accordance with Chapter 304, Subtitle 17A-740 et seq. of Ky. Rev. Stat. Ann –

- Member Pharmacy shall be given at least thirty (30) days' written notice prior to conducting the audit for each audit to be conducted.
- An audit that involves clinical or professional judgment shall be conducted in consultation with a pharmacist.
- Member Pharmacy may use the records of a hospital, physician, or other practitioner as defined in KRS 217.015(35), or transmitted by any means of communication, for purposes of validating pharmacy records with respect to orders or refills of a drug.
- Member Pharmacy shall not be required to keep records for a period of time longer than two (2) years, or as required by state or federal law or regulation.
- The recoupment of claims shall be based on the actual overpayment or underpayment of claims unless Member Pharmacy agrees to a settlement to the contrary.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- The period covered by the audit shall not exceed two (2) years from the date the claim was submitted for payment except if a longer period is allowed by federal law or if there is evidence of fraud.
- MedImpact audit shall not schedule an audit during the first seven (7) calendar days of any month, unless consented to by Member Pharmacy.
- The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after the exit interview.
- The final audit report shall be delivered to Member Pharmacy within six (6) months after receipt of the preliminary audit report or after all appeals have been exhausted, whichever is later.
- Member Pharmacy shall have at least thirty (30) days following receipt of the preliminary audit report to produce documentation to address any discrepancies found during an audit.
- The final audit report shall provide claim-level detail of the amounts and reasons for each claim recovery found due. If no amounts have been found due, the final audit report shall so state.
- The auditor shall not receive payment based on the amount recovered in an audit.
- The auditor shall conduct an exit interview at the close of the audit. The exit interview shall be conducted at a time reasonably agreed to by the audited Member Pharmacy.
- The exit interview shall provide the audited Member Pharmacy an opportunity to: respond to questions from the auditor; review and comment on the initial findings of the auditor; and provide additional documentation to clarify the initial findings of the auditor.
- Clerical or recordkeeping errors such as typographical errors, scrivener's errors, omissions, or computer errors, shall not subject Member Pharmacy to recoupment of funds by MedImpact unless there is proof of intent to commit
fraud or the error results in an actual overpayment to Member Pharmacy or the wrong medication being dispensed to the patient.

- Member Pharmacy shall have the right to submit amended claims within thirty (30) days of the discovery of an error to correct clerical or recordkeeping errors in lieu of recoupment if the prescription was dispensed according to requirements set forth in state or federal law.
- In the case of overpayment, MedImpact may seek a refund or recoupment of the overpayment in accordance with KRS 304.17A-712.
- The amount refunded or recouped shall be limited to the amount paid to Member Pharmacy minus the amount that should have been paid to the pharmacy absent the overpayment and shall not include the dispensing fee if the correct medication was dispensed to the patient.
- MedImpact shall have an appeals process under which Member Pharmacy may appeal a final audit report.
- MedImpact shall provide to Member Pharmacy, prior to or at the time of the delivery of the preliminary audit report, a written explanation of the appeals process, including the name, address, and phone number of the person to whom the appeal should be addressed.
- Following the appeal, if it is determined that an audit report or any portion thereof is unsubstantiated, the audit report or unsubstantiated portion shall be dismissed without the necessity of further proceedings.
- MedImpact shall not recoup disputed funds or collect interest on disputed funds until the final internal disposition of the audit, including the appeals process.
- The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse; and shall not apply to any audit conducted by or on behalf of a state agency pursuant to KRS Chapter 205.

**Maine:**

The following shall apply to audits conducted in Maine in accordance with 24-A MRSA Section 4317:

- Member Pharmacy shall be given 10 days’ advance written notice of an audit and the range of prescription numbers and the range of dates included in the audit.
- Member Pharmacy has the right to request mediation by a private mediator, agreed upon by the parties, to resolve any disagreements related to the audit. A request for medication does not waive any existing rights of appeal available to a pharmacy.

**Maryland:**

The following shall apply to audits conducted in Maryland in accordance with MD Code, Insurance, § 15-1629 –

- An onsite audit shall not be scheduled to begin during the first five (5) calendar days of a month unless requested by Member Pharmacy.
- Member Pharmacy shall be provided written notice at least two (2) weeks before conducting an initial onsite audit for each audit cycle.
• The services of a pharmacist shall be employed if the audit requires the clinical or professional judgment of a pharmacist.
• Auditors will be permitted to enter the prescription area of Member Pharmacy only when accompanied by or authorized by a member of the pharmacy staff.
• Member Pharmacy may use any prescription, or authorized change to a prescription, that meets the requirements of COMAR 10.34.20.02 to validate claims submitted for reimbursement for dispensing of original and refill prescriptions.
• To validate the pharmacy record with respect to orders or refills of a drug, Member Pharmacy may use records of a hospital or a physician or other prescriber authorized by law that are written or transmitted electronically or by any other means of communication to the extent authorized by the Agreement between Member Pharmacy and MedImpact.
• Audits of Member Pharmacy shall be under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
• Only audit claims submitted or adjudicated within the two (2) year period immediately preceding the audit will be audited, unless a longer period is permitted under federal or state law.
• The preliminary audit report will be delivered to Member Pharmacy within one hundred twenty (120) calendar days after the completion of the audit, with reasonable extensions allowed.
• Member Pharmacy will be allowed to produce documentation to address any discrepancy found during the audit to the extent required by law.
• The final audit report will be delivered to Member Pharmacy within six (6) months after delivery of the preliminary audit report if Member Pharmacy does not request an internal appeal or within thirty (30) days after the conclusion of the internal appeals process if Member Pharmacy requests an internal appeal.
• During an audit, the auditor will not disrupt the provision of services to the customers of a pharmacy.
• The accounting practice of extrapolation will not be used to calculate overpayments or underpayments.
• Auditor may not share information from an audit with another pharmacy benefits manager or use information from an audit conducted by another pharmacy benefits manager. This does not apply when required by federal or state law, in connection with a merger, or at the payor’s request.
• The recoupment of claims shall be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by Member Pharmacy.
• A clerical error, record-keeping error, typographical error, or scrivener’s error in a required document or record may not constitute fraud or grounds for recoupment of a claims payment from Member Pharmacy if the prescription was otherwise legally dispensed and the claim was otherwise materially correct.
• MedImpact shall have an internal appeals process under which Member Pharmacy may appeal any disputed claim in a preliminary audit report.
• MedImpact shall allow Member Pharmacy to request an internal appeal within thirty (30) working days after receipt of the preliminary audit report, with reasonable extensions allowed.
• The preliminary audit report shall include a written explanation of the internal appeals process, including the name, address, and telephone number of the person to whom an internal appeal should be addressed.
• The decision of MedImpact on an appeal of a disputed claim in a preliminary audit report by Member Pharmacy shall be reflected in the final audit report.
• The final audit report shall be delivered to Member Pharmacy within thirty (30) calendar days after conclusion of the internal appeals process.
• Moneys for an overpayment or denial of a claim may not be recouped by setoff until Member Pharmacy has an opportunity to review the audit findings and if Member Pharmacy concurs with the findings of overpayment or denial, thirty (30) working days have elapsed after the date the final audit report has been delivered to Member Pharmacy.
• If Member Pharmacy does not concur with the findings of overpayment or denial, MedImpact may not recoup by setoff any money pending the outcome of an appeal.
• Payor shall be responsible for remitting any money due to Member Pharmacy as a result of an underpayment of a claim within thirty (30) working days after the final audit report has been delivered to Member Pharmacy.
• MedImpact may withhold future payments before the date the final audit report has been delivered to Member Pharmacy if the identified discrepancy for all disputed claims in a preliminary audit report for an individual audit exceeds twenty-five thousand dollars ($25,000).
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

Minnesota:
The following shall apply to audits conducted in Minnesota in accordance with M.S.A. 151.60 – 151.70 –

• An amendment to the Agreement between Member Pharmacy and MedImpact with respect to pharmacy audits shall be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change.
• Unless otherwise prohibited by federal requirements or regulations, the following shall apply with respect to Member Pharmacy audits:
  o Member Pharmacy will be given notice fourteen (14) days before an initial on-site audit is conducted.
  o An audit that involves clinical or professional judgment will be conducted by or in consultation with a licensed pharmacist.
  o Member Pharmacy shall be audited under the same standards and parameters utilized by MedImpact as to other similarly situated pharmacies.
  o The period covered by the audit may not exceed twenty-four (24) months from the date that the claim was submitted to or adjudicated by MedImpact, unless a longer period is required under state or federal law.
  o If using a random sampling as a method for selecting a set of claims for examination, the sample size will be appropriate for a statistically reliable sample. Notwithstanding anything to the contrary herein,
Member Pharmacy shall be provided a masked list that provides a prescription number or date range that is being audited.

- An on-site audit will not take place during the first five (5) business days of the month unless consented to by Member Pharmacy.
- Auditors will not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.
- Any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final audit.
- MedImpact will not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if:
  
  (i) additional information is required in the Agreement (including the Manual); or
  
  (ii) the information is required by the Food and Drug Administration (FDA); or
  
  (iii) the information is required by the drug manufacturer's product safety program; and
  
  (iv) the information in clauses (i), (ii), or (iii) is not readily available for the auditor at the time of the audit.

