Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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Interim Chief Medical Officer

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www.dhs.lacounty.gov

To improve health through leadership, service and education

March 3, 2009

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF AGREEMENTS WITH MEDICARE PART D PRESCRIPTION DRUG PLAN PROVIDERS (SUPERVISORIAL DISTRICTS 2 and 4) (3 VOTES)

SUBJECT

Request approval of six Agreements with Medicare Part D Prescription Drug Plan providers for electronic billing and claims adjudication at two outpatient pharmacy sites in the Department of Health Services (DHS); delegate authority to expand the agreements to other DHS facilities and enter into future Agreements.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize the Interim Director of Health Services, or his designee, to execute up to six Agreements with the 2009 Medicare Part D Prescription Drug Plan providers (Caremark, Health Net, Medco, RxAmerica, Walgreen Health Initiative and Wellpoint), effective upon Board approval through December 31, 2009, (Exhibits I – V).

2. Delegate authority to the Interim Director of Health Services, or his designee, to expand the Medicare Part D prescription services to additional DHS facilities, subject to review and approval of County Counsel and the Chief Executive Officer (CEO), with notification to your Board.

3. Delegate authority to the Interim Director of Health Services, or his designee, to execute future Medicare Part D agreements through December 31, 2012, on condition that future agreements are substantially similar to the recommended agreements, subject to review and approval of County Counsel and the CEO, with notification to your Board.

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PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Congress previously initiated prescription discounts for Medicare patients, but in 2006, a more comprehensive program was instituted and is currently known as the Medicare Part D Prescription Plan.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency charged with administering the Medicare Part D Prescription Plan and there are private prescription drug plan providers that contract with CMS to execute the program. The private prescription drug plan providers contract further with pharmacies to dispense medications to Medicare Part D patients. Within California, there are over 50 plans with different levels of prescription benefits approved to fill Medicare Part D prescriptions. Pharmacy networks are established within those 50 plans to be the outlet for prescription drug dispensing. Approval of the agreements will allow DHS to become part of the Medicare Part D provider pharmacy network and dispense medications to low-income and Medi-Cal/Medicare patients at Martin Luther King, Jr. Multi-Service Ambulatory Care Center (MLK-MACC) and Rancho Los Amigos National Rehabilitation Center (Rancho).

Currently, DHS outpatients with Medicare Part D prescription benefits are referred to nearby community pharmacies to fill their prescriptions. Approval of the first recommendation will allow DHS to fill Medicare Part D prescriptions and to perform electronic billing and claims adjudication with the contracted Medicare Part D Prescription Drug Plan providers at MLK-MACC and Rancho. DHS will initiate a pilot program at these two DHS facilities to dispense prescriptions for these patients. Approval of the second and third recommendations will allow DHS to expand the pilot program to other DHS sites and more expediently execute future Agreements, subject to review and approval of County Counsel and the CEO, with notification to your Board.

On August 5, 2008, your Board accepted a report by the Chief Executive Officer, in concert with the Interim Director of Health Services, on findings and recommendations to enable our healthcare system to accept Medicare Part D prescription drug coverage. The approval of the three recommendations in this Board letter is consistent with your August 5, 2008 adopted action.

The pilot project will gather data on the impact of Medicare Part D prescription dispensing on pharmacy operations, expenditures and revenue, patient acceptance, and patient satisfaction. Following the collection of data, the effectiveness of the pilot project and the impact to patient care will be assessed. After evaluation, it will be determined whether it is efficient and feasible to expand to additional DHS facilities.

Implementation of Strategic Plan Goals

These actions support Goal 7, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The estimated initial start up costs at MLK-MACC and Rancho are less than $7,700. The cost components consist of computer hardware and software for electronically submitting billing information and a $.10 transaction fee per prescription. The estimated annual yearly transaction fees are $55 at MLK-MACC and $225 at Rancho. Program costs will be absorbed within existing resources at each facility. Should prescription volume at the two pilot sites increase significantly due to the Medicare Part D pilot implementation, there may be a need to add additional pharmacy staff to ensure that patient care needs are met.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

There are six Medicare Part D plans (Caremark, Health Net, Medco, RxAmerica, Walgreen Health Initiative and Wellpoint) approved for low-income and Medi-Cal/Medicare patients for calendar year 2009 by CMS. DHS obtained agreements from five providers which were reviewed by both DHS and County Counsel. When the Medco agreement is received, it will be reviewed by DHS and County Counsel and a determination will be made whether it will be one of the Medicare Part D providers for County patients.

The recommended Agreements are standard agreements for all Medicare Part D participating pharmacies and as such, they do not include the County's required provisions.

County Counsel has approved the attached Agreements, Exhibits I - V, as to form.

CONTRACTING PROCESS

The County must utilize CMS approved prescription providers for Medicare Part D, therefore the County's contracting process is not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will allow DHS to implement a pilot program, evaluate the effectiveness, and potentially expand the program within DHS as a service enhancement to DHS' Medicare patients.

CONCLUSION

When approved, DHS requires three signed copies of the Board's action.

Respectfully submitted,

John F. Schunhoff, Ph.D.
Interim Director

JFS:rf

Attachment (5)

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

Medicare Part D BL
RF:r board letter pharmacy medicare part d 02.17.09

Caremark
9501 E Shea Boulevard
Scottsdale, Arizona 85260-6719
480-391-4623

Caremark
EXHIBIT I

Dear Pharmacy Provider:

Thank you for your interest in a Caremark pharmacy membership. Caremark is the largest and most well-known of the nation's prescription benefit managers (PBMs). Currently, more than 75 million plan members are enrolled in a Caremark prescription drug benefit management program. As you may be aware, Caremark consists of both, Caremark, L.L.C Inc. and CaremarkPCS, L.L.C.

Enclosed is the membership enrollment package. The documents in the package will explain the options available to you. When complete you will be a member of all Caremark claims processing systems.

Please do not hold claims for Caremark members while your application is being processed. We are unable to retro-process your effective date.

PLEASE NOTE THAT BY ACCEPTING THIS MEMBERSHIP ENROLLMENT PACKET FROM CAREMARK, YOU HAVE AGREED THAT THE ENCLOSED MATERIALS CONTAIN CONFIDENTIAL AND PROPRIETARY TRADE SECRETS OF CAREMARK, AND THAT THEIR CONTENTS MAY NOT BE DISCLOSED BEYOND AUTHORIZED RECIPIENTS WITHOUT CAREMARK'S PRIOR WRITTEN CONSENT.

Please complete and return: (please ensure all documents reflect name of pharmacy as it appears on contract)

_____ **Signed and initialed Caremark Provider Agreement (Return all 4 pages)**

_____ **Signed Credentialing/Service Level Worksheet with printed name and title of Corporate Officer, Owner, or Authorized Agent. Only one person can sign contract (See reverse under Authorized Agents)**

_____ **Signed Network Enrollment Forms**

_____ **Legible, current copy, of DEA Certificate (Supplied by Pharmacy)**

_____ **Legible, current copy, of State License Certificate (Supplied by Pharmacy)**

_____ **Legible, current copy, of Liability Policy or TORT (Supplied by Pharmacy)**

_____ **Legible, current copy, of Pharmacy NPI Confirmation Letter from Government NPI Enumerator**

***If you have purchased an existing pharmacy, please also include:**

_____ **The Bill of Sale**

***If you have assumed the existing NCPDP#, please also include:**

_____ **A Notarized letter from the previous owner or NCPDP authorizing the use of the same NCPDP#.**

***If your pharmacy is owned by an LLC/Partnership, please include:**

_____ **A letter listing all members and titles.**

Documents above must be completed and returned to Caremark before your pharmacy will be enrolled with any Caremark programs. ***Caremark reserves the right to deny enrollment to any provider.***

Be sure to notify Caremark of any changes in status, such as address, telephone or FAX number, ownership, or corporate restructure. Because a change may affect pharmacy payment, please submit the change request on letterhead via mail or FAX signed by the owner or appropriate representative. Changes in status should also be reported to NCPDP (National Council for Prescription Drug Programs) at 480-477-1000.

To ensure a prompt and accurate enrollment, please complete and **FAX** all required documentation to: **480-661-3054**

Or, mail the documentation to:

Provider Enrollment MC 129
Caremark
PO BOX 52115
Phoenix, AZ 85072-9982

If you have any questions related to enrollment, please call the Caremark Pharmacy Provider Message Center at 480-391-4623.

Sincerely,

Caremark Pharmacy Provider Enrollment

See Reverse Side for Additional Details

FAQs

Q: I've been enrolled and I have questions related to claims adjudication, who do I contact:

A: The Pharmacy Help Desk can answer most questions related to claims adjudication. Refer to page three of the Provider Manual for a complete list of BINs and Help Desk numbers.

Q: I'm receiving a reject code of 40 – Pharmacy Not Contracted With Plan on Date of Service or 50-Non-Matched Pharmacy Number:

A: This is a good indication that your pharmacy is online with Caremark, but is not enrolled in one or more networks, please call 480-314-8457 for assistance.

Q: Do I need to return the Provider Manual?

A: You do not need to return the "Provider Manual" or any other documents not listed in the "Please complete and return" section on the front page of this document. These documents are required to complete pharmacy membership with Caremark.

Q: What is an NCPDP #?

A: The NCPDP# (formerly NABP#) is an identification number assigned to each pharmacy by The National Council for Prescription Drug Programs (NCPDP). If you do not have an NCPDP provider number, contact NCPDP at 480-477-1000, or via e-mail at prosrvs@ncpdp.org. Please list your NCPDP provider number on all documents, and all communications with Caremark.

Q: Is there an alternative to on-line adjudication of claims?

A: Some plans may offer options for claim submission in special circumstances. To become an Caremark member pharmacy, you must have the ability to submit claims electronically utilizing software certified by Caremark and adhere to the NCPDP standards in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, provider must support NCPDP updates as requested from time to time from Caremark.

Things to remember when filling out the enrollment information:

- Please have the appropriate person sign each of the network contracts and keep all signatures consistent.
- If a **corporation** owns the pharmacy, the corporate name should be listed in all fields labeled as "Name of Owner." The contract signer shall be an "officer of the corporation" or an "authorized agent of the corporation."
- **Authorized agents** shall be only those persons assigned the authority to enter into contracts on behalf of the organization as indicated in the entity's corporate resolutions. A letter must be provided to Caremark listing the name and relationship of the authorized agent and signed by the President or C.E.O. of the corporation.
- If a **limited liability corporation** owns the pharmacy, the corporate name should be listed in all fields labeled as "Name of Owner." The contract signer shall be a member of the limited liability corporation. A letter must be provided to Caremark listing the members of the board, including each member's title and/or relationship and **signed by a member**.
- If a **partnership** owns the pharmacy, the partnership name should be listed in all fields labeled as "Name of Owner". A letter must be provided to Caremark listing the names and relationship of the partners. A partner listed on the letter provided to Caremark must sign the contract.
- **Change of Ownership:** By entering into the Provider Agreement, Provider agrees to assume and satisfy all liabilities and obligations, if any, of the provider operating the pharmacy immediately prior to the Provider's entry into the Provider Agreement.
- Caremark requires a valid copy of the bill of sale for all **changes of ownership**. The bill of sale should indicate the previous owner, the new owner, and the finalized date of sale. Caremark encourages providers to obtain a new NCPDP number in order to maintain a unique identifier for each pharmacy. If you decide to use the same NCPDP provider number as the previous owner, a notarized letter from the previous owner is required. This letter should also include information relating to the previous owner, new owner, and the effective date of the change of ownership.
- If you provide **incomplete enrollment information**, your application may be delayed. Caremark membership will not be granted until all required forms have been submitted. The membership will be activated as of the date Caremark accepts and executes your application.
- **Please do not hold claims for Caremark members while your application is being processed. We are unable to retro-process your effective date.**

Caremark Credentialing/Service Level Worksheet

Please complete this form and return to Caremark with your signed Provider Agreement

NPI #: ☐☐☐☐☐☐☐☐☐☐ NCPDP #: ☐☐☐☐☐☐☐

Pharmacy/Corp Name: _____

Pharmacy Name (DBA): _____

Phone: _____

Fax: _____

Physical Address: _____

City: _____ ST: _____ ZIP: _____

Email Address: _____

Mailing Address: _____

City: _____ ST: _____ ZIP: _____

URL: _____

In order to participate in Caremark programs, you are required to submit claims using approved and certified software.

Software Vendor: _____

Software ID# (10 digits): 510 __ __ __ __ __ __ __

Phone: _____

Circle One:

1. Host to Host 2. PC to Host

Mark the appropriate box(s) below with a ✓ to indicate the services your pharmacy provides. This information may be used to create patient member directories. Please notify Caremark of any changes to the services provided.