- The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:
  
  (i) the plan sponsor and MedImpact have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and
  
  (ii) a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

- For recoupment or chargeback, the following apply:
  
  - Audit parameters will consider consumer-oriented parameters based on manufacturer listings.
  
  - A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the Agreement (including its attachments and exhibits, etc. thereto).
  
  - A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the
number of similar orders or refills for similar drugs.

- Extrapolation shall not be used in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.

- Calculations of overpayments will not include dispensing fees unless a prescription was not actually dispensed; the prescriber denied authorization; the prescription dispensed was a medication error by the pharmacy; or the identified overpayment is solely based on an extra dispensing fee.

- Clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record shall not be considered as fraud; however, such errors may be subject to recoupment.

- In the case of errors that have no actual financial harm to the patient or plan, chargebacks will not be accessed. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery.

- Interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

- With respect to documentation during an audit:
  
  - To validate the pharmacy record and delivery, Member Pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the Agreement (including the Manual).

  - Any legal prescription that meets the requirements set forth in Minnesota Statutes Chapter 151 may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.

- MedImpact shall have a written appeals process which includes appeals of preliminary reports and final reports.

- Audit information and reports:
  
  - A preliminary audit report will be delivered to Member Pharmacy within sixty (60) days after the conclusion of the audit.

  - Member Pharmacy will be allowed at least forty-five (45) days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.

  - A final audit report will be delivered to Member Pharmacy within one hundred twenty (120) days after receipt of the preliminary audit report or final appeal, whichever is later.
Payor is responsible for remitting any money due to Member Pharmacy as a result of an underpayment of a claim within forty-five (45) days after the appeals process has been exhausted and the final audit report has been issued.

- Where contractually required, MedImpact will provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor.
- The foregoing do not apply to any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or any audit completed by Minnesota health care programs.

**Mississippi:**

The following shall apply to audits conducted in Mississippi in accordance with Miss. Code Ann. §§ 73-21-175 to 73-21-189 –

- Member Pharmacy shall be given written notice at least two (2) weeks before conducting the initial on-site audit for each audit cycle.
- Member Pharmacy shall have at least fourteen (14) days to respond to any desk audit requirements.
- The auditor shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process.
- Any audit that involves clinical or professional judgment will be conducted by or in consultation with a pharmacist.
- Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud.
- Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- A finding of an overpayment or an underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except that recoupment shall be based on the actual overpayment or underpayment.
- A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- The period covered by an audit may not exceed two (2) years from the date the claim was submitted or adjudicated.
- An audit shall not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by Member Pharmacy.
- Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions.
• The auditor shall conduct an exit interview that provides Member Pharmacy with an opportunity to respond to questions and comment on and clarify findings at the end of an audit. The time of the interview must be agreed to by Member Pharmacy.
• Unless superseded by state or federal law, MedImpact shall only have access to previous audit reports on a particular pharmacy conducted by MedImpact.
• An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan.
• The parameters of an audit will comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:
  (i) The day supply for eye drops will be calculated so that the consumer pays only one (1) thirty (30) day copayment if the bottle of eye drops is intended by the manufacturer to be a thirty (30) day supply;
  (ii) The day supply for insulin will be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;
  (iii) The day supply for a topical product will be determined by the judgment of the pharmacist based upon the treated area.
• Where the audit is for a specifically identified problem that has been disclosed to Member Pharmacy, the audit shall be limited to claims that are identified by prescription number.
• For all other audits, the audit shall be limited to one hundred (100) individual prescriptions that have been randomly selected and if the audit reveals the necessity for a review of additional claims, the audit shall be conducted on site. Individual prescription means the original prescription for a drug signed by the prescriber, and excludes refills referenced on the prescription.
• Except for audits for a specifically identified problem, an audit of a pharmacy shall not be initiated more than one (1) time in any quarter.
• Recoupment shall not be based on additional required documentation or performance that is in addition to or exceeding that prescribed by the State Board of Pharmacy.
• Except for Medicare claims, approval of drug, prescriber or patient eligibility upon adjudication of a claim shall not be reversed unless Member Pharmacy obtained the adjudication by fraud or misrepresentation of claim elements and MedImpact does not base, directly or indirectly, its commission or other payment on the amounts recouped.
• A written preliminary audit report will be provided to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit, with a reasonable extension to be granted upon request.
• Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request.
• A final audit report shall be delivered to Member Pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, as provided for in Section 73-21-185, whichever is later.
• The audit report must be signed by the auditor.
• Recoupments of any disputed funds or repayment of funds by Member Pharmacy pursuant to the Agreement shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185.
• If the identified discrepancy for an individual audit exceeds twenty-five thousand dollars ($25,000), future payments in excess of that amount to Member Pharmacy may be withheld pending finalization of the audit.
• Interest shall not accrue during the audit period.
• A copy of the final audit report may (and to the extent required by law, will) be delivered, after completion of any review process, to the plan sponsor.
• MedImpact shall have a written appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report to MedImpact.
• If, following the appeal, MedImpact finds that an unfavorable audit report or any portion thereof is unsubstantiated, MedImpact shall dismiss the audit report or that portion without the necessity of any further action.
• If, following the appeal, any of the issues raised in the appeal are not resolved to the satisfaction of either party, that party may ask for mediation of those unresolved issues. A certified mediator shall be chosen by agreement of the parties from the Court Annexed Mediators List maintained by the Mississippi Supreme Court.
• The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits. An extrapolation audit means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

Missouri:

The following shall apply to audits conducted in Missouri in accordance with RSMo. 338.600 and RSMo. 376.384 –

• Member Pharmacy shall be provided with notice at least one (1) week prior to conducting the initial on-site audit for each audit cycle.
• Any audit which involves clinical judgment shall be conducted by or in consultation with a licensed pharmacist.
• Any clerical error, record-keeping error, typographical error, or scrivener’s error regarding a required document or record shall not constitute fraud or grounds for recoupment, so long as the prescription was otherwise legally dispensed and the claim was otherwise materially correct. Such claims may be otherwise subject to recoupment and claims may be subject to criminal penalties if proof of intent to commit fraud is found.
• Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts involving drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
• Electronically stored images of prescriptions, electronically created annotations, and other related supporting documentation shall be considered valid prescription records to the extent permitted by law.
• Hard copy and electronic signature logs that indicate the delivery of pharmacy services shall be considered valid proof of receipt of such services by a program enrollee.
• A finding of an overpayment or underpayment may be a projection based on the number of patients served and having a similar diagnosis or on the number of similar orders or refills for similar drugs.
• Recoupment of claims shall be based on the actual overpayment or underpayment unless the projection for overpayment or underpayment is part of a settlement as agreed to by Member Pharmacy.
• Member Pharmacy shall be audited under the same standards and parameters as other pharmacies audited by MedImpact.
• Member Pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.
• The period covered by the audit shall not exceed a two (2) year period beginning two (2) years prior to the initial date of the on-site portion of the audit unless otherwise provided by contractual agreement or if there has been a previous finding of fraud or as otherwise provided by state or federal law.
• An audit shall not be initiated or scheduled during the first three (3) business days of any month due to the high volume of prescriptions filled during such time unless otherwise consented to by Member Pharmacy.
• The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit, with reasonable extensions permitted.
• The final audit report shall be delivered to Member Pharmacy within six (6) months of receipt by Member Pharmacy of the preliminary audit report or final appeal, as provided herein, whichever is later.
• The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits.
• Recoupments of any disputed moneys shall only occur after final internal disposition of the audit, including the appeals process. Should the identified discrepancy for an individual audit exceed twenty-five thousand dollars ($25,000), future payments to Member Pharmacy in excess of twenty-five thousand dollars ($25,000) may be withheld pending finalization of the audit.
• MedImpact shall have an appeals process, lasting no longer than six (6) months, under which a licensed pharmacy may appeal an unfavorable preliminary audit report to MedImpact.
• If, following such appeal, MedImpact finds that an unfavorable audit report or any portion thereof is unsubstantiated, MedImpact shall dismiss the audit report or such portion without the necessity of any further proceedings.
• A copy of the final audit report may (and to the extent required by law, will) be delivered to the plan sponsor after completion of any appeal process.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.
• This section shall not apply to any audit conducted as part of any inspection or investigation conducted by any governmental entity or law enforcement agency.
• To the extent prohibited by law, a refund or offset will not be requested more than twelve (12) months after a claim is paid, absent fraud or misrepresentation by Member Pharmacy.

Montana:

The following shall apply to audits conducted in Montana in accordance with Montana Pharmacy Audit Integrity Act:

• Audits of pharmacies shall be conducted using the same standards and parameters as used in auditing other pharmacies on behalf of the same audit client.
• An audit that involves clinical or professional judgment will be conducted by
or in consultation with a licensed pharmacist who is employed by or working
with the entity conducting the audit.
• If an audit is conducted onsite at a pharmacy:
  a. The pharmacy will be given 10 days’ advance written notice of the
     audit, along with the range of prescription numbers or a range that
     will be included in the audit; and
  b. The pharmacy will not be audited during the first 5 business days
     of the month unless the pharmacy agrees to the timing of the
     audit.
• The period covered by the audit will not exceed 24 months from the date that
  the prescription was submitted to or adjudicated by MedImpact unless a
  longer period is required under state or federal law. An audit will not exceed
  275 selected prescriptions.
• Except as required by state or federal law, the entity conducting the audit
  may have access to a pharmacy’s previous audit report only if the previous
  audit report was prepared by that entity.
• To validate a pharmacy record, a pharmacy may use documented statements
  of records in the pharmacy or pharmacy system, including medication
  administration records of a nursing home, assisted living facility, hospital,
  physician, surgeon, or other prescriber authorized by the law of Montana.
• If an audit results in the dispute or denial of a claim, the pharmacy will be
  permitted to produce additional claims documentation using any commercially
  reasonable method, including fax, mail, or email.
• Dispensing fees will not be included in an audit recoupment unless a
  prescription was not actually dispensed, the prescriber denied authorization,
  the prescription dispensed was a dispensing error by the pharmacy, or the
  identified overpayment is based solely on an extra dispensing fee.
• Funds will not be recouped for prescription clerical or recordkeeping errors,
  including typographical errors, scrivener’s errors, and computer errors, in a
  required document or record unless the error results in actual financial harm
  to the entity or to a consumer.
• Funds, charge-backs, and penalties will not be collected until the audit and all
  appeals are final unless there are allegations of fraud or other intentional or
  willful misrepresentation that is evidenced by the review of claims data,
  statements, physical review, or other investigative methods.
• Extrapolation or other statistical expansion techniques will not be used in
  calculating the amount of any recoupment or penalty.
• The agent or employee who conducts the audit will not be paid based on a
  percentage of the amount recovered.
• Interest will not be charged on the amount to be recovered during the audit
  period.
• For audits conducted onsite, the following apply:
  a. A preliminary audit report shall be provided to the pharmacy or its
     corporate office of record within 60 days after completion of the
     audit.
  b. The pharmacy will have 30 days following receipt of the preliminary
     audit report to respond to questions, provide additional
     documentation, and comment on and clarify findings of the audit.
     The date of receipt of the report will be determined by the
     postmark date or the date of the electronic transmission if
     transferred electronically.
  c. If an audit results in a dispute or denial of a claim, the entity
     conducting the audit will allow the pharmacy, for 30 days following
receipt of the preliminary audit report, to produce additional claims documentation using any commercially reasonably method, including fax, mail, or email.

d. Within 120 days after the completion of the appeals process, a final audit report will be delivered to the pharmacy or its corporate office of record.

e. The final audit report will include a disclosure of any money recovered.

- The foregoing shall not apply to an audit of pharmacy records with fraud or other intentional and willful misrepresentation is evidenced by the review of claims data, statements, physical review, or other investigative methods.

- Member Pharmacies can appeal audit results by contacting MedImpact.

**New Hampshire:**

The following shall apply to denials, withholds, and offsets in New Hampshire in accordance with N.H. Rev. Stat §§ 415:6-i(III), 415:18m(III), 420-A:17-e(III), 420-J:8-b –

- Denials, withholds, and offsets shall not exceed eighteen (18) months after payment unless fraud, duplicate payment, services not delivered, federal program, COB, or subject of legal action.

- Member Pharmacy will be given at least fifteen (15) days advance written explanation of the denial, withhold, and/or offset.

The following shall apply to audits conducted in New Hampshire (N.H. Rev. Stat. 318:61, et seq. (2013 NH SB 38, effective 1/1/2014)) –

- Member Pharmacy shall be provided with at least seven (7) days' advance notice of the initial on-site audit for each audit cycle. A Member Pharmacy that requests in writing an additional seven (7) days prior to the commencement of an audit shall be granted seven (7) additional days.

- Any audit that involves clinical judgment shall be conducted by or with a pharmacist who is licensed and is employed or working under contract with the auditing entity.

- Any clerical or record-keeping errors, including typographical errors, scrivener's errors, and computer errors, on a required document or record, in the absence of any other evidence, shall not itself be deemed fraudulent. This subdivision does not prohibit recoupment of fraudulent payments.

- If otherwise required under the terms of the contract, MedImpact will provide Member Pharmacy, upon written request, all records related to the audit in an electronic format or contained in digital media.

- Member Pharmacy may use properly documented records of a hospital or any person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug, in compliance with state laws.

- If an on-site audit is conducted for a reason other than an identified problem, the audit will be limited to no more than 250 selected prescriptions and Member Pharmacy will be provided a masked list of prescriptions to assist in preparation. The list is considered masked if the last 2 numbers of the prescription are marked with an "X." This procedure allows the Member
Pharmacy to pull the book the audited prescription is in, however it does not allow the Member Pharmacy to pull the specific prescription audited. Additionally, Member Pharmacy acknowledges and agrees that all of the invoices for actual dispensed prescriptions, with prices redacted, may be obtained from the pharmacy’s wholesaler or distributor.

- Member Pharmacy shall not be subject to more than two (2) audits by MedImpact in one calendar year, unless fraud or misrepresentation is reasonably suspected.
- Except for cases of Food and Drug Administration regulation or drug manufacturer safety programs, Member Pharmacy shall be free of recoupments based on any of the following unless otherwise defined within the billing requirements set forth in the Agreement, including the Manual:
  a. Documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the pharmacy board or by the provider manual or contract.
  b. A requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the board.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- The period covered by an audit will be limited to 24 months from the date a claim was submitted/adjudicated, unless a longer period is permitted by a federal plan under federal law.
- Audits will not be initiated or scheduled during the first five (5) calendar days of any month for any Member Pharmacy that averages in excess of 600 prescriptions per week due to the high volume of prescriptions filled during that time and for patient care considerations, without the express consent of the Member Pharmacy. Member Pharmacy shall co-operate with the auditor to establish an alternate date should the audit fall within the days excluded.
- The accounting practice of extrapolation will not be used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.
- Dispensing fees will not be included in the calculations of overpayments unless the prescription is considered a misfill. A misfill shall be defined as a prescription not dispensed, a medication error, a prescription whereby the prescriber denied authorization, or where an extra dispensing fee was charged.
- Auditors shall only have access to previous audit reports on a particular pharmacy if the previous audit was conducted by the same entity, except as required for compliance with state or federal law.
- Member Pharmacies may use the following records at the time of the audit to validate a claim for a prescription, refill, or change in a prescription:
  a. Electronic or physical copies of records of a health care facility or a health care provider with prescribing authority.
  b. Any prescription that complies with state law.
- An audit report will be delivered to the Member Pharmacy within seventy-five (75) days, unless otherwise agreed to, after the conclusion of the audit. Member Pharmacy shall be allowed thirty (30) days, unless otherwise agreed to, following receipt of the audit report to appeal any discrepancy found in the audit. A final audit report will be delivered to Member Pharmacy within ninety (90) days, unless otherwise agreed to, after receipt of the appeal. A charge-back, recoupment, or other penalty may not be assessed until the appeal process has been exhausted and the final report issued except as specified in RSA 318:64. Except as provided by state or federal law or contract, audit
information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

- The foregoing shall not apply to any audit, review, or investigation that is based on suspected or alleged fraud, willful misrepresentation, or abuse. The foregoing shall not apply to claims that were paid for in part or in whole by Medicare or Medicaid program funds.

The following shall apply to Member Pharmacy appeals and recoupments (N.H. Rev. Stat. 318:61, et seq. (2013 NH SB 38, effective 1/1/2014)) -

- MedImpact has and shall maintain an appeals process under which Member Pharmacy may appeal an unfavorable audit report.
- If, following the appeal, an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the unsubstantiated portion of the audit report shall be dismissed without any further proceedings unless otherwise set forth in the contract.
- MedImpact may provide a copy of the audit findings to applicable plan sponsor(s) after completion of any appeals process.
- Recoupments of any disputed funds will occur only after final internal disposition of an audit, including the appeals process, unless fraud or misrepresentation is reasonably suspected or the discrepant amount exceeds $10,000.
- Recoupment on an audit shall be refunded to the responsible party as contractually agreed upon by the parties.
- MedImpact may charge or assess for audits, directly or indirectly, based on amounts recouped if both of the following conditions are met:
  a. The responsible party and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party.
  b. A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

New Jersey:


- To the extent prohibited by law, recoupment will not be sought over eighteen (18) months after payment of a claim and will not seek recoupment more than once on a particular claim.
- Member Pharmacy shall be provided with documentation of the error that justifies the recoupment request.
- Recoupment will not be based on extrapolation except where permitted by law.
- Unless otherwise required or permitted by law, recoupment and offset will not occur before forty-five (45) days after the request to Member Pharmacy and exhaustion of Member Pharmacy’s appeal rights.
- Without limiting more restrictive requirements set forth in the Agreement, in no case may Member Pharmacy seek reimbursement of an underpayment after eighteen (18) months from the date of the claim.
- In the event Member Pharmacy appeals payment of a claim, the internal review shall be conducted and its results communicated in a written decision to Member Pharmacy within ten (10) business days of receipt of
the appeal. The written decision will include, at a minimum, the information required by law. Member Pharmacy has available to it an independent external ADR mechanism to review adverse decisions of the internal appeals process as set forth in the Agreement.