Access

- ☐ Open 24 hours/day
- ☐ Open 7 days/week
- ☐ Drive-thru window
- ☐ After hours emergency RX service

Service

- ☐ Flu Shots
- ☐ Compounding

Durable Medical Equipment

- ☐ Limited
- ☐ Full-Line

Delivery

- ☐ Free Delivery
- ☐ Free Delivery w/ Limitations

Credit Service Available

- ☐ Major Credit cards
- ☐ Store Credit

Screening

- ☐ Blood pressure screening
- ☐ Other: _____

Patient Consultation

- ☐ Written material available for each Rx
- ☐ Counseling of all meds patient is taking
- ☐ Compliance monitoring

Languages

- ☐ Chinese ☐ Russian ☐ Japanese ☐ French
- ☐ Spanish ☐ German ☐ Other _____

Drug Enforcement Administration (DEA) #: _____

** Copy Required**

Federal Tax Identification (FEIN) #: ☐☐-☐☐☐☐☐☐☐

State Board of Pharmacy License #: _____

** Copy Required**

State Medicaid # **(Required for some plans)**: _____

Insurer Name: _____

Insurance Policy #: _____

** Policy Copy Required including levels of Coverage**
$ 1 million per occurrence & $ 3 million general aggregate

By: X _____

Signature of Owner, Corporate Officer or Letter of Authorization Must Accompany

_____

Printed Name & Title

_____

Date Signed

Pharmacy Ownership (Choose ALL that apply):

- ☐ Male ☐ Female
- ☐ African American ☐ Hispanic American
- ☐ Asian American ☐ Pacific Island American
- ☐ Caucasian ☐ Native Alaskan American
- ☐ Disabled Veteran ☐ Other, please specify _____

Please indicate facility type: (Check all that apply)

- ☐ Community Pharmacy ☐ Hospital Pharmacy
- ☐ Dispensing Physician ☐ Specialty Pharmacy
- ☐ Government Pharmacy ☐ Internet Pharmacy
- ☐ Long –Term Care Pharmacy ☐ 340B Pharmacy
- ☐ Other _____

Provider has a current valid permit and is conducted as a:

- ☐ Corporation ☐ Sole Proprietorship
- ☐ Partnership (** Attach SIGNED member list)
- ☐ Limited Liability Company (** Attach SIGNED member list)

Is your pharmacy open to the public without restriction to specific populations? YES NO

Does your pharmacy participate with the Institute for Safe Medication Practices self assessment process (www. ISMP.org)? YES NO

Are you interested in receiving an Electronic 835 remittance advice? (If no selection, defaults to NO) YES NO

HISTORY: If "YES" to any of the following questions, please explain in a separate document and supply to Caremark.

Has the pharmacy been known, now or in the past by any other trade or business name? If so, explain. For example change of ownership or corporate restructuring. YES NO

Has the pharmacy ever been denied a pharmacy license or permit in any state or had its license or permit revoked or suspended? YES NO

Has the pharmacy or any of its present owners, officers or employees ever been convicted of violating State or Federal drug or pharmacy service-related regulations? YES NO

Has the pharmacy ever been the subject of a disciplinary action in front of a state board of pharmacy? YES NO

Caremark
PROVIDER AGREEMENT

This Provider Agreement (the "Provider Agreement" or "Agreement") is entered into between Caremark, L.L.C., a California limited liability company and CaremarkPCS, L.L.C., a Delaware limited liability company (collectively "Caremark"), and the undersigned provider ("Provider"). Caremark and Provider agree as follows:

1. **Definitions.** Unless otherwise defined herein, capitalized terms used in the Agreement shall have the meanings set forth in the Glossary of Terms contained in the Provider Manual.

2. **Credentialing.** Provider represents, warrants, and agrees that as of the date of execution of the Agreement, Provider is and shall maintain in good standing, all federal, state and local licenses and certifications as required by Law. Provider will provide Caremark with the information required from time to time regarding Provider's credentials, including, but not limited to Provider's licensure, accreditation, certification, and insurance, and will comply with and maintain Caremark credentialing standards and requirements.

3. **Provider Services and Standards.** Unless Provider's professional judgment dictates otherwise, Provider will render to all Eligible Persons the Pharmacy Services to which the Eligible Person is entitled in accordance with the Agreement, the prescriber's directions, the applicable Plan, and applicable Law. Provider will submit all Claims for such Pharmacy Services electronically to Caremark in accordance with the Caremark Documents. Caremark may inspect all records of Provider relating to the Agreement.

4. **Eligible Person Identification and Cost Share.** Provider will require each person requesting Pharmacy Services to verify that he or she is an Eligible Person. With respect to each Covered Item dispensed to an Eligible Person, Provider will collect from the Eligible Person the applicable Patient Pay Amount communicated to Provider through the Caremark claims adjudication system or other method established by Caremark. Provider will not waive, discount, reduce, or increase the Patient Pay Amount indicated in the Caremark claims adjudication system unless otherwise authorized in writing by Caremark. Except for the collection of the applicable Patient Pay Amount, in no event will Provider seek compensation in any manner from an Eligible Person for Pharmacy Services with respect to a Covered Item.

5. **Network Participation and Payment.** Provider agrees to participate in the networks identified on the attached Schedule A according to the terms set forth therein. Caremark will pay Provider for Covered Items dispensed to Eligible Persons pursuant to the Agreement in accordance with Schedule A. Any overpayments made to Provider by Caremark may be deducted from amounts otherwise payable to Provider.

6. **Compliance with Law.** Provider will comply with all applicable Laws, including but not limited to those Laws referenced in the Federal and State Laws and Regulations section (and attached Addendums thereto) set forth in the Provider Manual.

7. **Indemnification.** All liability arising from the provision of prescription drugs and services rendered by Provider will be the sole responsibility of Provider. Provider will indemnify and hold harmless Caremark and Plan Sponsors and their respective shareholders, directors, employees, agents, and representatives from and against any and all liabilities, losses, settlements, claims, injuries, damages, expenses, demands, or judgments of any kind (including reasonable expenses and attorneys' fees) that may result or arise out of (i) any actual or alleged malpractice, negligence, misconduct, or breach by Provider in the performance or omission of any act or responsibility assumed by Provider or (ii) in the provision of Pharmacy Services or the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Provider.

8. **Limitation on Liability.** In no event will Caremark be liable to Provider for indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss

of customers or business.

9. **Term.** The Agreement will begin on the date of acceptance by Caremark and will remain in effect until terminated in accordance with the Provider Manual.

10. **Assignment.** Neither party may assign this Agreement without the prior written consent of the other party; provided, however, that Caremark may, without consent, assign this Agreement to any direct or indirect parent, subsidiary, or affiliated company or to a successor company. Any permitted assignee shall assume all obligations of its assignor under this Agreement. This Agreement shall inure to the benefit of and be binding upon each party, its respective successors and permitted assignees.

11. **Entire Agreement.** This Agreement, the Provider Manual, and all other Caremark Documents constitute the entire agreement between Provider and Caremark, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations concerning the subject matter covered by the Agreement are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Agreement, including the Provider Manual and other Caremark Documents will be a breach of the Provider Agreement. In the event there is a conflict between any of the provisions in this Provider Agreement, the Provider Manual, other Caremark Documents and a provision in an applicable State specific addendum attached to the Federal and State Laws and Regulations section of the Provider Manual, the terms of the applicable State specific addendum shall govern.

12. **Waiver.** Failure to exercise any of the rights granted under the Agreement for any one default will not be a waiver of any other or subsequent default. No act or delay shall be deemed to impair any of the rights, remedies, or powers granted in the Agreement.

13. **Lawful Interpretation and Jurisdiction.** Whenever possible, each provision of the Agreement shall be interpreted so as to be effective and valid under applicable Law. Should any provision of this Agreement be held unenforceable or invalid under applicable Law, the remaining provisions shall remain in full force and effect. Unless otherwise mandated by applicable Law, the Agreement will be construed, governed, and enforced in accordance with the laws of the State of Arizona without regard to choice of law provisions.

14. **Headings.** The headings of Sections contained in the Agreement are for convenience only and do not affect in any way the meaning or interpretations of the Agreement.

102708-0542337-25347
RANCHO LOS AMIGOS MED CTR PHCY
Attn: Pharmacy Corporate Officer
7601 E IMPERIAL HWY
DOWNEY, CA 90242-

Any changes to this agreement must be initialed.
By signing below, Provider agrees to the terms set forth above and acknowledges receipt of the Provider Manual.

Pharmacy Name: _____

NCPDP#: _____

NPI#: _____

By: _____
(Signature of authorized agent)

_____
(Print name of authorized agent)

Date: _____

********ATTENTION**********

PAGES 1, 2, AND 4 MUST BE INITIALED BY AUTHORIZED AGENT BEFORE CONTRACT WILL BE ACCEPTED

Caremark, L.L.C.

_____
(Signature of Officer)

By: _____
(Print name of Officer)

Date _____

CaremarkPCS, L.L.C.

_____
(Signature of Officer)

_____
(Print name of Officer)

SCHEDULE A
NETWORK PARTICIPATION AND PAYMENT

This Schedule A is comprised of this Schedule A and all prior and subsequent network addendums and network enrollment forms, all of which are incorporated herein by this reference and referred to collectively as "Schedule A". Provider agrees that it will participate in all Caremark and Plan Sponsor pharmacy networks in which: (1) Provider participates in as of the date of this Agreement; (2) Provider and Caremark have executed a network addendum or network enrollment form as of the date of this Agreement; (3) Provider and Caremark subsequently execute a network addendum or network enrollment form; and (4) Provider agrees to participate as evidenced by its provision of Pharmacy Services to an Eligible Person of a Plan Sponsor utilizing such pharmacy network(s).

Unless otherwise set forth in a network addendum or network enrollment form signed by both parties, claims submitted for a Plan Sponsor participating in an Caremark or Plan Sponsor network will be reimbursed at the lower of: (i) AWP less the applicable AWP Discount and Dispensing Fee less the applicable Patient Pay Amount; (ii) MAC plus the applicable Dispensing Fee less the applicable Patient Pay Amount; (iii) ingredient cost submitted by Provider plus the applicable Dispensing Fee less the applicable Patient Pay Amount; or (iv) Provider's U&C price less the applicable Patient Pay Amount. The applicable AWP Discount and Dispensing Fee will be set forth in the applicable network addendum or network enrollment form. If Provider has not executed and delivered to Caremark a network addendum or network enrollment form, the applicable AWP Discount and Dispensing Fee will be the reimbursement rate as indicated in the claims system as to such claim. AWP Discounts and Dispensing Fees may be amended in accordance with the terms of the Agreement.

Network Enrollment Form
For UICI Unfunded Network

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

UICI Unfunded Network:
The applicable Plan Sponsor AWP Discount for unfunded UICI brands and generics shall be 13%, and the applicable Plan Sponsor Dispensing fee shall be $2.00.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
CareSelect, CarePremier, CareElite

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

Check Selection Below

☐ (CareSelect, CarePremier)

CareSelect Network:

The applicable Plan Sponsor AWP Discount for brands and generics shall be 14%
The applicable Plan Sponsor Dispensing Fee shall be $1.40 for brands and generics.

CarePremier Network:

The applicable Plan Sponsor AWP Discount for brands shall be 15% and the applicable Plan Sponsor AWP Discount for generics shall be 25%. The applicable Plan Sponsor Dispensing Fee shall be $1.25 for brands and $1.50 for generics.

☐ (CareElite)

CareElite Network:

The applicable Plan Sponsor AWP Discount for brands shall be 16% and the applicable Plan Sponsor AWP Discount for generics shall be 25%. The applicable Plan Sponsor Dispensing Fee shall be $1.25 for brands and $1.50 for generics.

Participation in the CareElite Network requires Caremark receive this Network Enrollment Form, fully executed by Provider, prior to closing of enrollment in the CareElite Network.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. If no Network is selected or only CareElite is selected, Provider agrees to participate in all above Networks. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name _____ NCPDP# _____

NPI# _____

Name of Owner / Authorized Agent (if not owner) _____

Provider Signature _____ Title _____

Caremark Signature _____ Title _____

Date of Acceptance by Caremark _____

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
Consumer Card Provider Network II

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

Consumer Card Provider Network II:

- The applicable Plan Sponsor AWP Discount for brands shall be 13% and the applicable Plan Sponsor AWP Discount for generics shall be 13%. The applicable Plan Sponsor Dispensing fee shall be $2.50.
- Eligible Person may include individuals and groups with prepaid benefits, as well as those without underwritten benefits.
- Eligible Persons may be charged an administrative fee at the point of sale at the pharmacy. The administrative process fee will be included in the applicable field(s) of the claim Response Pricing Segment on the Caremark system. Provider agrees to collect the administrative process fee, which will be debited from the pharmacy remittance account. On all paid claims on which the Provider collects the administrative process fee, the applicable Plan Sponsor Dispensing Fee will be $2.65.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
Managed Care Network
Client Based Network
Performance Based Network 10
Performance Based Network 13

For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated for that selected network below.

Check Selection Below

☐ **Managed Care Network:**
The applicable Plan Sponsor AWP Discount for brands and generics shall be 10%.
The applicable Plan Sponsor Dispensing Fee shall be $3.00.

☐ **Client Based Network:**
The applicable Plan Sponsor AWP Discount for brands and generics shall be 13%.
The applicable Plan Sponsor Dispensing fee shall be $2.50.

☐ **Performance Based Network 10:**
The applicable Plan Sponsor AWP Discount for brands and generics shall be 10.5%.
The applicable Plan Sponsor Dispensing fee shall be $3.00.

☐ **Performance Based Network 13:**
The applicable Plan Sponsor AWP Discount for brands and generics shall be 13.5%.
The applicable Plan Sponsor Dispensing fee shall be $2.50.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name _____ NCPDP# _____

NPI# _____

Name of Owner / Authorized Agent (if not owner) _____

Provider Signature _____ Title _____

Caremark Signature _____ Title _____

Date of Acceptance by Caremark _____

No alterations to this Network Enrollment Form shall be binding on either party unless initialed By duly authorized representatives of Provider and Caremark.