New Mexico:

The following shall apply to audits conducted in New Mexico in accordance with N.M. Stat. Ann. § 61-11-18.2 –

- Member Pharmacy shall be given notice at least two (2) weeks prior to conducting the initial on-site audit for each audit cycle.
- An audit that involves clinical or professional judgment shall be conducted by or in consultation with a pharmacist.
- Any clerical or record-keeping error, regarding a required document or record shall not necessarily constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud.
- Member Pharmacy may use the records of a hospital, physician or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a dangerous drug or controlled substance.
- A finding of an overpayment or underpayment shall not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Recoupment of claims shall be based on the actual overpayment or underpayment unless a statistically justifiable method of projection is demonstrated or the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- Member Pharmacy shall be allowed at least twenty-one (21) business days, with reasonable extensions allowed, following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.
- The period covered by an audit shall not exceed two (2) years, unless otherwise set forth in the Agreement, from the date the claim was submitted to or adjudicated by MedImpact or unless it conflicts with state or federal law.
- An audit shall not be initiated or scheduled during the first five (5) calendar days of a month due to the high volume of prescriptions filled during that time unless otherwise consented to by Member Pharmacy.
- The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days, with reasonable extensions allowed, after conclusion of the audit.
- The final report shall be delivered to Member Pharmacy within six (6) months after receipt of the preliminary audit report or final appeal, whichever is later.
- Accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits.
- Recoupment of any disputed funds shall occur after final internal disposition of the audit, including the appeals process.
- Should the identified discrepancy for an individual audit exceed twenty-five thousand dollars ($25,000), future payments to Member Pharmacy may be withheld pending finalization of the audit.
• MedImpact shall have an appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report to MedImpact.
• If, following the appeal, MedImpact finds that an unfavorable audit report or any portion of the audit is unsubstantiated, MedImpact shall dismiss the audit report or the unsubstantiated portion of the report of the audit without the necessity of any further proceedings.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

The following shall apply to retro adjustments for overpayments in New Mexico in accordance with N.M. Admin. Code § 13.10.22.12(R) –

• Retro adjustments for overpayments shall be made within eighteen (18) months of the claim payment absent healthcare professional miscoding, claim submission error, suspected fraud/abuse, or adjustments required by federal or state agencies.

New York:
The following shall apply to recovery of overpayments in New York in accordance with NY CLS Ins. Section 3224-b –

• Member Pharmacy shall be provided with no less than thirty (30) days’ written notice before seeking recovery of an overpayments (except those overpayments based on duplicate payments) to give Member Pharmacy an opportunity to challenge it.
• Recovery of overpayments shall be limited to twenty-four (24) months except where there is fraud/misconduct, where required by a self-insured plan; or where required by a government program or state/municipal coverage.

North Carolina:
The following shall apply to audits conducted in North Carolina in accordance with N.C. Gen Stat. Ann. §§ 90-85.50 to 90-85.53 –

• Member Pharmacy shall be provided at least fourteen (14) days' advance notice of the initial on-site audit for each audit cycle.
• An audit that involves clinical judgment will be conducted with a pharmacist who is licensed and is employed or working under contract with MedImpact or the auditor.
• Clerical and record-keeping errors, such as typographical errors, scrivener’s errors, or computer error regarding a required document or record, in the absence of any other evidence, will not be deemed fraud; however, such errors may be subject to recoupment.
• If required under the terms of the Agreement, Member Pharmacy will be provided, upon request, all records related to the audit in an electronic format or contained in digital media.
• Member Pharmacy may validate the pharmacy record with respect to orders or refills for a controlled substance or narcotic drug, by the use of records of a hospital or any person authorized to prescribe controlled substances for
the purpose of providing medical or pharmaceutical care that are transmitted by any means of communication.

- A finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Recoupment must be based on the actual overpayment unless the projection for overpayment or underpayment is part of a settlement by Member Pharmacy.
- Where the audit is for a specifically identified problem, the audit shall be limited to claims that are identified by prescription number.
- For all other audits, the audit shall be limited to one hundred (100) selected prescriptions and if the audit reveals the necessity for a review of additional claims, the audit shall be conducted on-site.
- Except for audits for a specifically identified problem, audits shall not be initiated of Member Pharmacy more than one (1) audit in one calendar year, unless fraud or misrepresentation is reasonably suspected.
- Recoupment shall not be based on additional requirements beyond those prescribed by the State Board of Pharmacy (this is inapplicable to cases of Food and Drug Administration regulation or drug manufacturer safety programs).
- Member Pharmacy shall be subject to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim.
- Except for Medicare claims, Member Pharmacy shall be subject to reversals of approval for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements.
- Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
- Member Pharmacy shall have at least thirty (30) days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit.
- The period covered by an audit shall be limited to twenty-four (24) months from the date a claim was submitted or adjudicated, unless a longer period is permitted by a federal plan under federal law.
- Audits shall not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled during that time, without the express consent of Member Pharmacy. Member Pharmacy shall cooperate with the auditor to establish an alternate date should the audit fall within the days excluded.
- The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.
- The final audit report shall be delivered to Member Pharmacy within ninety (90) days after the end of the appeals period.
- The accounting practice of extrapolation shall not be used to calculate recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.
- MedImpact shall have an appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report.
- If, following the appeal, MedImpact finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, MedImpact shall dismiss the unsubstantiated portion of the audit report without any further proceedings.
• A copy of the audit findings will be delivered to the plan sponsor after completion of any appeals process if required under contractual terms.
• Recoupments of any disputed funds shall occur only after final internal disposition of an audit, including the appeals process, unless fraud or misrepresentation is reasonably suspected.
• Recoupment on an audit shall be refunded to the responsible party as contractually agreed upon by the parties.
• MedImpact may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met: there is a contract that explicitly states the percentage charge or assessment to the plan sponsor; and no commission or financial incentive is paid to an agent or employee of MedImpact based, directly or indirectly, on amounts recouped.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged Medicaid fraud, Medicaid abuse, insurance fraud, or other criminal fraud or misrepresentation.

The following shall apply to audits and recoupments occurring in North Carolina. Member Pharmacy shall not to be subject to recoupment on any portion of the reimbursement for the dispensed product of a prescription, unless otherwise provided in this subdivision: (2013 NC HB 675, effective 10/1/2013)

• Recoupment of reimbursement, or a portion of reimbursement, for the dispensed product of a prescription may be had in the following cases:
  a. Fraud or other intentional and willful misrepresentation evidenced by a review of the claims data, statements, physical review, or other investigative methods.
  b. Dispensing in excess of the benefit design, as established by the plan sponsor.
  c. Prescriptions not filled in accordance with the prescriber's order.
  d. Actual overpayment to the pharmacy.
• Recoupment of claims in cases set out above shall be based on the actual financial harm to the entity or the actual underpayment or overpayment. Calculations of overpayments shall not include dispensing fees unless one of the following conditions is present:
  a. A prescription was not actually dispensed.
  b. The prescriber denied authorization.
  c. The prescription dispensed was a medication error by the Member Pharmacy. For purposes of this subdivision, a medication error is a dispensing of the wrong drug or dispensing to the wrong patient or dispensing with the wrong directions.
  d. The identified overpayment is based solely on an extra dispensing fee.
  e. The Member Pharmacy was noncompliant with Risk Evaluation and Mitigation Strategies (REMS) program guidelines.
  f. There was insufficient documentation, including electronically stored information, as described in this subsection.
  g. Fraud or other intentional and willful misrepresentation by the pharmacy.
• To have an audit based only on information obtained by MedImpact conducting the audit and not based on any audit report or other information gained from an audit conducted by a different auditing entity. This subdivision does not prohibit MedImpact from using an earlier audit report prepared by MedImpact for the same pharmacy. Except as required by State or federal
law, an entity conducting an audit may have access to a pharmacy's previous audit report only if the previous report was prepared by that entity.

- If the audit is conducted by a vendor or subcontractor, that entity is required to identify the responsible party on whose behalf the audit is being conducted without having this information being requested.
- Member Pharmacy may use any prescription that complies with federal or State laws and regulations at the time of dispensing to validate a claim in connection with a prescription, prescription refill, or a change in a prescription.
- MedImpact when conducting an audit shall not recoup any disputed funds, charges, or other penalties from a Member Pharmacy until (i) the deadline for initiating the appeals process established pursuant to G.S. 90-85.51 has elapsed or (ii) after the final internal disposition of an audit, including the appeals process as set forth in G.S. 90-85.51, whichever is later, unless fraud or misrepresentation is reasonably suspected.
- Recoupment on an audit shall be refunded to the responsible party as contractually agreed upon by the parties.
- MedImpact may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:
  a. The responsible party and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party.
  b. A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

**North Dakota:**

The following shall apply to audits conducted in North Dakota in accordance with N.D. Cent. Code §§ 19-03.6-01 to 19-013.6-04 –

- Member Pharmacy shall be given written notice of at least fourteen (14) business days before conducting an initial onsite audit.
- If the audit involves clinical or professional judgment, the audit will be conducted by or in consultation with a licensed pharmacist employed by or contracted with the auditor or MedImpact.
- The audit shall be limited to no more than twenty-four (24) months from the date that the claim was submitted or adjudicated.
- A claim may not be reviewed that is older than twenty-four (24) months from the date of the audit, unless a longer period is permitted under federal law.
- Audits will not be conducted during the first five (5) business days of the month unless otherwise consented to by Member Pharmacy.
- The auditor will refrain from entering pharmacy area where patient-specific information is available and remain out of sight and hearing range of the pharmacy customers.
- Member Pharmacy shall designate an area for auditors to conduct their business.
- Member Pharmacy is allowed to use the records, including a medication administration record, of a hospital, physician, or other authorized practitioner to validate the pharmacy record and delivery.
- Member Pharmacy may use any legal prescription, including medication administration records, electronic documents, or documented telephone calls from the prescriber or the prescriber's agents, to validate claims in connection with prescriptions and refills or changes in prescriptions.
• An audit may not allow a recoupment to be assessed for items on the face of a prescription not required by rules adopted by the state board of pharmacy with respect to patient hard copy prescription forms for controlled and uncontrolled drugs.