Network Enrollment Form
For PHC Standard National Network

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

PHC Standard National Network:
The applicable Plan Sponsor AWP Discount for brands shall be 15% and the applicable Plan Sponsor AWP Discount for generics shall be 30%. The applicable Plan Sponsor Dispensing fee for brands and generics shall be $2.00.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
For PHC Non-Funded Network

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

PHC Non-Funded Network:

The applicable Plan Sponsor AWP Discount for brands shall be 12% and the applicable Plan Sponsor AWP Discount for generics shall be 35%. The applicable Plan Sponsor Dispensing fee for brands and generics shall be $4.00.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
For PHC Standard National Network

The undersigned hereby enrolls as a Provider in the Networks indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

PHC Standard National Network:
The applicable Plan Sponsor AWP Discount for brands shall be 15% and the applicable Plan Sponsor AWP Discount for generics shall be 30%. The applicable Plan Sponsor Dispensing fee for brands and generics shall be $2.00.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Network Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Network Enrollment Form
PatientChoice 90

The undersigned hereby enrolls as a Provider as indicated below. For the purposes of Section 4.3 or Schedule A, whichever is applicable, of the Caremark Provider Agreement, Provider agrees to accept the Plan Sponsor AWP Discount and Plan Sponsor Dispensing Fee and other unique requirements, if any, as indicated below.

Caremark PatientChoice 90:

For day's supplies of 84 or greater, the applicable Plan Sponsor AWP Discount for brands shall be 21% and the applicable Plan Sponsor AWP Discount for generics shall be 21%. For Plan Sponsors that do not utilize MAC, the Plan Sponsor AWP Discount for generics shall be 58%. The applicable Plan Sponsor Dispensing Fee shall be $0.00 for brands and $0.00 for generics. Quantities dispensed for other day's supplies shall be governed by the applicable Plan Sponsor reimbursement rate.

IN WITNESS WHEREOF, the parties hereto have caused this Network Enrollment Form to be executed by their respective officers or representatives duly authorized so to do. By signing below, Provider agrees to become a participant in the Caremark Network(s) above effective as of the date Caremark accepts this Network Enrollment Form. Further, Provider understands and agrees that all the terms and conditions established in the Caremark Provider Agreement shall apply to Pharmacy Services provided hereunder. Capitalized terms not defined herein shall have the meanings used in the Caremark Provider Agreement. The Network Enrollment form constitutes the entire agreement of the parties with respect to the subject matter of Enrollment Form, and supersedes any and all other agreements, writings, and understandings.

Provider Info: (Please Print)

Provider Name NCPDP#

NPI#

Name of Owner / Authorized Agent (if not owner)

Provider Signature Title

Caremark Signature Title

Date of Acceptance by Caremark

No alterations to this Enrollment Form shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

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SAFETY NET PHARMACY RETAIL ADDENDUM TO CAREMARK PROVIDER AGREEMENT

TERMS OF PARTICIPATION IN MEDICARE PART D

The Caremark Provider Agreement is hereby amended as set forth in the Provider Agreement to incorporate the following language. In the event any provision in this Addendum conflicts with the terms of the Provider Agreement (including the Provider Manual), the terms of this Addendum shall govern. Provider acknowledges that SilverScript, Inc, together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark") is responsible for providing Part D services on behalf of Part D Plan Sponsors.

To the extent that Provider shall provide Pharmacy Services to a Part D Enrollee, Provider agrees to comply with any applicable Part D requirements for participation in Part D as a dispensing pharmacy.

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

1. Provider agrees to participate as, and perform the functions of, a Part D Safety Net Provider, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Addendum.
2. Provider agrees to perform its services under this Addendum in a manner that is consistent with and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.
4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a dispensing pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable Federal and State laws, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable State and Federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 CFR §423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available to CMS in accordance with, and for the period required by 42 CFR §423.505(I)(2). Specifically, Provider agrees to allow HHS, the Comptroller General, or their designees, the right to inspect, evaluate and audit any pertinent contracts, books, documents, papers, and records of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor, and agrees that this right continues for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later.
7. Provider agrees that any service, activity or responsibility delegated to Provider pursuant to this Addendum may be revoked by Caremark (on its own behalf or that of any Part D Plan Sponsor with respect to that Plan Sponsor's enrollees only) or CMS if CMS or Caremark determines that Provider has not performed such service, activity, or responsibility satisfactorily. Caremark may also exercise any remedies available at Law or under the Provider Agreement in lieu of revocation.
8. Provider agrees that Caremark and any Plan Sponsor (with respect to its enrollees only) each has the right to approve, suspend, or terminate this Addendum in their sole discretion at any time.
9. Provider agrees that Caremark, on its own behalf and on behalf of any Part D Plan Sponsor, will monitor the performance of Provider on an ongoing basis.
10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for Covered Part D Drugs as required by and in accordance with 42 CFR §423.104(g).

No alterations to this Addendum shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

_____Initial

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11. Provider agrees to submit Claims to Caremark's real-time claims adjudication system. If Provider does not have the information technology capability to comply with this provision, claims must be submitted in the UCF (Universal Claim Form) or HCFA 1500 format within the required timeframe.

12. Provider agrees that when it dispenses a Covered Part D Drug to a Part D Enrollee, it will inform such Part D Enrollee at the point of sale of the lowest-priced, generically equivalent version of that Covered Part D Drug, if one exists for the beneficiary's prescription, as well as any associated differential in price in accordance with 42 CFR §423.132.

13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information such as, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.

14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 CFR §423.153(b), (c) and (d). If Provider does not have the reasonable information technology capacity to comply with this provision, then this provision shall not apply to Provider. Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by law.

15. Provider agrees to fill a prescription for a 90-day supply of a Covered Part D Drug upon a Part D Enrollee's request, and with a supporting prescription, at the appropriate cost-sharing and Negotiated Price including that which applies to individuals qualifying for the low-income subsidy.

16. Provider agrees to charge and apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.

17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor specific network.

18. As of the compliance date for any electronic prescribing standards issued by CMS, Provider agrees to engage in electronic prescribing transactions with respect to Part D Enrollees in compliance with such standards if Provider has the reasonable information technology capacity to engage in such transactions.

19. Provider acknowledges that it is not a mail order pharmacy.

20. **Entire Agreement.** This Addendum, the Provider Agreement, the Provider Manual, the Medicare Network Enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider's participation as a Medicare Part D pharmacy, all of which are incorpprated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations related to the terms of this Addendum are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark's confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.

21. The following terms and phrases, when capitalized, have the meanings set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.

a. **"340B Drug Pricing Program"** refers to the federal drug discount program established under Section 340B of the Public Health Service Act.

b. **"Claims"** means those claims processed through the Caremark on-line, real-time claims adjudication system.

c. **"CMS"** means the Centers for Medicare and Medicaid Services under the Department of Health and Human Services.

d. **"Covered Part D Drug(s)"** has the same meaning as that term as defined in 42 CFR §423.100.

e. **"Dispensary"** means a clinic where medicine is dispensed by a prescribing physician or other practitioner.

f. **"Federally Qualified Health Center"** (FQHC) has the meaning given to that term in §1905(l)(2)(B) of the Social Security Act as well as any implementing regulations.

g. **"HHS"** means the Department of Health and Human Services.

No alterations to this Addendum shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

_____ Initial

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h. **"Insurance Risk"** has the same meaning as such term as defined in 42 CFR §423.4.

i. **"Medicare Part D Retail Network"** means Claims priced for a Part D Enrollee pursuant to the Addendum to the Caremark Provider Agreement entitled " Caremark Medicare Part D Retail Pharmacy Network."

j. **"National Health Service Corps Provider"** has the meaning given to the term in §331(a) of the Public Health Service Act [42 U.S.C. §254d(a)];

k. **"Negotiated Prices"** has the same meaning as such terms as defined 42 CFR §423.100.

l. **"Part D"** means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.

m. **"Part D Enrollee"** means an individual covered by a Part D Plan.

n. **"Part D Plan"** has the same meaning as such term as defined in §423.4, but limited to those Part D Plans that have contracted with Caremark to use pharmacy providers that have contracted with Caremark to provide pharmacy services to Part D Enrollees.

o. **"Part D Plan Sponsor"** has the same meaning as such term as defined in 42 CFR §423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.

p. **"Privacy Rule"** shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

q. **"Rural Health Clinic"** (RHC) has the meaning given to that term in §1861(aa)(2) of the Social Security Act;

r. **"Safety Net Provider"** means a provider that by mandate or mission organizes and delivers a significant level of healthcare and other health-related services to the uninsured, Medicaid, and other vulnerable populations.

s. **"Security Rule"** shall mean the Standards for Security of Electronic Protected Health Information at 45 CFR parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.

t. **"Transactions Standard"** means the Standards for Electronic Transactions under 45 CFR parts 160 and 162, subparts I *et.seq.*

22. If Provider does not maintain as a regular practice of doing business a full formulary as defined by the Part D Plan Sponsor, Provider shall not be held responsible for the provision of other formulary pharmaceuticals that are not stocked by Provider.

23. If Provider participates in the 340B Drug Pricing Program, then Provider may elect, but is not required, to provide Pharmacy Services to Part D Enrollees who are not eligible under section 340B(a)(5)(B) of the Public Health Service Act and implementing guidelines; however, Provider shall not dispense drugs purchased through the 340B Drug Pricing Program to such Part D Enrollees not eligible under section 340B(a)(5)(B) of the Public Health Service Act.

24. Provider must have a separate National Council for Prescription Drug Programs (NCPDP) provider number for each location for reimbursement, or other provider number as required by Caremark, or applicable Law.

25. Nothing in this Addendum shall affect Provider's acquisition of pharmaceuticals from any source, including the Federal Supply Schedule and/or participation in the 340B Drug Pricing Program. Nor shall anything in this Addendum require Provider to acquire drugs from the Part D Plan Sponsor or from any other source.

26. The hours of operation made available by the Provider shall be established by the Provider. At the request of the Part D Plan Sponsor, Provider shall provide written notification to the Part D Plan Sponsor of its hours of operation.

27. If Provider waives or reduces Part D Enrollee cost-sharing (if any) as permitted by CMS or applicable Law, such waiver or reduction shall not alter reimbursement amounts owing to Provider by Caremark under the Agreement. Providers, whose waivers or reductions in Part D Enrollee cost-sharing do not qualify as "incurred costs" under 42 CFR 423.100 and therefore do not count towards TrOOP, must notify Caremark

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when a Part D Enrollee cost-sharing is waived or reduced and by what amount through procedures established by Caremark.

28. As of the implementation date of any NCPDP identifier for Claims which utilize drugs purchased under the 340B Drug Pricing Program, Provider will submit the appropriate information to identify which Claims have been dispensed with drugs purchased under the 340B Drug Pricing Program.

29. No clause, term or condition of this Addendum shall be construed to change, reduce, expand or alter the eligibility of persons eligible for services of the Provider.

30. If Provider has current deemed status under the Federal Tort Claims Act, then such deemed status shall be sufficient to satisfy the insurance requirements of the Provider Manual and Provider Agreement. Provider must furnish documentation of Provider's deemed status under the Federal Tort Claims Act.

31. If Provider has current deemed status under the Federal Tort Claims Act, the indemnification provision of the Provider Agreement under sections 7 and 7.2, whichever is applicable, is deleted in its entirety. Provider must furnish documentation of Provider's deemed status under the Federal Tort Claims Act.

32. Notwithstanding the terms of the Provider Agreement and Provider Manual, the definition of Usual and Customary is as follows:

> The lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable discounts offered to attract customers. Discounts which are provided as a result of a customer's ability to pay shall be excluded.

No alterations to this Addendum shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

_____Initial

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SIGNATURE REQUIRED

Safety Net Pharmacy Retail Addendum To Caremark Provider Agreement Signature Page

The undersigned hereby enrolls as a Safety Net Provider for Medicare Part D. The parties hereto have caused this Addendum to be executed by their respective officers or representatives duly authorized so to do effective as of the date Caremark accepts this Addendum. By signing below, the undersigned Provider represents and warrants to Caremark that it has read the Safety Net Pharmacy Retail Addendum to the Caremark Provider Agreement, and agrees to be bound by the terms of the Addendum(as such agreement may be amended from time to time in accordance with the terms of the Provider Agreement).

Check all that apply;

☐ Provider is a TrOOP excluded entity (e.g. government-funded health program)

☐ Provider intends to waive all LIS (low-income subsidy) Part D Enrollee cost sharing

Pharmacy Name:

_____

Chain Code/Affiliation Code/NCPDP#:

_____

NPI#_____

By: _____
(Print name of authorized agent)

_____
(Signature of authorized agent)

Date: _____

Caremark, L.L.C.

By: _____
(Print name of Officer)

_____
(Signature of Officer)

Date: _____

CaremarkPCS, L.L.C.

By: _____
(Print name of Officer)

_____
(Signature of Officer)

Date: _____

No alterations to this Addendum shall be binding on either party unless initialed by duly authorized representatives of Provider and Caremark.

Health Net
EXHIBIT II

Health Net®
Pharmaceutical Services

PHARMACY NETWORK PARTICIPATION REQUEST FORM

Instructions to Provider:

This form allows pharmacies to request participation in the Health Net network.
Please type or print legibly.
Please note that completion of the nomination form does not guarantee acceptance in the Health Net pharmacy network.
Your nomination will be reviewed and a contract will be sent to you upon receipt of this form.

PHARMACY INFORMATION

Pharmacy Name		
Pharmacy DBA (if applicable)		
Mailing Address		
Phone		Fax
First Name	MI	Last Name
NCPDP		NPI

Contract Type Requested:

- ☐ Retail
- ☐ 340(B)
- ☐ LTC (Medicare D Only)
- ☐ Indian/Tribal
- ☐ Home Infusion (Medicare D Only)
- ☐ Mail Order (Medicare D Only)

PLEASE RETURN THIS FORM TO:

Health Net Pharmaceutical Services
PO Box 3530
Rancho Cordova, CA 95741-3530

Fax: 1-800-206-7011

If you have any questions, please call 1-800-968-9004 or send an email to RxNetwork@healthnet.com

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HEALTH NET PHARMACEUTICAL SERVICES AGREEMENT

THIS PHARMACEUTICAL SERVICES AGREEMENT 340(B) PARTICIPATING PROVIDER (340(B)) (**"Agreement"**) is entered into on the date the last party signs the Agreement (the **"Execution Date"**), to be effective as of _____ (the **"Effective Date"**), by and between the undersigned 340(B) pharmacy on behalf of itself and any affiliates, subsidiaries and franchisees listed on **Exhibit A** attached hereto (collectively and individually **"PARTICIPATING PHARMACY"**), and **HEALTH NET PHARMACEUTICAL SERVICES**, a California corporation, on behalf of itself and its affiliates and subsidiaries listed on **Exhibit B** attached hereto (collectively and individually referred to herein as, **"HEALTH NET"**).

RECITALS

A. WHEREAS, HEALTH NET contracts and maintains a pharmaceutical services network on behalf of certain of its affiliated managed care organizations, self-funded, and state and federal programs;

B. WHEREAS, PARTICIPATING PHARMACY wants to be included in the HEALTH NET pharmaceutical services network under the terms and conditions set forth in this Agreement;

C. WHEREAS, HEALTH NET wants to include PARTICIPATING PHARMACY in the HEALTH NET pharmaceutical services network under the terms and conditions set forth in this Agreement;

NOW THEREFORE, it is agreed:

ARTICLE I
DEFINITIONS

1.1 **"Adjudicated Amount"** - The calculated amount for a specific Covered Pharmaceutical Service, including an outpatient prescription drug or other supply or service, as calculated pursuant to **Exhibit C**.

1.2 **"Agreement"** - This written document, as amended from time to time, and all exhibits attached hereto, including without limitation Exhibits A through E.

1.3 **"Ancillary Charges"** - The charge, in addition to a Copayment, Coinsurance or Deductible that a Beneficiary is required to pay to a PARTICIPATING PHARMACY for prescription medication that is dispensed without conforming to the Beneficiary's pharmacy benefit, either at the request of the Beneficiary or the Licensed Prescriber. In the case of an Ancillary Charge applied as permitted under Section 2.1.6 or 2.1.7 of this Agreement, the Ancillary charge shall equal the difference between the Adjudicated Amount for the brand name medication and the Adjudicated Amount for the generic medication.

1.4 **"Average Wholesale Price (AWP)"** - The average wholesale price for a prescription drug or other supply which is established, no less than monthly, by First Data Bank, Medispan, Micromedex, or by such other national drug databases as HEALTH NET, or its designee, may designate from time to time at its sole discretion.

1.5 **"Benefit Program"** - The group agreement, evidence of coverage, summary plan description or similar agreements in effect at the time Covered Pharmaceutical Services are rendered, including but not limited in type to individual, group, family, Medicare or Medicaid, whereby HEALTH NET or any Payor is obligated to provide or arrange for Covered Pharmaceutical Services or compensation therefore, to Beneficiaries in accordance with the provisions contained in such agreements, plans and contracts.

1.6 **"Beneficiary"** - A person who is properly enrolled in and/or eligible to receive Covered Pharmaceutical Services under a Benefit Program at the time services are rendered.

1.7 **"Clean Claim"** - A Clean Claim means a request submitted to HEALTH NET, or its designee, by PARTICIPATING PHARMACY for payment of Covered Pharmaceutical Services that may be processed by HEALTH NET, or its designee, without obtaining additional information from PARTICIPATING PHARMACY or from a third party.

1.8 **"Compounded Drug"** - A mixture of two or more ingredients combined together at the PARTICIPATING PHARMACY. At least one ingredient must be a federal legend product, and a drug that is covered according to the Beneficiary's Benefit Program.

1.9 **"Coordination of Benefits"** - The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Pharmaceutical Services to a Beneficiary at the same time.

1.10 **"Copayment, Coinsurance or Deductible"** - The charge which is specified in each Benefit Program as applicable to a specific prescription medication or other supply or service or other payment for which the Beneficiary is liable under the Benefit Program.

1.11 **"Covered Pharmaceutical Services"** - Those outpatient pharmaceutical services to which a Beneficiary is entitled, as defined in the Benefit Program, and which a PARTICIPATING PHARMACY is licensed to offer.

1.12 **"Dispensing Fee"** – If applicable, the fee (compensation) for dispensing medications as set forth in the pharmacy reimbursement rate outlined in Exhibit C.

1.13 **"Drug Formulary"** - Listing of Covered Pharmaceutical Services. This document is periodically updated by HEALTH NET and made available to PARTICIPATING PHARMACY, and may also be known as the "Preferred Drug List" or "Recommended Drug List".

1.14 **"HEALTH NET Company"** - A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Health Net, Inc., a Delaware Corporation, its successors and assigns including without limitation those entities listed on **Exhibit B**.

1.15 **"Health Net Policies"** - The policies, procedures and programs established by HEALTH NET and applicable to all participating providers, including PARTICIPATING PHARMACY, in effect at the time Covered Pharmaceutical Services are delivered, including without limitation HEALTH NET's grievance and appeal procedures, provider dispute and/or appeal process, Drug Formulary, fraud detection, recovery procedures, eligibility verification, payment and coding guidelines, anti-discrimination requirements, medical management programs, credentialing, utilization management, quality improvement, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, referral, and Benefit Program requirements.

1.16 **"Identification Card"** - The Benefit Program identification card issued to a Beneficiary by HEALTH NET, or its designee, for the Beneficiary's convenience.

1.17 **"Licensed Prescriber"** - Any duly licensed health care practitioner authorized to prescribe prescription drugs pursuant to the applicable Benefit Program.

1.18 **"Maximum Allowable Cost List" ("MAC List")** - The list established by HEALTH NET, or its designee, of prescription medications that will be reimbursed at a generic product level. The MAC List includes, adjacent to each prescription medication listed, the corresponding maximum allowable cost per unit that will be used in calculating reimbursement by HEALTH NET. This list is subject to periodic review and modification by HEALTH NET, or its agent, at its sole discretion.

1.19 **"Medically Necessary"** - A Covered Pharmaceutical Service determined by HEALTH NET through its professional review process to be necessary and appropriate for treatment of the Beneficiary's illness or injury according to professionally recognized standards of medical practice and which is consistent with HEALTH NET's medical policies and Drug Formulary. Attending participating providers are exclusively responsible for making all medical determinations and treatment decisions. However, payment for medications dispensed will be conditioned on HEALTH NET's review and determination as to consistency with these standards and HEALTH NET's medical policies and Drug Formulary. The fact that a Licensed Prescriber may prescribe, order, recommend or approve a medication does not, in itself, make it Medically Necessary or make the charge allowable.

1.20 **"Payor"** - Any public or private entity contracted with HEALTH NET which provides, administers, funds, insures or is responsible for paying PARTICIPATING PHARMACIES for Covered Pharmaceutical Services rendered to Beneficiaries under a Benefit Program, including without limitation self-funded health plans, or that has been authorized by HEALTH NET to access one or more networks of participating providers.

1.21 **"Pharmacist"** - A duly licensed pharmacist employed by, contracting with, or otherwise associated with PARTICIPATING PHARMACY for the purpose of performing Covered Pharmaceutical Services pursuant to this Agreement.

1.22 **"Point-of-Sale System"** - On-line pharmacy claims processing system used to adjudicate pharmacy claims in accordance with the Beneficiary's Benefit Program.

1.23 **"Prior Authorization"** - Prior approval by HEALTH NET for the rendition of Covered Pharmaceutical Services that may be required under a Benefit Program or a Health Net Policy.

1.24 **"Usual and Customary"** - The "usual" charge is the retail price charged for a given pharmaceutical product or service to PARTICIPATING PHARMACY's cash paying customers. A charge is "customary" when it is within the range of the usual fees charged by pharmacies for the same pharmaceutical product or service within the same specific and limited geographic area.

1.25 **"Utilization Review"** - The system of review and quality assurance established and amended from time to time by HEALTH NET or its designee, and mandated by federal and state law to monitor the quality and appropriateness of health care and pharmaceutical services provided to Beneficiaries.

1.26 **"Wholesale Acquisition Cost (WAC)"** – The wholesale price for a prescription drug or other supply which is established no less than monthly, by the drug manufacturer, First Data Bank, Medispan, Micromedex, or by such other national drug database as HEALTH NET or its designee may designate from time to time at its sole discretion.

ARTICLE II
OBLIGATIONS OF PARTICIPATING PHARMACY

2.0 **Beneficiary Identification and Eligibility Verification**

2.0.1 **Provision of Services.** PARTICIPATING PHARMACY shall, upon presentation by a Beneficiary of a valid Identification Card or, if appropriate, a valid HEALTH NET enrollment form, and a medical prescription written for the Beneficiary, compound and/or dispense all Covered Pharmaceutical Services. PARTICIPATING PHARMACY agrees to participate with HEALTH NET on an all-Benefit Program, all-Payor basis as determined by HEALTH NET.

2.0.2 **Eligibility Verification.** PARTICIPATING PHARMACY shall verify Beneficiary eligibility through the Point-of-Sale System. Presentation of an Identification Card or an enrollment form does not guarantee Beneficiary eligibility. Failure to utilize the Point-of-Sale System may result in rejected claims.

2.1 **Provision of Pharmaceutical Services**

2.1.1 **Claims Processing.**

A. **Electronic Claims.** PARTICIPATING PHARMACY shall submit claims for HEALTH NET Beneficiaries to the pharmacy claims processor designated by HEALTH NET. PARTICIPATING PHARMACY shall transmit claims electronically using the current standard N.C.P.D.P. Version. The parties acknowledge that the necessary claims processing obligations in this Agreement will be accomplished in whole, or in part, by implementation of a continuous, real time, on-line computer network interfacing between HEALTH NET's computers or the computers of any designated agent or subcontractor of HEALTH NET, and PARTICIPATING PHARMACY's computers or terminals. PARTICIPATING PHARMACY shall be responsible for all costs, charges, and fees relating to on-line communication by PARTICIPATING PHARMACY of claims or other information to or from HEALTH NET or its designee.

B. **Manual Claims.** PARTICIPATING PHARMACY may only submit a manual claim (Universal Claim Form) if PARTICIPATING PHARMACY receives prior written approval from HEALTH NET to submit such claim manually. For prior approval and submission procedures, PARTICIPATING PHARMACY shall contact the prior authorization department for the participating Benefit Program. Any manually submitted claim must be submitted within thirty (30) days of the date of compounding and/or dispensing to a Beneficiary.

2.1.2 **Provide Covered Pharmaceutical Services.** PARTICIPATING PHARMACY shall make available and provide to eligible Beneficiaries all Covered Pharmaceutical Services under each applicable Benefit Program in accordance with the terms of the applicable Benefit Program. A Beneficiary's Covered Pharmaceutical Services shall be verified through the Point-of-Sale System by the designated claims processor. At the sole discretion of the PARTICIPATING PHARMACY, PARTICIPATING PHARMACY may also offer any special discounts or other promotions to Beneficiaries for items or services not covered under the applicable Benefit Program.

2.1.3 **Prescription Verification.** PARTICIPATING PHARMACY shall verify that each prescription order presented by a Beneficiary is prescribed by a Licensed Prescriber.

2.1.4 **Licensed Prescriber Participation Verification.** PARTICIPATING PHARMACY shall submit the Licensed Prescriber's valid DEA number or unique identifier as determined by HEALTH NET in the appropriate field of the electronic claim. When required by the Benefit Program, Licensed Prescriber participation will be verified through the Point-of-Sale System, or, in the event of a manual submission, such other means as HEALTH NET may deem reasonably appropriate.

2.1.5 **Drug Formulary.** PARTICIPATING PHARMACY shall provide Covered Pharmaceutical Services in compliance with the provisions and guidelines of the Drug Formulary and in accordance with state and federal laws. A Drug Formulary will be made available to the PARTICIPATING PHARMACY.

2.1.6 **Generic Substitution.** PARTICIPATING PHARMACY shall substitute generic medications for equivalent brand name medications in compliance with Drug Formulary or Benefit Program and to the extent permitted by applicable federal and state laws and regulations. Generic medications may be subject to the Maximum Allowable Cost (MAC) list designated by HEALTH NET or its designee.