• A finding of overpayment or underpayment may be based only on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

• A calculation of an overpayment may not include dispensing fees, unless a prescription was not dispensed or the prescriber denied authorization. In the case of an error that has no financial harm to the patient or plan, chargeback may not be assessed.

• Extrapolation may not be used in calculating the recoupment or penalties for audits.

• Any recoupment may not be deducted against future remittances and must be invoiced to the pharmacy for payment.

• The auditor may not receive payment based on a percentage of the amount recovered and interest may not accrue during the audit period, which begins with the notice of audit and ends with the final audit report.

• A clerical or recordkeeping error may not be considered fraud, but may be subject to recoupment. A person is not subject to criminal penalty without proof of intent to commit fraud.

• MedImpact’s parameters of an audit shall comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:
  a. The day supply for eye drops will be calculated so that the consumer pays only one thirty (30) day copayment if the bottle of eye drops is intended by the manufacturer to be a thirty (30) day supply.
  b. The day supply for insulin will be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment.
  c. The day supply for a topical product will be determined by the judgment of the pharmacist based upon the treated area.

• Unless an alternate price is set forth in the Agreement (including any attachment, exhibit, etc. thereto) and signed by both parties, the usual and customary price charged by Member Pharmacy for compounded medications is considered to be the reimbursable cost.

• The same standards and parameters shall be used in auditing a pharmacy MedImpact uses with other similarly situated pharmacies.

• MedImpact shall have a written appeals process.

• The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after the conclusion of the audit.

• Member Pharmacy will be allowed at least sixty (60) days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.

• The final audit report shall be delivered to Member Pharmacy within ninety (90) days after receipt of the preliminary audit report or final appeal, whichever is later.

• No chargeback, recoupment, or other penalty may be assessed until the appeal process has been exhausted and the final report issued.

• Payor is responsible for remitting any money due to a pharmacy as a result of an underpayment of a claim within thirty (30) days after the appeals process has been exhausted and the final audit report has been issued.
• A copy of the final report may (and to the extent required by law, will) be delivered to the plan sponsor for which claims were included in the audit. Any funds recouped will be returned to the plan sponsor.
• The foregoing does not apply to state Medicaid programs.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.
• Any case of suspected fraud or violation of law must be reported by an auditor to the licensing board.

Oklahoma:

The following shall apply to audits conducted in Oklahoma in accordance with 59 Okla. Stat. § 356 et. seq. –

• Unless otherwise agreed to in the Agreement, prescription claim documentation and record-keeping requirements shall not exceed the requirements set forth by the Oklahoma Pharmacy Act or other applicable state or federal laws or regulations.
• Member Pharmacy shall be given written notice, including identification of prescription numbers to be audited, at least two (2) weeks prior to conducting an on-site audit.
• Member Pharmacy shall have the opportunity to reschedule the audit no more than seven (7) days from the date designated on the original audit notification.
• The auditor shall not interfere with the delivery of pharmacist services to a patient and shall utilize every reasonable effort to minimize inconvenience and disruption to Member Pharmacy operations during the on-site audit process.
• Any audit involving clinical or professional judgment shall be conducted by means of or in consultation with a licensed pharmacist.
• Clerical or record-keeping errors, such as a typographical error, scrivener's error, or computer error regarding a required document or record, shall not be considered fraud; however, such errors may be subject to recoupment.
• Member Pharmacy shall have the right to submit amended claims to correct clerical or record-keeping errors in lieu of recoupment, provided that the prescription was dispensed according to prescription documentation requirements set forth by the Oklahoma Pharmacy Act and there is no proof of intent to commit fraud or such error.
• To the extent that an audit results in the identification of any clerical or record-keeping errors, the pharmacy shall not be subject to recoupment of funds unless there is proof of intent to commit fraud or such error results in actual financial harm to MedImpact, a Payor, or a consumer. A person shall not be subject to criminal penalties for errors provided for in this paragraph without proof of intent to commit fraud.
• Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
• MedImpact may base a finding of an overpayment or underpayment on a projection based on the number of patients served having similar diagnoses or on the number of similar orders or refills for similar drugs.
• Recoupment of claims shall be based on the actual overpayment or underpayment of each identified claim.
A projection for overpayment or underpayment may be used to determine recoupment as part of a settlement as agreed to by Member Pharmacy.

The dispensing fee amount shall not be included in the recoupment unless a prescription was not actually dispensed or a physician denied authorization or as otherwise agreed to by contract.

Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.

The audit period shall not exceed two (2) years from the date the claim was submitted or adjudicated.

Audits shall not be scheduled or initiated during the first seven (7) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by Member Pharmacy.

MedImpact may (and to the extent required by law, will) disclose to any plan sponsor whose claims were included in the audit and any money recouped in the audit.

Member Pharmacy may provide the pharmacy's computerized patterned medical records or the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of supporting the pharmacy record with respect to orders or refills of a legend or narcotic drug.

Audits shall not include more than seventy-five (75) prescriptions per initial audit.

If paper copies of records are requested by MedImpact, the pharmacy may charge up to twenty-five cents ($0.25) per page to cover the costs incurred by Member Pharmacy.

Member Pharmacy shall be provided with a written report of the audit.

A preliminary audit report shall be delivered to Member Pharmacy within ninety (90) calendar days after conclusion of the audit.

Member Pharmacy shall have at least sixty (60) calendar days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit; provided, however, Member Pharmacy may request an extension, not to exceed an additional sixty (60) calendar days.

A final audit report shall be delivered to Member Pharmacy signed by the auditor within one hundred twenty (120) calendar days after receipt of the preliminary audit report or final appeal, whichever is later.

MedImpact shall recoup any disputed funds after final internal disposition of the audit, including the appeals process.

Unless otherwise agreed by the parties, future payments to Member Pharmacy may be withheld pending finalization of the audit should the identified discrepancy exceed twenty-five thousand dollars ($25,000); and interest shall not accrue during the audit and appeal period.

A copy of the final audit results may (and to the extent required by law, will) be delivered, and a final audit report upon request, after completion of any review process to the plan sponsor.

The full amount of any recoupment on an on-site audit shall be refunded to the plan sponsor.

A charge or assessment for an audit shall not be based, directly or indirectly, on amounts recouped to the extent prohibited by law. MedImpact may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met: the plan sponsor and MedImpact have a contract that explicitly states the percentage charge or assessment to the plan sponsor, and the commission to an agent or
employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

- Unless superseded by state or federal law, MedImpact shall only have access to previous audit reports on a particular pharmacy conducted by the auditor for MedImpact, a Payor, or a Plan. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan.

**Oregon:**

The following shall apply to audits and recoupments conducted in Oregon in accordance with 2013 OR H.B. No. 2123, effective 1/1/2014 –

- MedImpact has and maintains, in writing, a procedure for Member Pharmacy to appeal audit findings with respect to a claim and will provide Member Pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the Member Pharmacy's claims.
- Audits of claims shall be limited to no more than 24 months after the date the claim was adjudicated.
- Member Pharmacy will be given at least fifteen (15) days' advance written notice of an on-site audit to the Member Pharmacy or corporate headquarters of the pharmacy.
- On-site audits will not be conducted during the first five (5) days of any month without Member Pharmacy's consent.
- Audits will be conducted in consultation with a licensed pharmacist if the audit involves clinical or professional judgment.
- On-site audits will not include more than 250 unique prescriptions of Member Pharmacy to be audited in any 12-month period except in cases of alleged fraud.
- More than one on-site audit of a pharmacy will not be conducted in any 12-month period.
- Audits of Member Pharmacy shall be conducted using the same standards and parameters used to audit other similarly situated pharmacies.
- Any outstanding claims of Member Pharmacy related to the audit will be paid in accordance with the Agreement no more than forty-five (45) days after the earlier of the date all appeals are concluded or the date a final report is issued.
- Dispensing fees and/or interest will not be included in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly.
- Costs associated with clerical errors or other errors that do not result in financial harm will not be recouped.
- Member Pharmacy will not be charged for a denied or disputed claim until the audit and the appeals are final.
- Finding that a claim was incorrectly presented or paid will be based on identified transactions and not based on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs.
- If MedImpact contracts with an independent third party to conduct audits, MedImpact will not, to the extent prohibited by law, disclose information
obtained during an audit except to the Member Pharmacy subject to the audit or the holder of the policy or certificate of insurance that paid the claim.