If a prescription can be dispensed with a generic medication and a Beneficiary refuses the generic substitution (DAW2), or the Licensed Prescriber requests the brand name medication (DAW1), the Beneficiary may be required to pay a higher copay and/or an ancillary charge of the difference between the cost of the brand and the cost or MAC of the generic in addition to the applicable Copayment. HEALTH NET Beneficiaries may be subject to the following MAC programs:

A. **MAC A Generic Policy.** This program requires the Beneficiary to pay the applicable Copayment ***plus*** 100 percent of the additional Ancillary Charge of the prescription drug for both DAW "1" and DAW "2" prescriptions.

B. **MAC B Generic Policy.** This program does not charge an Ancillary Charge to the Beneficiary when the Licensed Prescriber has indicated "do not substitute" or "dispense as written" and the claim is coded by the pharmacist as DAW "1". If a Beneficiary requests that a brand name drug be dispensed, code the claim as a DAW "2". The Beneficiary will pay the applicable Copayment ***plus*** 100 percent of the additional Ancillary Charge of the prescription drug.

2.1.7 **DAW Codes.** PARTICIPATING PHARMACY shall submit the appropriate DAW code on all claims. HEALTH NET recognizes the following DAW codes:

DAW 0: *No "Dispense as Written" or "Do Not Substitute" on the prescription*
DAW 1: *PRESCRIBER mandated brand dispensed - "DAW" or "DNS"*
DAW 2: *Patient (Beneficiary) requested brand dispensed.*
DAW 5: *Substitution allowed, brand dispensed as generic.*
DAW 8: *Substitution allowed, generic drug not available in the marketplace (applicable to Health Net California only.)*

2.1.8 **Dispensing Limitations.** PARTICIPATING PHARMACY shall dispense Covered Pharmaceutical Services in quantities not to exceed a one month's supply, except where the applicable Benefit Program specifies alternative quantities, subject to legal restrictions, professional ethics and judgment. PARTICIPATING PHARMACY shall dispense Covered Pharmaceutical Services in accordance with preferred product and quantity restrictions established by HEALTH NET and controlled through the Point-of-Sale System, or, in the event of a manual submission, such other means as HEALTH NET may deem reasonably appropriate.

2.1.9 **Prescription Refill Limitations.** PARTICIPATING PHARMACY shall not refill prescriptions until HEALTH NET's established percentage of the previously dispensed quantities have been consumed, based on dosage instructions of Licensed Prescriber. Refill limitations shall be verified through the Point-of-Sale System by the designated claims processor. Beneficiaries must pay in full for any quantities exceeding the terms of this Agreement.

2.1.10 **Compounded Drugs.**

A. PARTICIPATING PHARMACY shall submit electronic claims for all Compounded Drugs. PARTICIPATING PHARMACY shall submit claims for Compounded Drugs as follows:

1. Identify the prescription as a Compounded Drug on the submitted claim.
2. Submit the NDC for the most expensive covered legend ingredient.
3. Enter the total metric quantity for the final compounded product for all ingredients combined.
4. Enter the combined cost of all ingredients in the prescription as the submitted cost.

B. As a condition to payment under this Agreement, PARTICIPATING PHARMACY shall dispense Compounded Drugs in accordance with the following restrictions:

1. Compounded Drugs must contain a drug that is covered according to the Beneficiary's Benefit Program.
2. Compounded Drugs may not be covered for all HEALTH NET Beneficiaries.
3. Compounded Drugs may require Prior Authorization before dispensing.
4. Compounded Drugs must be for a FDA approved indication. The ingredients in Compounded Drugs must contain at least one Legend Drug that is FDA approved for

a covered indication. Compounded Drugs are not covered if they contain one or more ingredients that are specifically excluded from coverage per the Beneficiary's Benefit Program.

C. Upon implementation of N.C.P.D.P. Version 5.1, PARTICIPATING PHARMACY shall submit electronic claims for all Compounded Drugs in accordance with this standard.

2.1.11 **Unclaimed Pharmaceutical Services.** After up to a maximum of fourteen (14) days, PARTICIPATING PHARMACY shall reverse claims (full or partial) for Covered Pharmaceutical Services unclaimed by a Beneficiary.

2.1.12 **Accessibility of Pharmacy Services.** PARTICIPATING PHARMACY shall be available and accessible to Beneficiaries during reasonable hours of operation. HEALTH NET shall monitor the availability and accessibility of pharmacy services to Beneficiaries, including availability of Covered Pharmaceutical Services and customer services levels.

2.1.13 **Comply With All HEALTH NET Policies and Procedures.** PARTICIPATING PHARMACY agrees to comply with all applicable HEALTH NET policies, procedures and manual provisions, which may specifically include but are not limited to PARTICIPATING PHARMACY administrative manual (if applicable), and HEALTH NET's policies governing notice of non-coverage. In the event of any conflicts between HEALTH NET policies and procedures, and this Agreement, this Agreement shall control. Such applicable Health Net Policies and procedures will be made available to PARTICIPATING PHARMACY upon request.

2.1.14 **Non-Discrimination.** PARTICIPATING PHARMACY shall not discriminate or differentiate in the treatment of Beneficiaries based on their color, creed, age, gender, marital status, religion, health factors, social-economic status, claims experience, receipt of healthcare, medical history, genetic information, evidence of disability or otherwise. PARTICIPATING PHARMACY shall not discriminate against a Beneficiary solely on the grounds that the Beneficiary files a complaint against the PARTICIPATING PHARMACY and/or HEALTH NET.

2.1.15 **Staffing.** PARTICIPATING PHARMACY shall always maintain adequate staffing and personnel, both professional and administrative, to promptly and effectively perform its obligations under this Agreement.

2.1.16 **Training and Licensure.** PARTICIPATING PHARMACY shall ensure that all Pharmacists, employees and independent contractors who provide Covered Pharmaceutical Services under this Agreement shall at all times have at least the minimum training, licensure, certifications, and qualifications required by all applicable federal and state laws. PARTICIPATING PHARMACY shall provide such training and information to all personnel in its facilities that are involved in providing Covered Pharmaceutical Services regarding HEALTH NET, its services, Benefit Program designs, and utilization management, as necessary.

2.1.17 **Pharmacist and Pharmacy Credentialing.**

A. PARTICIPATING PHARMACY represents, warrants and covenants to HEALTH NET that PARTICIPATING PHARMACY is not and at no time has been suspended or excluded from participation in any state or federal health care program, including without limitation Medicare and Medicaid, for any reason, including fraud or misrepresentation. PARTICIPATING PHARMACY hereby agrees to immediately notify HEALTH NET of any threatened, proposed, or actual suspension or exclusion from any state or federal health care program, including without limitation Medicare and Medicaid, for any reason, including fraud or misrepresentation. PARTICIPATING PHARMACY shall immediately notify HEALTH NET of: a) any action to restrict, revoke, or suspend the licenses or certificates that are necessary for PARTICIPATING PHARMACY to operate; b) any changes in its business address(es); c) any other serious

situation that could interfere with PARTICIPATING PHARMACY's duties and obligations under this Agreement. PARTICIPATING PHARMACY shall also report in writing to HEALTH NET within fifteen (15) calendar days of PARTICIPATING PHARMACY's knowledge of any and all judgments against PARTICIPATING PHARMACY related to the delivery of any healthcare item or service (regardless of whether the judgment is the subject of a pending appeal). Upon receipt of any such notice, HEALTH NET shall assess PARTICIPATING PHARMACY's ability to continue to adequately meet HEALTH NET's needs under this Agreement and may terminate this Agreement as provided in **Section 8.2**.

B. PARTICIPATING PHARMACY represents, warrants and covenants that PARTICIPATING PHARMACY shall credential each Pharmacist prior to the employment of any such Pharmacist by PARTICIPATING PHARMACY. This includes a background check that includes, at a minimum, verification of education, verification of past employment, verification of Pharmacist's licensure status with regulatory agencies in each state that individual Pharmacist is or has been licensed, verification that Pharmacist has not been excluded or suspended from any state or federal health care program, and review of any actions taken by the respective state or federal agency against the Pharmacist. PARTICIPATING PHARMACY further certifies, represents, warrants and covenants that PARTICIPATING PHARMACY does not, and shall not while this Agreement is in effect, employ or contract for the provision of any services with any individual or entity excluded from participation in any state or federal health care program, including without limitation Medicare and Medicaid. PARTICIPATING PHARMACY shall monitor Pharmacists employed by PARTICIPATING PHARMACY on an ongoing basis, including communications with the state regulatory agencies and visual inspection of the Pharmacist's license or renewal certificate posted at the pharmacy. PARTICIPATING PHARMACY shall at all times maintain written documentation of license review. The review will be done in accordance with PARTICIPATING PHARMACY's policy on such review, but will be done at least annually. PARTICIPATING PHARMACY further acknowledges that it shall take action as deemed appropriate by PARTICIPATING PHARMACY with individual Pharmacists whose professional activities are reviewed by state or federal regulatory agencies whether or not the review resulted in any restrictions being placed on the individual's license to practice pharmacy.

C. PARTICIPATING PHARMACY agrees to submit to HEALTH NET immediately upon request information relating to: (i) PARTICIPATING PHARMACY'S credentialing process; (ii) any part of, up to and including the entire, credentials file relevant to any Pharmacist employed by PARTICIPATING PHARMACY; and (iii) any other information relating to the professional qualification of a Pharmacist employed by PARTICIPATING PHARMACY as HEALTH NET may require. PARTICIPATING PHARMACY further hereby consents to allow HEALTH NET to review all such credential records maintained by PARTICIPATING PHARMACY for its own purposes including, but not limited to, utilization and quality assurance.

2.1.18 **Misfilled Prescriptions.** PARTICIPATING PHARMACY is responsible for and agrees to immediately notify HEALTH NET of any instance when a Beneficiary has received a prescription that was misfilled by the PARTICIPATING PHARMACY.

2.1.19 **Downstream Entities.** PARTICIPATING PHARMACY shall ensure that all of the requirements set forth in this Agreement shall be applicable to and enforceable against any provider or "downstream" entity to which PARTICIPATING PHARMACY delegates any of its obligations under the Agreement, provided that any such delegation shall be subject to **Section 10.8** of this Agreement.

2.1.20 **Chain Pharmacies.** In the event that PARTICIPATING PHARMACY is entering into this contract on behalf of more than one physical pharmacy site, affiliates, subsidiaries, franchisees, or other entities, PARTICIPATING PHARMACY hereby represents, warrants and covenants to HEALTH NET that: (i) all pharmacies that shall be providing Covered Pharmaceutical Services on behalf of PARTICIPATING PHARMACY are listed in **Exhibit A**; and (ii) each pharmacy that provides Covered Pharmaceutical Services on behalf of PARTICIPATING PHARMACY is duly licensed to provide such services in the state in which the pharmacy is located and has been credentialed by PARTICIPATING PHARMACY; and (iii) each pharmacy that provides Covered Pharmaceutical Services on behalf of PARTICIPATING PHARMACY has

agreed in writing to be bound by the terms and conditions of the Agreement. Notwithstanding the foregoing, PARTICIPATING PHARMACY understands and agrees that no entity may be added to **Exhibit A** without HEALTH NET's prior written approval of such addition.

2.2 **Books and Records**

2.2.1 **Records Maintenance.** PARTICIPATING PHARMACY shall preserve all claims record logs for audit at any reasonable time for a period of six (6) years following the date of provision of Covered Pharmaceutical Services. "**Claims record logs**" means prescriptions received, claim forms, signature logs, and invoices prepared by PARTICIPATING PHARMACY. PARTICIPATING PHARMACY also shall preserve all credentialing files relating to an employed Pharmacist for a period of six (6) years following the last date of employment of such Pharmacist for audit at any reasonable time.

2.2.2 **Regulatory Access.** PARTICIPATING PHARMACY shall also make books, records, invoices, and prescription files of PARTICIPATING PHARMACY relating to payment of Covered Pharmaceutical Services rendered to Beneficiaries available to applicable state and federal regulatory agencies, as may be necessary for compliance of HEALTH NET with the rules and regulations of said agencies. This provision shall be construed in accordance with all applicable state and federal laws and regulations pertaining to the confidentiality of prescription and health information, and shall extend as required under state and federal law, or for a period of six (6) years, whichever is longer.

2.2.3 **Audit.** PARTICIPATING PHARMACY shall allow HEALTH NET or HEALTH NET's designated representatives at any time during the term of this Agreement, and for six (6) years after termination hereof, upon reasonable notice, and without charge to HEALTH NET, to conduct audits of the books, records, invoices, and prescription files of PARTICIPATING PHARMACY relating to payment of Covered Pharmaceutical Services rendered to Beneficiaries. Such audits may be performed on-site at PARTICIPATING PHARMACY during regular business hours and may include review of all reasonably necessary records and databases to ensure PARTICIPATING PHARMACY's compliance with the terms and conditions of this Agreement. Alternatively, at HEALTH NET's discretion, such audits may be performed by HEALTH NET based upon records and data supplied by PARTICIPATING PHARMACY to HEALTH NET, which PARTICIPATING PHARMACY shall supply via facsimile or otherwise to HEALTH NET within seventy two (72) hours of HEALTH NET's request. PARTICIPATING PHARMACY shall cooperate fully with HEALTH NET or its designated representatives in conducting such audits and in any retrospective review of records required by HEALTH NET in connection therewith. When the audit or retrospective utilization review performed by HEALTH NET or its designated representatives discloses that PARTICIPATING PHARMACY has been overpaid under this Agreement, HEALTH NET may, but shall not be required to, offset amount of overpayment against any current or future obligation to PARTICIPATING PHARMACY. If no current or future obligation exists, PARTICIPATING PHARMACY shall refund to HEALTH NET any such payment in excess of the amount actually owed within thirty (30) days following receipt by PARTICIPATING PHARMACY of notice of the overpayment. PARTICIPATING PHARMACY may request reconsideration of findings by HEALTH NET made under this **Section 2.2.3**. Such requests must be made in writing within thirty (30) days following PARTICIPATING PHARMACY's receipt of the determination and must include thorough documentation of the reasons for the proposed reconsideration. The decision of HEALTH NET following any such reconsideration shall be final.