- The following may be used as evidence for validation of a claim:
  - An electronic or physical copy of a prescription that complies with law if the prescribed drug was, within 14 days of the dispensing date:
    - Picked up by the patient or the patient’s designee;
    - Delivered by the pharmacy to the patient; or
    - Sent by the pharmacy to the patient using the United States Postal Service or other common carrier;
  - Point of sale electronic register data showing purchase of the prescribed drug, medical supply or service by the patient or the patient’s designee; or
  - Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy’s central operations and any other reasonably clear and accurate electronic documentation that corresponds to a claim.

- Member Pharmacy will be provided with a preliminary report of the audit so as to be received by Member Pharmacy no later than 45 days after the date on which the audit was completed and will be sent by mail or common carrier with a return receipt requested; or electronically with electronic receipt confirmation.

- Member Pharmacy shall be given no fewer than 45 days after receiving the preliminary audit report to contest the report or any findings in the report in accordance with the appeals procedure and to provide additional documentation in support of the claim. MedImpact will consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

- If an audit results in the dispute or denial of a claim, Member Pharmacy will be permitted to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail.

- Member Pharmacy will be provided with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure. The final report will include a final accounting of all moneys to be recovered.

- Recoupment of disputed funds from Member Pharmacy or repayment of funds by Member Pharmacy, unless otherwise agreed to by MedImpact and Member Pharmacy, shall occur after the audit and the appeals procedure are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to Member Pharmacy may be withheld by MedImpact until the audit and the appeals procedure are final.

- The foregoing: (i) does not preclude MedImpact from instituting an action for fraud against Member Pharmacy; (ii) does not apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data or statements or other investigative methods; or (iii) does not apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the state medical assistance program.

**South Carolina:**

The following shall apply to audits conducted in South Carolina in accordance with South Carolina Stat. §§ 38-71-1810 through 38-71-1840 –
• Member Pharmacy shall be given at least fourteen (14) days’ advance notice of the initial audit for each audit cycle.
• An audit will not be initiated or scheduled during the first five (5) days of any month without the express consent of Member Pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days.
• An audit that involves clinical judgment shall be conducted with a pharmacist who is licensed and employed by or working under contract with MedImpact or the auditor.
• Clerical or record-keeping errors, including typographical errors, scrivener's errors and computer errors, on a required document or record shall not be considered fraudulent in the absence of any other evidence. However, they may be subject to recoupment.
• If required under the terms of the contract with MedImpact, Member Pharmacy has a right to have MedImpact provide Member Pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media.
• Member Pharmacy may use properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication approved by MedImpact in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug pursuant to federal and state regulations.
• The finding of an overpayment or underpayment may be based on a projection of either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; however, recoupments can be based on actual overpayments unless the projection for overpayment or underpayment is part of a settlement by the pharmacy.
• Recoupment shall not be based on additional requirements beyond those prescribed by the State Board of Pharmacy except as otherwise set forth in the Agreement or otherwise agreed to by the parties (this is inapplicable to cases of Food and Drug Administration regulation or drug manufacturer safety programs).
• Member Pharmacy shall be subject, so long as a claim is made within the contractual claim submission time period, to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim unless a prescription error occurs.
• Member Pharmacy may be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which Member Pharmacy obtained the adjudication by fraud or misrepresentation of claim elements.
• Member Pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by MedImpact.
• Member Pharmacy shall have at least thirty (30) days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit.
• The period covered by an audit shall be limited to twenty-four (24) months from the date a claim was submitted or adjudicated, unless a longer period is permitted by or under federal law.
• The preliminary audit report shall be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.
• The final audit report shall be delivered to Member Pharmacy within ninety (90) days after the end of the appeals period.
• The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.
• Member Pharmacy shall be provided, if requested, a masked list that provides a prescription number range the auditor is seeking to audit.
• MedImpact shall have an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report.
• If, following the appeal, MedImpact finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, MedImpact shall dismiss the unsubstantiated portion of the audit report without any further proceedings.
• If required under the terms of the contract with the responsible party, MedImpact shall provide a copy of the audit findings to the plan sponsor after completion of any appeals process.
• Recoupments of any funds disputed on the basis of an audit will occur only after final internal disposition of the audit, including the appeals process, unless fraud or misrepresentation is reasonably suspected.
• Recoupment on an audit will be refunded to the responsible party as contractually agreed upon by the parties involved in the audit.
• MedImpact may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both the following conditions are met: a contract explicitly states the percentage charge or assessment to the responsible party; and the commission or other payment to MedImpact’s agent or employee is not based, directly or indirectly on amounts recouped.
• The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse; and does not apply to state Medicaid programs under Titles XIX and XXI of the Social Security Act.

South Dakota:

The following shall apply to audits conducted in South Dakota in accordance with 2013 South Dakota Bill No.133-

• MedImpact shall disclose amendment(s) to the pharmacy audit terms in a contract between the Member Pharmacy and MedImpact at least sixty days prior to the effective date of the proposed change.
• Unless otherwise prohibited by federal statutes or regulations, MedImpact shall:
  i. Give a Member Pharmacy a minimum fourteen (14) days written notice before conducting initial on-site audit;
  ii. Conduct an audit that involves clinical or professional judgment in consultation with a licensed pharmacist; and
  iii. Audit each Member Pharmacy under the same standards and parameters as other similarly situated pharmacies.
• The period covered by the audit may not exceed twenty-four (24) months from the date that the claim was submitted to or adjudicated MedImpact, unless a longer period is required under state or federal law;
• If MedImpact uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample. Notwithstanding any other provision, MedImpact shall provide the
Member Pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit;

- An on-site audit may not take place during the first five (5) business days of the months of December and January unless the Member Pharmacy consents;
- MedImpact may not enter any portion of the Member Pharmacy area where patient-specific information is available unless escorted, and to the extent possible shall remain out of sight and hearing range of the pharmacy patients;
- Any recoupment may not be deducted against future remittances until final completion of any appeals process and both parties have received the results of the final audit;
- MedImpact may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if:
  (a) Additional information is required in the provider manual; or
  (b) The information is required by the Food and Drug Administration; or
  (c) The information is required by the drug manufacturer's product safety program; and
  (d) The information in subsections (a), (b), or (c) is not readily available for MedImpact at the time of the audit;
- The auditor may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if:
  1. The plan sponsor and MedImpact conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and
  2. A commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

The following criteria shall apply to recoupment or chargeback:

- Audit parameters shall consider consumer-oriented parameters based on manufacturer listings;
- A Member Pharmacy’s usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the provider contract;
- A finding of overpayment or underpayment can only be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;
- MedImpact may not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulation;
- Calculations of overpayments may not include dispensing fees unless:
  1. A prescription was not actually dispensed;
  2. The prescriber denied authorization;
  3. The prescription dispensed was a medication error by the pharmacy; or
  4. The identified overpayment is solely based on an extra dispensing fee;
- MedImpact may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud. However, such errors may be subject to recoupment;
- In the case of errors that have no actual financial harm to the patient or plan, MedImpact may not assess any chargebacks. Errors that are a result of the
Member Pharmacy's failing to comply with a formal corrective action plan may be subject to recovery; and

- Interest may not accrue during the audit period for either party. The audit period begins with the notice of the audit and ends with the final audit report.
- To validate the pharmacy record and delivery, the Member Pharmacy may use authentic and verifiable statements or record including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual. Any legal prescription that meets the requirements in this chapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.
- A preliminary audit report shall be delivered to the Member Pharmacy within sixty days after the conclusion of the audit. A Member Pharmacy shall be allowed at least forty-five days following receipt of the preliminary audit, to provide documentation to address any discrepancy found in the audit. A final audit report shall be delivered to the pharmacy within one hundred twenty days after receipt of the preliminary audit report or final appeal, whichever is later. An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within forty-five days after the appeals process has been exhausted and the final audit report has been issued.
- MedImpact maintains written appeals process, which includes appeals of preliminary reports and final reports.
- If contractually required, MedImpact shall provide a copy of the claims included in the audit to the plan sponsor, and any recouped money shall be returned to the plan sponsor.
- This section does not apply to any investigative audit that involves fraud, willful misrepresentation, or on any audit completed by the State of South Dakota on health care programs operated by the state.
- In addition to above remedies, or under general South Dakota law, any Member Pharmacy subject to an audit procedure may bring a civil action to enforce South Dakota law and to seek damages from MedImpact and any person or organization representing the entity during the audit process for the violation of the provisions of South Dakota law.

Tennessee:

The following shall apply to audits conducted in Tennessee in accordance with Tenn. Code Ann. § 56-7-3103 –

- Member Pharmacy shall be given at least two (2) weeks prior written notice to conducting the initial on-site audit for each audit cycle.
- Any audit performed under this section that involves clinical or professional judgment shall be conducted in consultation with a pharmacist who has knowledge of the Tennessee Pharmacy Practice Act.
- Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record may not, in and of itself, constitute fraud; however, the claims may be subject to recoupment and may be subject to criminal penalties if proof of intent to commit fraud is found.
- Member Pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medical supplies written or transmitted by any means of communication for purposes of
validating pharmacy records with respect to orders or refills of a legend or narcotic drug.