2.2.4 **Beneficiary Grievances.** PARTICIPATING PHARMACY shall cooperate with HEALTH NET and Beneficiaries in any grievance procedures, including the provision of records and other information. PARTICIPATING PHARMACY shall provide to HEALTH NET any and all pharmaceutical records relevant to any grievance proceeding, arbitration, or other legal proceeding between HEALTH NET and a Beneficiary at no charge. PARTICIPATING PHARMACY shall submit to HEALTH NET a written plan(s) of correction and sustained improvement relating to Beneficiary grievances upon the request of HEALTH NET. Such pharmaceutical records shall be provided to HEALTH NET as soon as possible, but not more than ten (10) business days after such request. In the event that PARTICIPATING PHARMACY fails to provide such records, HEALTH NET may withhold payments of amounts owed. PARTICIPATING PHARMACY shall

respond to all Beneficiary grievances forwarded to PARTICIPATING PHARMACY by HEALTH NET within ten (10) business days after receipt of the grievance.

2.2.5 **Product Recalls**. In the event that a product recall is initiated by the action of a manufacturer, court, governmental body or otherwise, PARTICIPATING PHARMACY shall conduct such product recall according to its established procedure and shall notify HEALTH NET, and its Beneficiaries in accordance with applicable law. PARTICIPATING PHARMACY will reverse claims for any unused portion of a recalled product immediately upon its return by a Beneficiary.

ARTICLE III
OBLIGATIONS OF HEALTH NET

3.1 **Beneficiary ID Card.** HEALTH NET shall provide Beneficiaries with an Identification Card containing sufficient information for PARTICIPATING PHARMACY to provide Covered Covered Pharmaceutical Services.

3.2 **On-Line Claims Processing.** HEALTH NET shall designate a pharmacy claims processor for on-line claims adjudication. HEALTH NET's designated claims processor will maintain direct communication lines with all major claims switching facilities.

3.3 **Eligibility and Benefit Verification.** HEALTH NET shall provide proof of eligibility to PARTICIPATING PHARMACY at the point-of-sale for both Beneficiaries and Licensed Prescribers. Such information shall be made available through the HEALTH NET's designated claims processor and HEALTH NET is responsible for the accuracy of such information. PARTICIPATING PHARMACY shall be entitled to rely upon the accuracy of such verification as proof of eligibility and shall be paid for all claims where eligibility has been indicated. HEALTH NET shall establish procedures as may be necessary to enable PARTICIPATING PHARMACY to verify Beneficiary and Licensed Prescriber eligibility and benefit verification.

ARTICLE IV
BILLING AND COMPENSATION

4.1 **Submit All Claims.** PARTICIPATING PHARMACY shall submit a Clean Claim to HEALTH NET's designated claims processor for all items dispensed to Beneficiaries as a Covered Pharmaceutical Service. This includes Clean Claims for Covered Pharmaceutical Services that may be less than the Beneficiary's Copayment, Coinsurance or Deductible, and zero-balance claims. PARTICIPATING PHARMACY shall submit all Clean Claims at the time the Covered Pharmaceutical Service is dispensed.

4.2 **Amounts To Be Collected.** Amounts to be collected by PARTICIPATING PHARMACY shall be specified by HEALTH NET's designated claims processor through the Point-of-Sale System.

4.3 **Collection From Beneficiaries.** At the time of dispensing, PARTICIPATING PHARMACY shall collect (i) the applicable Copayment, Coinsurance, Deductible or the Adjudicated Amount, whichever is less, and (ii) Ancillary Charges, if any, for its own account.

4.4 **Payment Terms.** HEALTH NET or Payor shall compensate PARTICIPATING PHARMACY in accordance with the compensation provisions outlined in **Exhibit C** to this Agreement.

4.5 **Payment in Full.** For Covered Pharmaceutical Services provided to Beneficiaries in accordance with this Agreement, HEALTH NET or the applicable Payor shall pay PARTICIPATING PHARMACY such compensation as is specified in **Exhibit C**, attached hereto and incorporated herein by reference. HEALTH NET or Payor shall provide check remittance detail with each payment. Except as otherwise provided herein, PARTICIPATING PHARMACY shall accept payment made by Payor in accordance with this Agreement as complete and full discharge of the liability of HEALTH NET, Payor and Beneficiaries for the rendering of

Covered Pharmaceutical Services. PARTICIPATING PHARMACY agrees to look only to the applicable Payor for reimbursement when Payor is not HEALTH NET.

4.6 **Prompt Payment.** HEALTH NET and PARTICIPATING PHARMACY agree to accept and abide by applicable state statutes or regulations regarding the prompt payment of Clean Claims.

4.7 **Billing Requirements.** PARTICIPATING PHARMACY shall, within fourteen (14) days of the date of compounding and/or dispensing a prescription to a Beneficiary, submit to HEALTH NET's designated claims processing agent a Clean Claim for payment via electronic Point-of-Sale System data transmission. Transmission charges for Clean Claims shall be paid by PARTICIPATING PHARMACY and processing charges for Clean Claims shall be the responsibility of HEALTH NET.

4.8 **Coordination of Benefits.** PARTICIPATING PHARMACY agrees to cooperate with HEALTH NET in Coordination of Benefits. The proceeds and savings derived from Coordination of Benefits are the exclusive property of HEALTH NET. HEALTH NET will seek recovery from other group health plans for the value of services rendered under HEALTH NET contracts when Coordination of Benefits is applicable. PARTICIPATING PHARMACY consents to release of prescription information by HEALTH NET to other group health plans necessary and lawful to accomplish Coordination of Benefits. When a Beneficiary has coverage which is primary through another payor, PARTICIPATING PHARMACY shall bill the primary payor and PARTICIPATING PHARMACY shall collect the remaining balance directly from the Beneficiary. The Beneficiary shall be responsible for submitting a claim for reimbursement of secondary coverage directly to HEALTH NET.

4.9 **Third Party Liability and Workers' Compensation Recoveries.** PARTICIPATING PHARMACY shall cooperate in HEALTH NET's third party liability and workers' compensation recoveries. Such recoveries are the exclusive property of HEALTH NET.

4.10 **Beneficiary Hold Harmless.**

A. PARTICIPATING PHARMACY hereby agrees that in no event, including, but not limited to nonpayment by HEALTH NET, Payor, or a HEALTH NET parent, subsidiary, affiliate or intermediary, or the insolvency or breach of this Agreement by HEALTH NET, Payor, or HEALTH NET's parent, subsidiary, affiliate or intermediary shall PARTICIPATING PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Beneficiary or other person, other than Payor, acting on a Beneficiary's behalf, for Covered Pharmaceutical Services. This provision shall not prohibit PARTICIPATING PHARMACY from collecting Ancillary Charges, Copayments, Coinsurance or Deductibles, and/or fees for non-Covered Pharmaceutical Services delivered on a fee-for-service basis to Beneficiaries, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for Coordination of Benefits, from Beneficiaries in accordance with the terms of the Beneficiary's Benefit Program.

B. PARTICIPATING PHARMACY agrees, in the event of HEALTH NET's insolvency, to continue to provide the Covered Pharmaceutical Services to HEALTH NET Beneficiaries for the duration of the period for which premiums on behalf of the Beneficiary were paid to HEALTH NET.

C. PARTICIPATING PHARMACY agrees (i) that this **Section 4.11** shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of HEALTH NET's Beneficiaries, and (ii) that this **Section 4.11** supersedes any oral or written contrary agreement now existing or hereafter entered into between PARTICIPATING PHARMACY and a Beneficiary or a person acting on behalf of a Beneficiary.

ARTICLE V
UTILIZATION REVIEW

5.1 **Pharmacy Participation.** PARTICIPATING PHARMACY shall participate and support all Utilization Review programs as may be amended from time to time by HEALTH NET. PARTICIPATING PHARMACY shall not charge HEALTH NET for this assistance and cooperation.

5.2 **Other Individuals' Participation.** PARTICIPATING PHARMACY understands and hereby agrees that HEALTH NET may from time to time require the assistance of PARTICIPATING PHARMACY's Pharmacists, employees or independent contractors in connection with Utilization Review. PARTICIPATING PHARMACY shall require its Pharmacists, employees and independent contractors to cooperate fully with any reasonable request made by the Utilization Review personnel of HEALTH NET in the course and scope of Utilization Review.

ARTICLE VI
DATA OWNERSHIP AND CONFIDENTIALITY

6.1 **Confidentiality.**

A. PARTICIPATING PHARMACY acknowledges that all non-public information and data generated or otherwise made available to PARTICIPATING PHARMACY as a result of the participation of HEALTH NET and/or its Beneficiaries under this Agreement, including, but not limited to all data regarding the business or operations of HEALTH NET, all pharmacy utilization data, all prescription data, all Utilization Review information, all Beneficiary information, all Payor information, and any term set forth hereunder, including pricing or compensation schedules or arrangements, constitute confidential information (the "**Confidential Information**") that derives independent economic value from not being generally known or readily accessible to others who can obtain economic value from its disclosure or use. PARTICIPATING PHARMACY shall use such Confidential Information only as necessary and appropriate for the performance of its obligations under this Agreement and shall not use, disclose, sell, convert, market, appropriate, commercialize, create derivative products or applications based on or otherwise use or release to any third party any Confidential Information, without the prior written consent of HEALTH NET, except as otherwise required by applicable state or federal law or government regulatory authorities. Confidential Information shall be deemed confidential and proprietary information of HEALTH NET and violation of this provision shall be a material breach of the Agreement as that term is used in **Section 8.2** herein.

B. HEALTH NET shall not disclose or release to any third party person or entity, except agents, employees, or subcontractors of HEALTH NET, within the course and scope of their agency, employment, or subcontract, any information regarding this Agreement or any term set forth hereunder, including pricing or compensation schedules or arrangements, without the prior written consent of PARTICIPATING PHARMACY, except as otherwise required by applicable state or federal law or government regulatory authorities. Notwithstanding the foregoing, HEALTH NET may disclose the reimbursement terms under this Agreement to prospective and current Payors and employer groups.

6.2 **Use of Symbols and Service Marks.** Each party agrees not to utilize any patented, trade-named, trademarked, service-marked, copyrighted material, or property belonging to the other party except as agreed to in writing by the parties. Notwithstanding the foregoing, PARTICIPATING PHARMACY shall have the right to designate and make public reference to its status as a participating pharmacy and HEALTH NET shall have the right to designate and make public reference to PARTICIPATING PHARMACY as a participating pharmacy. PARTICIPATING PHARMACY acknowledges and agrees that HEALTH NET will need to use the name of PARTICIPATING PHARMACY in various administrative contexts internally and in communications to Beneficiaries, Payors and groups regarding their Covered Pharmaceutical Services in order to accomplish the objectives of this Agreement.

6.3 **Compliance with Laws.** Each party shall comply with all applicable local, state and federal statutes, laws, rules and regulations, now or hereafter in effect, regarding the performance of the party's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, security, appeal and dispute resolution procedures to the extent that they directly or indirectly effect the party, a Beneficiary, a Benefit Program, or a Payor and bear upon the subject matter of this Agreement. If HEALTH NET is sanctioned by any regulatory body for non-compliance which is caused by PARTICIPATING PHARMACY, PARTICIPATING PHARMACY shall compensate HEALTH NET for monetary penalties or other amounts tied to this sanction incurred by HEALTH NET, including HEALTH NET'S costs of defense.

6.4 **Remedies.** The parties each acknowledge that in the event of a breach of this **Article VI**, the party whose confidential information has been disclosed will not have an adequate remedy at law and will suffer irreparable damage and injury. Therefore, the parties each agree that, in addition to any other remedy available under the law and this Agreement, the non-breaching party shall be entitled to injunctive relief from a court of competent jurisdiction.

ARTICLE VII
PARTICIPATING PHARMACY AND HEALTH NET BENEFICIARY RELATIONSHIP

7.1 **Sole Responsibility.** PARTICIPATING PHARMACY shall be solely responsible for all pharmaceutical advice and service, including the right to refuse to serve any Beneficiary where such service would violate pharmacy ethics or any pharmacy laws or regulations. Neither, HEALTH NET, its directors, officers, agents, consultants, employees, Beneficiaries, Licensed Prescribers, Payors, HEALTH NET contracting medical groups, their agents and employees, either singly or collectively, is the agent or representative of PARTICIPATING PHARMACY, and none of them shall be liable for any act or omission of PARTICIPATING PHARMACY or of its agents, employees, independent contractors, or other persons providing services, including Covered Pharmaceutical Services, for or at the request of PARTICIPATING PHARMACY.

7.2 **Professional Standards.** PARTICIPATING PHARMACY shall be solely responsible for the quality of services rendered to Beneficiaries. PARTICIPATING PHARMACY is responsible for and agrees to render Covered Pharmaceutical Services herein provided in accordance with the professionally recognized standards of pharmacy practice, rules and regulations of the Board of Pharmacy and applicable state and federal law. It is expressly understood that relations between the individual Beneficiary and PARTICIPATING PHARMACY shall be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship. HEALTH NET and PARTICIPATING PHARMACY hereby acknowledge and agree that nothing in this Agreement shall be construed to require PARTICIPATING PHARMACY or its professionally licensed pharmacists to dispense any prescription medication if, in the pharmacist's professional judgment, such medication should not be dispensed for any health or other reason. PARTICIPATING PHARMACY shall be responsible for utilizing professional judgment in evaluating and identifying any medical contraindications in the prescribed medication, identifying any Beneficiary who may be abusing prescription medications and in identifying any misuse of a Beneficiary's Benefit Program. PARTICIPATING PHARMACY shall monitor the quality of Covered Pharmaceutical Services provided.

7.3 **Relationship.** It is further understood and agreed that the operation and maintenance of the pharmacies, facilities and equipment and the rendition of all Covered Pharmaceutical Services shall be solely and exclusively under the control and supervision of PARTICIPATING PHARMACY. HEALTH NET shall have no rights, authority or control over the selection of personnel, their supervision, or the rendition of any of the Covered Pharmaceutical Services. It is further understood and agreed that nothing contained in this Agreement shall be construed as giving HEALTH NET any right to manage or conduct a pharmacy, to determine PARTICIPATING PHARMACY's retail prices for prescription drugs provided hereunder, or to induce PARTICIPATING PHARMACY to deny, reduce, limit, or delay specific, Medically Necessary, and appropriate pharmaceutical services provided with respect to a specific Beneficiary or groups of Beneficiaries

with similar medical conditions. PARTICIPATING PHARMACY may establish or change its retail prices at any time at its sole discretion.

7.4 **Treatment of Beneficiaries.** PARTICIPATING PHARMACY and PARTICIPATING PHARMACY's staff and administrative personnel shall treat Beneficiaries promptly, fairly and courteously. PARTICIPATING PHARMACY shall take measures to ensure that its personnel at all times portray HEALTH NET in a positive light in their interactions with Beneficiaries and the public.

ARTICLE VIII
CONTRACT TERM AND TERMINATION

8.1 **Term.** This Agreement shall be in effect for an initial period of twelve (12) months from the effective date set forth above. This Agreement and all rights and obligations shall be continued in their entirety for consecutive annual periods, unless terminated as provided herein.

8.2 **Termination.** This Agreement may be terminated only as follows:

A. By the giving of ninety (90) days prior written notice of the election to terminate the Agreement by either party to the other, with or without cause; or

B. By the mutual agreement in writing by both parties at any time; or

C. Upon the material breach of this Agreement by either party, provided that a party alleging a material breach hereunder shall give thirty (30) days prior written notice to the other party of the intent to terminate the Agreement for material breach and include a statement of facts sufficient to set out the reason for such allegation of material breach, in which case the other party may propose in writing to cure the material breach. If the breaching party fails to cure the breach within such thirty (30) day period of written notice, the non-breaching party may terminate this Agreement at the end of such period. If the parties mutually agree in writing upon a resolution, the Agreement will continue in full force and effect as if no material breach had occurred. Without limitation of the foregoing, any of the following shall be deemed to be material breach by PARTICIPATING PHARMACY: (i) if PARTICIPATING PHARMACY materially violates a law or regulation pertinent to this Agreement; (ii) If PARTICIPATING PHARMACY fails to maintain professional liability insurance as specified hereunder; or (ii) if PARTICIPATING PHARMACY fails to submit all prescription claims for Beneficiaries to HEALTH NET's designated claims processor.

D. Immediately for failure by PARTICIPATING PHARMACY to provide Covered Pharmaceutical Services, except as expressly set forth herein while this Agreement is in effect. The parties agree that the damages HEALTH NET would incur in such event would be impossible to determine and the liquidated damages to be assessed will be a forfeiture by PARTICIPATING PHARMACY of all amounts then due from HEALTH NET as of the date of the material breach. Such forfeited amounts shall not be billed or assessed to any Beneficiary by PARTICIPATING PHARMACY.

E. Immediately upon the filing by or against the other 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 other party's assets.

F. Automatically, in the event that PARTICIPATING PHARMACY's license is revoked, suspended, or restricted, or if PARTICIPATING PHARMACY's ability to provide Covered Pharmaceutical Services in accordance with this Agreement, is otherwise materially impaired.

G. Automatically, in the event that PARTICIPATING PHARMACY has provided Covered Pharmaceutical Services and/or prescription medication in a negligent or fraudulent manner, including, but not limited to actions involving intentional misrepresentation.

H. In the event that PARTICIPATING PHARMACY is suspended or excluded from participation in any state or federal health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that PARTICIPATING PHARMACY is in breach of this subsection, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

8.3 **Termination of Individual Pharmacies.** In the event that a pharmacy listed on **Exhibit A** hereto shall take or omit any action which would be a breach of this Agreement if taken or omitted by PARTICIPATING PHARMACY, then this Agreement shall automatically terminate as to that pharmacy, and that pharmacy shall be removed from **Exhibit A**.

8.4 **Effect of Termination and Survival.** The effect of a termination shall be that, as of the date of termination, this Agreement shall no longer be of any force or effect, and each of the parties shall be relieved and discharged of their obligations hereunder, except as follows:

A. Except as provided in Section 8.2, obligations for payments due to PARTICIPATING PHARMACY incurred in accordance with the terms of this Agreement with respect to Covered Pharmaceutical Services rendered prior to the termination date shall be paid; and

B. Obligations of **Sections 2.2.1 through 2.2.3 for six (6) years following termination (Records Maintenance, Regulator Access, Audit); Section 4.10 (Beneficiary Hold Harmless); Article VI (Data Ownership and Confidentiality); Section 8.4 (Effect of Termination and Survival); Sections 9.1 through 9.2 for two (2) years following termination (Insurance and Indemnification); Section 9.3 (Dispute Resolution); and Article X (Miscellaneous Provisions)** as applicable, shall be continuing obligations which shall not expire except as set forth in this Section; and

C. Obligations regarding Utilization Review under **Article V**, herein, shall remain in effect to the extent necessary to comply with applicable laws and regulations and the reasonable quality control standards of HEALTH NET.

ARTICLE IX
INSURANCE, INDEMNIFICATION, ARBITRATION

9.1 **Insurance.** At all times relevant to this Agreement, and for a period of two (2) years following termination of this Agreement, PARTICIPATING PHARMACY shall procure and maintain, at PARTICIPATING PHARMACY's sole expense, a comprehensive general liability policy, as well as such policies of professional liability and other insurance with limits of no less than the greater of (i) any amount as may be required by state law, or (ii) any amount as may be necessary to insure it and its employees and agents against any claims for damages occasioned directly or indirectly in connection with the performance, lack of performance, or facilities provided by PARTICIPATING PHARMACY, the use of any products, property or facilities provided by PARTICIPATING PHARMACY, and the activities performed by PARTICIPATING PHARMACY in connection with this Agreement. PARTICIPATING PHARMACY shall also ensure that all pharmacies and other health care professionals employed or under contract with PARTICIPATING PHARMACY to render Covered Pharmaceutical Services to Beneficiaries procure and maintain such insurance, unless they are covered under PARTICIPATING PHARMACY's insurance policies. PARTICIPATING PHARMACY's, Pharmacists and other health care professionals' professional liability insurance shall either be occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by HEALTH NET. Copies of such certificates of insurance shall be made available to HEALTH NET upon request. PARTICIPATING PHARMACY shall provide HEALTH NET immediate notice of any change in insurance coverage required under this Section.

9.2 **Indemnification.** The parties agree that the provisions of this Section 9.2 shall survive termination of this Agreement with respect to acts, omissions, events, and/or claims that arose during the term of this Agreement.

9.2.1 **Responsibility for Own Acts**. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demand and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

9.2.2 **PARTICIPATING PHARMACY Indemnification**. PARTICIPATING PHARMACY agrees to indemnify, defend, and hold harmless HEALTH NET, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from PARTICIPATING PHARMACY's performance or failure to perform its obligations under this Agreement, negligence or intentional misconduct.

9.2.3 **HEALTH NET Indemnification.** HEALTH NET agrees to indemnify, defend, and hold harmless PARTICIPATING PHARMACY, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from HEALTH NET's performance or failure to perform its obligations under this Agreement, negligence or intentional misconduct. In the event PARTICIPATING PHARMACY seeks indemnification under this Section, PARTICIPATING PHARMACY shall give notice to HEALTH NET of a claim or other circumstances likely to give rise to a request for indemnification, promptly after PARTICIPATING PHARMACY becomes aware of the same. No compromise or settlement of any such claim shall be made without the prior written consent of HEALTH NET.

9.3 **Dispute Resolution.** PARTICIPATING PHARMACY and HEALTH NET agree to resolve any controversy or dispute that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract, or otherwise, (a "Dispute") pursuant to the terms of this Section 9.3. Either party may initiate the dispute resolution process set forth herein by giving the other party written notice of a Dispute. Such notice shall set forth the precise nature of the Dispute. PARTICIPATING PHARMACY and HEALTH NET agree to meet and confer in good faith to resolve the Dispute. Such negotiation shall be a condition precedent to the filing of any arbitration demand by either party, and no arbitration demand may be filed until the exhaustion of applicable HEALTH NET internal appeal procedures. If the parties are unable to informally resolve the Dispute within 30 days of the date of the initial notice of the Dispute, the aggrieved party may send written notice to the other party demanding arbitration under the terms of this Agreement (the "Arbitration Notice"). Such Arbitration Notice shall contain a detailed statement of the Dispute and facts and include copies of all related documents supporting the arbitration demand. In addition, should the parties, prior to submitting the Dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), Judicial Arbitration and Mediation Services ("JAMS"), or the parties may initiate such other procedures as they may mutually agree upon at such time. Notwithstanding the foregoing, nothing contained herein is intended to require arbitration of disputes for pharmacy malpractice between a Beneficiary and PARTICIPATING PHARMACY.

The parties further agree that upon the Arbitration Notice of either party, any Dispute shall be settled by final and binding arbitration under the appropriate rules of the AAA or JAMS, as agreed by the parties. The arbitration shall be conducted by a single, neutral arbitrator who is licensed to practice law. All such arbitration proceedings shall be conducted in the following location as applicable: in Phoenix, Arizona for Health Net of Arizona; Los Angeles, California, for HEALTH NET of California; Hartford, Connecticut, for HEALTH NET of the North East; Portland, Oregon, for HEALTH NET of Oregon; Sacramento, California, for HEALTH NET Federal Services; and Los Angeles, California for Health Net Plus, or such other location

as the parties may mutually agree. Arbitration must be initiated within one (1) year after the date the Dispute occurred by submitting a written Arbitration Notice to the other party. The failure to initiate arbitration within that period shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable state and federal law, and shall issue a written opinion setting forth the reasons for an award. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce this Agreement or to make any award that could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within the earlier of sixty (60) days of the date of the award or the date of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable state or federal law or regulation. The terms of this Section 9.3 shall survive termination of this Agreement.

ARTICLE X
MISCELLANEOUS PROVISIONS

10.1 **Headings.** The headings of the articles, sections, and subsections of this Agreement and any index to this Agreement are inserted for convenience only and do not constitute a part of this Agreement with any force or effect. Any reference to gender shall be deemed to include both the masculine and the feminine as applicable.

10.2 **Benefit Program.** Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Beneficiary's Benefit Program.

10.3 **Non-Exclusive Agreement.** This Agreement shall not be construed to be an exclusive agreement between HEALTH NET and PARTICIPATING PHARMACY, nor shall it be deemed to be an agreement requiring HEALTH NET to refer Beneficiaries to PARTICIPATING PHARMACY for services. This Agreement is non-exclusive and shall not prohibit HEALTH NET from entering into agreements with other providers, including providing pharmaceutical services directly or indirectly through alternative arrangements. PARTICIPATING PHARMACY reserves the right to participate in other prescription programs.

10.4 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state where Covered Pharmaceutical Services are rendered except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Any provision required to be in this Agreement by applicable state or federal law shall bind HEALTH NET and PARTICIPATING PHARMACY whether or not provided in this Agreement.

10.5 **Regulation.** HEALTH NET is subject to the requirements of various local, state, and federal laws, rules and regulations. Any provision required to be in this Agreement by any of the above shall bind PARTICIPATING PHARMACY and HEALTH NET whether or not provided herein. In the event there are state or federal law regulatory addenda attached hereto, the parties agree to comply with such addenda as applicable, and the parties acknowledge and agree that such addenda shall supercede and replace any inconsistent terms and conditions of this Agreement.

10.6 **Non-Waiver.** No waiver of any term, provision or condition of this Agreement, whether by conduct or otherwise, in any one or more instances, shall be deemed to be or construed as a further and continuing waiver of any such term, provision or condition of the Agreement.