- A finding of overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Recoupment of claims will be based on the actual overpayment or underpayment, unless the projection for overpayment or underpayment is part of a settlement as agreed to by Member Pharmacy.
- Member Pharmacy shall be audited under the standards and parameters as other similarly situated pharmacies audited by MedImpact.
- Member Pharmacy shall be allowed the length of time described in the Agreement with MedImpact, which shall not be less than thirty (30) days, following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.
- The period covered by an audit may not exceed two (2) years from the date the claim was submitted to or adjudicated by MedImpact, a covered entity, the state or its political subdivisions, or any other entity representing the same, except where a longer period is required by any federal rule or law.
- An audit shall not be initiated or scheduled during the first seven (7) calendar days of any month due to the high volume of prescriptions filled during that time, unless otherwise consented to by Member Pharmacy.
- The preliminary audit report will be delivered to Member Pharmacy within one hundred twenty (120) days after conclusion of the audit.
- The final audit report shall be delivered to Member Pharmacy within six (6) months after receipt of the preliminary audit report or final appeal, whichever is later.
- The accounting practice of extrapolation shall not be used in calculating recoupments or penalties for audits.
- Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeal process.
- MedImpact shall have an appeals process under which Member Pharmacy may appeal an unfavorable preliminary audit report.
- Before or at the time of delivery of the preliminary audit report, Member Pharmacy shall be provided with a written explanation of the appeals process, including the name, address and telephone number of the person to whom an appeal should be addressed.
- If, following the appeal, it is determined that an unfavorable audit report or any portion of the audit report is unsubstantiated, the audit report or the portion thereof shall be dismissed without the necessity of further proceedings.
- Member Pharmacy may use any prescription that meets the requirements of being a legal prescription as defined by applicable Tennessee law to validate claims submitted for reimbursement for dispensing of original and refill prescriptions, or changes made to prescriptions.
- Auditors shall be permitted to enter the prescription department when accompanied by or authorized by a member of the pharmacy staff. During the auditing process, auditors shall not disrupt the provision of services to Member Pharmacy’s customers.
- A demand for recoupment, repayment or offset against future reimbursement for an overpayment on a claim for dispensing of an original or refill prescription shall not include the dispensing fee, unless the prescription that is the subject of the claim was not actually dispensed, was not valid, was fraudulent, or was outside the provisions of the contract. This shall not apply where Member Pharmacy is requested, pursuant to the
Agreement or to § 56-7-2362(b) or § 56-32-138(b), to correct an error in a claim submitted in good faith.

- Audit information from an audit conducted by one pharmacy benefits manager shall not be shared with or utilized by another pharmacy benefits manager. This shall not apply to an audit that is believed to involve fraud or willful misrepresentation.
- Except as otherwise set forth in the Agreement, no audit finding or demand for recoupment, repayment or offset against future reimbursement shall be made for any claim for dispensing of an original or refill prescription for the reason of information missing from a prescription or for information not placed in a particular location on a prescription when the information or location of the information is not required or specified by federal or state law.
- In the event the actual quantity dispensed on a valid prescription for a covered beneficiary exceeds the allowable maximum days supply of the product as defined in the applicable pharmacy benefit provider agreement, the amount allowed to be recouped, repaid or offset against future reimbursement shall be limited to an amount that is calculated based on the quantity of the product dispensed found to be in excess of the allowed days supply quantity and using the cost of the product as reflected on the original claim.
- To the extent required, Member Pharmacy shall be allowed to dispense and shall be reimbursed for the full quantity of the smallest available commercially packaged product, including, but not limited to, eye drops, insulin, and topical products, which contains the total amount that is required to be dispensed to meet the days supply ordered by the prescriber, even if the full quantity of the commercially prepared package exceeds the maximum days supply allowed.
- The highest daily total dose which may be utilized by the patient pursuant to the prescriber’s directions shall be used to make a determination of the days supply. For prescriptions having a titrated dose schedule, the schedule shall be used to determine the days supply.
- The aforementioned does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

**Texas:**

Beginning September 1, 2013, the following will also apply to audits conducted in Texas in accordance with Tex. Ins. Code §§1369.251, 843.3401, 1301.1041:

- Member Pharmacy shall be provided with written notice of an audit via certified mail no later than fifteen (15) days before an on-site audit is scheduled to occur, and such notice shall be sent by a means that allows tracking of delivery to Member Pharmacy.
- Not later than the seventh (7th) day after the date a Member Pharmacy receives notice, the pharmacy may request that an on-site audit be rescheduled to a mutually convenient date. The request must be reasonably granted.
- Unless Member Pharmacy consents in writing, MedImpact may not schedule or have an on-site audit conducted: (1) except as provided in the bullet point below, before the 14th day after the date the pharmacy receives notice as set forth above, if applicable; (2) more than twice annually in connection with a particular payor; or (3) during the first five (5) calendar days of January and December.
MedImpact is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, MedImpact suspects the Member Pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business. Member Pharmacy may not request that the audit be rescheduled.

Member Pharmacy will be required to submit documents in response to a desk audit within 30 days after the date MedImpact requests the documents.

If MedImpact proposes a change to the audit procedures for an on-site audit or a desk audit, MedImpact will notify Member Pharmacy in writing of a change in an audit procedure not later than the 60th day before the effective date of the change.

The list of the claims subject to an on-site audit will be provided in the notice to the Member Pharmacy and will identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be omitted.

If MedImpact in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size will not be greater than 300 individual prescription claims.

An audit of a claim will be completed on or before the one-year anniversary of the date the claim is received by MedImpact.

When MedImpact conducts an on-site audit or a desk audit involving a pharmacist’s clinical or professional judgment, MedImpact will conduct the audit in consultation with a licensed pharmacist.

When conducting an on-site audit, the auditor will not enter the pharmacy area unless escorted by an individual authorized by Member Pharmacy.

Member Pharmacy that is being audited may validate a prescription, refill of a prescription, or change in a prescription with a prescription that complies with applicable federal laws and regulations and state laws and rules; and/or validate the delivery of a prescription with a written record of a hospital, physician, or other authorized practitioner of the healing arts.

MedImpact will not calculate the amount of a recoupment based on:

1. an absence of documentation the Member Pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain; or
2. an error that does not result in actual financial harm to the patient or enrollee, or MedImpact.

Extrapolation shall not be used to complete an audit of Member Pharmacy, and nothing in the Agreement shall be construed as requiring Member Pharmacy to agree to extrapolation audits as a condition of participation under the Agreement.

The amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

MedImpact may not include a dispensing fee amount in the calculation of an overpayment unless:

1. the fee was a duplicate charge;
2. the prescription for which the fee was charged:
   (A) was not dispensed; or
   (B) was dispensed:
(i) without the prescriber's authorization;
(ii) to the wrong patient; or
(iii) with the wrong instructions; or
(3) the wrong drug was dispensed.

- An unintentional clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error, found during an on-site audit or a desk audit:
  (1) is not prima facie evidence of fraud or intentional misrepresentation; and
  (2) may not be the basis of a recoupment unless the error results in actual financial harm to a patient or enrollee, health benefit plan issuer, or MedImpact.

- If MedImpact alleges that Member Pharmacy committed fraud or intentional misrepresentation, MedImpact will state the allegation in the final audit report required by state law.

- After an audit is initiated, Member Pharmacy may resubmit a claim if the deadline for submission of a claim under state law has not expired.

- MedImpact may have access to an audit report of Member Pharmacy only if the report was prepared in connection with an audit conducted by the health benefit plan issuer or MedImpact.

- MedImpact may have access to audit reports other than the reports described above if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, MedImpact suspects the audited Member Pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

- MedImpact will conduct on-site audits or desk audits of similarly situated pharmacies under the same audit standards.

- The individual performing an on-site audit or a desk audit will not directly or indirectly receive compensation based on a percentage of the amount recovered as a result of the audit.

- At the conclusion of an on-site audit or a desk audit, MedImpact shall:
  (1) provide to Member Pharmacy a summary of the audit findings; and
  (2) allow Member Pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings.

- Not later than the 60th day after the date the audit is concluded, MedImpact shall send by a means that allows tracking of delivery to Member Pharmacy a preliminary audit report stating the results of the audit and a list identifying documentation, if any, required to resolve discrepancies, if any, found as a result of the audit.

- Member Pharmacy may, by providing documentation or otherwise, challenge a result or remedy a discrepancy stated in the preliminary audit report not later than the 30th day after the date Member Pharmacy receives the report.

- Member Pharmacy may request an extension to provide documentation supporting a challenge. The request shall be reasonably granted.

- If MedImpact grants an extension MedImpact is not subject to the deadline to send the final audit report under state law.

- Not later than the 120th day after the date Member Pharmacy receives a preliminary audit report, MedImpact shall send by a means that allows tracking of delivery to the Member Pharmacy a final audit report that states:
(1) the audit results after review of the documentation submitted by Member Pharmacy in response to the preliminary audit report; and
(2) the audit results, including a description of all alleged discrepancies and explanations for and the amount of recoupments claimed after consideration of Member Pharmacy’s response to the preliminary audit report.

- MedImpact is not subject to the deadlines for sending a report above if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or MedImpact suspects the audited Member Pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

- If an audit is conducted, MedImpact:
  (1) may recoup from Member Pharmacy an amount based only on a final audit report; and
  (2) may not accrue or assess interest on an amount due until the date Member Pharmacy receives the final audit report.

- The limitations on recoupment and interest accrual or assessment do not apply to a health benefit plan issuer or MedImpact that, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, suspects the audited Member Pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Utah:

The following shall apply to audits conducted in Utah in accordance with Utah Code §§ 31A-22-640 and 58-17b-622 –

- An audit that involves clinical or professional judgment will be conducted by or in consultation with a licensed pharmacist who is employed by or working with MedImpact or the auditor.
- Member Pharmacy shall be given ten (10) days advanced written notice of the on-site audit and the range of prescription numbers or a date range included in the audit.
- Member Pharmacy shall not be audited during the first five (5) business days of the month, unless Member Pharmacy agrees to the timing of the audit.
- Claims may not be audited that are submitted more than eighteen (18) months prior to the audit, unless required by federal law; or the originating prescription is dated in the preceding six (6) months; or that exceed 200 selected prescription claims.
- Dispensing fees may not be included in the calculations of overpayments unless the prescription is considered a misfill.
- Funds may not be recouped for prescription clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors on a required document or record, unless there are allegations of fraud or other intentional or willful misrepresentation and there is evidence that Member Pharmacy's actions reasonably indicate fraud or intentional and willful misrepresentation.
- MedImpact may not collect any funds, charge-backs, or penalties until the audit and all appeals are final, unless there are allegations of fraud or other intentional or willful misrepresentation and there is evidence that Member
Pharmacy's actions reasonably indicate fraud or intentional and willful misrepresentation.

- MedImpact shall only have access to previous audit reports on a particular pharmacy if the previous audit was conducted by MedImpact except as required for compliance with state or federal law.
- Member Pharmacy may use the following records to validate a claim for a prescription, refill, or change in a prescription: electronic or physical copies of records of a health care facility, or a health care provider with prescribing authority; and any prescription that complies with state law.
- Member Pharmacy shall be provided with a preliminary audit report, delivered to the pharmacy or its corporate office of record within sixty (60) days after completion of the audit.
- Member Pharmacy has thirty (30) days following receipt of the preliminary audit report to respond to questions, provide additional documentation, and comment on and clarify findings of the audit. Receipt of the report shall be based on the postmark date or the date of a computer transmission if transferred electronically.
- If an audit results in the dispute or denial of a claim, Member Pharmacy shall be allowed to resubmit a claim using any commercially reasonable method, including fax, mail, or electronic claims submission provided that the period of time when a claim may be resubmitted has not expired under the rules of the plan sponsor.
- Within one hundred twenty (120) days after the completion of the appeals process, a final audit report shall be delivered to Member Pharmacy or its corporate office of record.
- The final audit report shall include a disclosure of any money recovered by MedImpact.
- MedImpact shall have a written appeals process for appealing a preliminary audit report and a final audit report, and shall provide Member Pharmacy with notice of the written appeals process.
- The foregoing does not apply to an audit of pharmacy records for a federally funded prescription drug program, including the state Medicaid program, the Medicare Part D program, a Department of Defense prescription drug program, and a Veteran’s Affairs prescription drug program. The foregoing also does not apply when fraud or other intentional and willful misrepresentation is alleged and there is evidence that the pharmacy’s actions reasonably indicate fraud or intentional and willful misrepresentation.

Virginia:

The following shall apply to retroactive denial of payments, recoveries, and refunds in Virginia in accordance with Va. Code Ann. § 38.2-3407.15(B)(7) --

- Neither MedImpact nor Payor may impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless MedImpact or Payor specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and provides a written explanation of why the claim is being retroactively adjusted.

Washington:

The following shall apply to refunds in Washington –

- Except in cases of fraud or as provided below, MedImpact or Payer may not (i) request a refund from Member Pharmacy of a payment previously made to

4/16/2014
satisfy a claim unless it does so in writing to Member Pharmacy within twenty-four (24) months after the date the payment was made; or (ii) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request will specify why MedImpact and/or Payer believes Member Pharmacy owes the refund. If Member Pharmacy fails to contest the request in writing to MedImpact within thirty (30) days of its receipt, the request is deemed accepted and the refund will be paid in accordance with the Agreement.

- MedImpact and/or Payer (as applicable) may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (i) request a refund from Member Pharmacy of a payment previously made to satisfy a claim unless it does so in writing to Member Pharmacy within thirty (30) months after the date the payment was made; or (ii) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request will specify why MedImpact and/or Payer (as applicable) believes Member Pharmacy owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Member Pharmacy fails to contest the request in writing to MedImpact within thirty (30) days of its receipt, the request is deemed accepted and the refund will be paid in accordance with the Agreement.

- MedImpact may at any time request a refund from Member Pharmacy of a payment previously made to satisfy a claim if: (i) a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (ii) MedImpact and/or Payer (as applicable) is unable to recover directly from the third party because the third party has either already paid or will pay Member Pharmacy for the services covered by the claim.

- Nothing in this section prohibits Member Pharmacy from choosing at any time to refund to MedImpact any payment previously made to satisfy a claim.

- For purposes of this section, “refund” means the return, either directly or through an offset to a future claim, of some or all of a payment already received by Member Pharmacy.

- This section neither permits nor precludes Member Pharmacy from recovering from an Eligible Person any amounts paid to Member Pharmacy for benefits to which Eligible Person was not entitled under the terms and conditions of the Plan or other benefit agreement or policy.

- Except in cases of fraud or as provided below, Member Pharmacy may not (i) request additional payment from MedImpact or Payer (as applicable) to satisfy a claim unless it does so in writing to MedImpact or Payer within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made; or (ii) request that the additional payment be made any sooner than six (6) months after receipt of the request. Any such request must specify why Member Pharmacy believes MedImpact or Payor owes the additional payment.

- Member Pharmacy may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (i) request additional payment from MedImpact or Payer to satisfy a claim unless Member Pharmacy does so in writing to MedImpact or Payer within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made; or (ii) request that the additional payment be made any sooner than six (6) months after receipt of the request. Any such request must specify why Member Pharmacy believes MedImpact or Payor owes the
additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

- The foregoing provisions do not apply to claims for services provided through dental-only health payors, health care services provided under Title XVIII (Medicare) of the Social Security Act, or Medicare supplemental Plans regulated under chapter 48.66 RCW. RCW 48.43.605 and 48.43.600.

**West Virginia:**

The following shall apply to retro denials in West Virginia in accordance with W. Va. Code § 33-45-2 –

- A previously paid claim may be retroactively denied only if: (i) the claim was submitted fraudulently; (ii) the claim contained material misrepresentations; (iii) the claim payment was incorrect because Member Pharmacy was already paid on the claim or the services were not delivered by Member Pharmacy; (iv) Member Pharmacy was not entitled to reimbursement; (v) the service was not a Prescription Drug Benefit; or (vi) the person to whom the service was rendered was not an Eligible Person.

a. Upon receipt of notice of a retroactive denial, Member Pharmacy shall notify MedImpact within forty (40) days of its intent to pay or demand written explanation of the reasons for the denial.

b. Upon receipt of explanation for retroactive denial, Member Pharmacy shall reimburse MedImpact within thirty (30) days for allowing an offset against future payments or provide written notice of dispute.

c. Disputes shall be resolved between the parties within thirty (30) days of receipt of notice of dispute.

d. Upon resolution of dispute, Member Pharmacy shall pay any amount due or provide written authorization for an offset against future payments.

e. MedImpact may retroactively deny a claim for the reasons set forth in the first bullet point above, subsections (iii)-(vi) within one (1) year from the date the claim was originally paid. There shall be no time limit for retroactively denying a claim for the reasons set forth in subsections (h)(i)-(ii) of the first bullet point above for West Virginia.

f. Member Pharmacy acknowledges that at the time the Agreement was presented to Member Pharmacy for execution it included or was accompanied by (i) a fee schedule, reimbursement policy, and statement as to the manner in which claims will be calculated and paid and the range of services reasonably expected to be delivered by Member Pharmacy; and (ii) all referenced addenda, schedules, and exhibits.

g. An amendment to the Agreement that relates to payment or the delivery of care by Member Pharmacy shall not be effective as to Member Pharmacy unless Member Pharmacy has been provided with the proposed amendment and has failed to notify MedImpact within twenty (20) business days of receipt of Member Pharmacy’s intent to terminate the Agreement at the earliest date thereafter permitted under the Agreement.
h. MedImpact shall complete its initial credentialing process and accept or reject Member Pharmacy within four (4) months after submission of Member Pharmacy’s completed application. This time frame may be extended for an additional three (3) months because of delays in primary source verification. MedImpact shall make available to Member Pharmacy a list of all information required to be included in the application. If Member Pharmacy is permitted by MedImpact to provide services during the credentialing period, Member Pharmacy shall be paid for the services pursuant to the terms and conditions of the Agreement if Member Pharmacy’s application is approved.