10.7 **Amendments.** No amendment to this Agreement shall be effective unless in writing and signed by the parties or their respective authorized representatives. Notwithstanding the foregoing, HEALTH NET may amend this Agreement to the extent necessary to comply with applicable federal and state law, regulatory requirements, accreditation standards or licensing guidelines or rules. Any such amendment shall be effective as specified in the notice of such amendment. Additionally, HEALTH NET may amend this Agreement at any time on thirty (30) days advance written notice to PARTICIPATING PHARMACY. If PARTICIPATING PHARMACY does not agree to any amendment, PARTICIPATING PHARMACY may terminate the Agreement on ninety (90) days written notice to HEALTH NET. PARTICIPATING PHARMACY may exercise its termination right under this Section 10.7 only within 60 days of receiving HEALTH NET's notice of amendment. If PARTICIPATING PHARMACY exercises its termination right hereunder, PARTICIPATING PHARMACY agrees that during the ninety (90) day termination notice period, PARTICIPATING PHARMACY shall abide by the Agreement as amended. Any subsequent understanding between the parties, whether oral or written, not formally denominated and executed as an amendment to this Agreement, which authorizes or approves any course of performance deviating from the terms hereof, shall be presumed to be a temporary waiver, revocable at the will of either party and not an amendment to the provisions of this Agreement, regardless of the duration of such understanding.

10.8 **Assignment, Transfer, Delegation.** Neither this Agreement or any interest or benefit hereunder shall be assignable, transferable or delegatable by PARTICIPATING PHARMACY without the express written consent of HEALTH NET. HEALTH NET may assign this Agreement or any rights hereunder delegated to any parent or subsidiary corporation, or to any corporation owned by or under common ownership and control with HEALTH NET. The parties acknowledge that certain HEALTH NET obligations under this Agreement may be performed by HEALTH NET affiliates, subsidiaries, agents or subcontractors, and that such performance shall not be considered an assignment of this Agreement.

10.9 **Rights and Remedies.** No right or remedy contained herein is intended to be exclusive of any other right or remedy contained herein or provided by law, and every such right or remedy shall be cumulative and not alternative.

10.10 **Severability.** If any provision of this Agreement is adjudged to be illegal or unenforceable as written, then the scope, extent, or duration of such provision shall be reduced to the maximum or broadest interpretation which is capable of enforcement at law or, if such reinterpretation is either impossible or would unreasonably alter the original intent of the parties, shall be severed from this Agreement and all other provisions hereof shall remain in full force and effect.

10.11 **Third-Party Beneficiaries.** Other than as expressly set forth herein, no third persons or entities are intended to be or are third party beneficiaries of or under this Agreement, including, without limitation, Beneficiaries. Nothing in this Agreement shall be construed to create any liability on the part of HEALTH NET, PARTICIPATING PHARMACY or their respective directors, officers, shareholders, employees or agents, as the case may be, to any such third parties for any act or failure to act of any Party hereto.

10.12 **Entire Agreement.** The parties agree that this Agreement, the Exhibits and any Addenda attached hereto constitute the entire agreement and understanding between them with respect to the subject matter set forth herein and the transaction contemplated hereby and supersedes all prior discussions, negotiations, memoranda, writings, and oral or written agreements.

10.13 **Representation.** Each party represents and warrants that it has had the opportunity to be represented by counsel of his/her/its choice with respect to this Agreement. In view of the foregoing and notwithstanding any otherwise applicable principles of construction or interpretation, this Agreement shall be deemed to have

been drafted jointly by the Parties and in the event of any ambiguity, shall not be construed or interpreted against the drafting Party.

10.14 **Authorized Representatives.** Each party represents and warrants that the signatories below are authorized to enter into and execute this Agreement on behalf of all entities contracting hereto.

10.15 **Notice.** Whenever it shall become necessary for either party to give notice to the other respecting this Agreement, the notice shall be in writing and shall be sent by first class, registered, or certified mail, postage prepaid, or hand delivered to the person and address set forth below; provided that either party may change the designation herein through notice provided pursuant to this subsection:

If to PARTICIPATING PHARMACY:

_____

_____

_____

_____

If to HEALTH NET:

Health Net Pharmaceutical Services

PO Box 3530

Rancho Cordova, CA 95741-3530

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, intending to be bound, duly authorized representatives of the parties have executed and entered into this Agreement as of the Effective Date.

PARTICIPATING PHARMACY
(on behalf of itself and any affiliates, subsidiaries and franchisees listed on **Exhibit A)**

Pharmacy Name: _____

By: _____

Print Name: _____

Print Title: _____

Date: _____

HEALTH NET
(on behalf of itself and its affiliates and subsidiaries listed on **Exhibit B)**

By: _____

Print Name: _____

Print Title: _____

Date: _____

EXHIBIT A
PHARMACY LIST AND INFORMATION SHEET

Provide the following information for the location or locations of your Pharmacy covered by this Agreement. If necessary, attach additional Pharmacy Information Sheets to this Agreement or a list of the applicable locations of your pharmacy including the name, address, federal tax identification number and NABP number for each location.

Pharmacy Name: _____

Pharmacy Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____/_____ Fax: _____/_____ County: _____

Mailing address (if different): _____

City: _____

State: _____ Zip Code: _____

NCPDP: _____ NPI #: _____ Federal Tax ID #: _____

State License #: _____ DEA #: _____

Medicaid #:_____ Medi-Cal #:_____

Store Hours M-F: _____ Sat _____ Sun _____ 24 Hours _____

Language spoken other than English: _____

Professional Liability Insurance Carrier: _____

Policy Limits/Level of Coverage: _____

Self-Insured (check here): _____

Is your pharmacy subject to any outstanding regulatory or disciplinary action? _____ Yes _____ No

Other: _____

If yes, explain: _____

_____

_____

_____

Name of Software/Practice Management System Vendor:

_____ Phone: _____

EXHIBIT B
PARTICIPATING HEALTH NET COMPANIES

The parties agree that the Health Net Companies accessing this Agreement include without limitation the following as of the Effective Date of this Agreement:

Health Net of Connecticut, Inc.
Health Net of New York, Inc.
Health Net Insurance of New York, Inc.
Health Net of New Jersey, Inc.
Health Net of Arizona, Inc.
Health Net of California, Inc.
Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company
Managed Health Network, Inc. and its subsidiaries

EXHIBIT C
COMPENSATION – 340(B) ALL STATES

Payor shall pay PARTICIPATING PHARMACY the Adjudicated Amount for each Covered Pharmaceutical Service provided to a Beneficiary. The Adjudicated Amount shall equal the lesser of: (i) the sum of the Drug Acquisition Cost, plus the Professional Dispensing Fee, both as defined below; or (ii) PARTICIPATING PHARMACY's Usual and Customary charge. These amounts are exclusive of any applicable Copayments, Coinsurance, Deductibles or sales taxes, for which HEALTH NET shall not be liable, and Ancillary Charges.

A. **Drug Acquisition Cost**

The Drug Acquisition Cost for each Covered Pharmaceutical Service shall be equal to the lesser of the following amounts:

I. Average Wholesale Price (AWP) less **45%** for the prescription brand medication or item, or

II. The Maximum Allowable Cost for the prescription generic medication or item as set forth in the MAC List, or

III. Average Wholesale Price (AWP) less **20%** for the prescription generic medication or item, or

IV. The ingredient cost billed by PARTICIPATING PHARMACY for the prescription medication, or

B. **Compounded Drug Claims**

Compounded Drug Claims shall be reimbursed as follows and only if minimum requirements in Section 2.1.10 of this Agreement are met:

I. Drug Acquisition Cost per NCPDP Billing Unit (e.g. gram or milliliter) for each individual ingredient multiplied by the total units of each individual ingredient within the final compounded product; and

C. **Professional Dispensing Fees**

I. The Professional Dispensing Fee for brand name medications shall equal **$8.00** for each new or refill prescription.

II. The Professional Dispensing Fee for generic medications shall equal **$1.75** for each new or refill prescription.

III. The Professional Dispensing Fee for compounded medications shall equal **$8.00** for each brand and **$1.75** for each generic new or refill prescription.

D. **Payment to Pharmacy**

Upon receipt of a Clean Claim, Payor shall make payments to PARTICIPATING PHARMACY in accordance with all applicable state or federal law requirements regarding prompt payment and in accordance with this Agreement.

E. **Zero-Balance Claims**

Notwithstanding the above, in the event the PARTICIPATING PHARMACY's Drug Acquisition Cost plus the Professional Dispensing Fee is less than the Beneficiary's Copayment, the Adjudicated Amount will be the lesser of the Usual and Customary Price and the Beneficiary's Copayment. This provision may not apply to certain federal and state programs.

F. Except as may be provided in any addenda to this Agreement, PARTICIPATING PHARMACY acknowledges and agrees that the terms of this Exhibit C shall not apply to any Covered Pharmaceutical Services that are considered specialty pharmaceuticals, mail order, or other third party offerings (e.g., home IV infusion therapy, durable medical equipment or long term care).

EXHIBIT D

MEDICARE PART D PRESCRIPTION DRUG PROGRAM

The terms and conditions set forth on this Exhibit D shall amend and replace any inconsistent terms and conditions of the Agreement and other prior arrangements between the Parties whether oral or written, insofar as such agreements relate to HEALTH NET'S participation in the Program (as defined below). To the extent that the terms and conditions of the Agreement directly conflict with or contradict any terms and conditions set forth in this Exhibit D, the terms and conditions of this Exhibit D shall control. All other terms shall have their same meaning and intent. Capitalized terms used in this Exhibit D that are not otherwise defined herein shall have the meaning set forth in the Agreement.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, enacted at Public Law 108-173 and codified at Social Security Act 1860D-1, ("**MMA**") and the regulations promulgated thereunder at 42 C.F.R. Part 423, ("**MMA Regulations**"), each as may be amended, supplemented or interpreted from time to time, establishes the Medicare Voluntary Prescription Drug Benefit Program (the "**Program**"). Certain Health Net Companies have submitted applications and obtained determinations from the Centers for Medicare & Medicaid Services ("**CMS**") of the United States Department of Health and Human Services ("**HHS**") that each qualifies to contract with CMS as an organization sponsoring one or more MA-PD plans and/or Prescription Drug Plans to offer Qualified Prescription Drug Coverage pursuant to, and in accordance with the MMA and the MMA Regulations. Certain Health Net Companies also may enter into agreements to provide administrative services including, but not limited to, pharmacy network services to unaffiliated MA-PD plans and/or Prescription Drug Plans that have entered into contracts with CMS to offer Qualified Prescription Drug Coverage pursuant to, and in accordance with the MMA and the MMA Regulations.

1. PARTICIPATING PHARMACY hereby agrees to comply with all applicable Federal and state laws, regulations and Program instructions issued by CMS. Applicable state laws and regulations shall include, but not be limited to, the minimum standards for pharmacy practice as established by the state(s) in which PARTICIPATING PHARMACY practices.

2. PARTICIPATING PHARMACY agrees to comply with all applicable Federal and state laws, regulations, agency(ies) guidance and Health Net Policies relating to the privacy, confidentiality and security of Beneficiary medical records and other personal information. PARTICIPATING PHARMACY shall ensure the privacy and accuracy of Beneficiary health records in accordance with the provisions of 42 C.F.R. § 423.136

3. All services or other activities performed by PARTICIPATING PHARMACY pursuant to the Agreement including, but not limited to, this Exhibit D shall comply and be consistent with HEALTH NET's contractual obligations to CMS under the Program.

4. PARTICIPATING PHARMACY agrees to cooperate and comply with HEALTH NET's fraud, waste and abuse program.

5. HEALTH NET acknowledges that it shall not require PARTICIPATING PHARMACY to accept any insurance risk as a condition to PARTICIPATING PHARMACY's participation under this Agreement with respect to the Program.

6. PARTICIPATING PHARMACY shall submit claims for Program Beneficiaries to the pharmacy claims processor designated by HEALTH NET. PARTICIPATING PHARMACY shall transmit claims electronically using the current standard N.C.P.D.P. Version. HEALTH NET and PARTICIPATING PHARMACY each acknowledge and agree that the necessary claims processing obligations in the Agreement, as further described in this Exhibit D, will be accomplished in whole, or in part, by the implementation of a continuous, real time, on-line Point-of-Sale System that interfaces between HEALTH

NET's computers, or the computers of the pharmacy claims processor designated by HEALTH NET, and PARTICIPATING PHARMACY's computers or terminals.

7. In accordance with Program requirements, PARTICIPATING PHARMACY agrees to charge the Beneficiary (including those Beneficiaries who qualify for the low-income subsidy provided by the Program) only the Cost Share Amount owed by the Beneficiary ("**Cost Share Amount**"). Beneficiaries shall be entitled to the lesser of the Drug Acquisition Cost plus Professional Dispensing Fee in accordance with the Exhibit C of the Agreement, or the PARTICIPATING PHARMACY's Usual and Customary charges on all Covered Pharmaceutical Services covered by HEALTH NET and the Program. The lesser of (i) or (ii) shall be referred to as the "Contracted Rate" for purposes of this Exhibit D. PARTICIPATING PHARMACY acknowledges and agrees that in certain instances, the Cost Share Amount owed by the Beneficiary may equal the total PARTICIPATING PHARMACY Contracted Rate. The Contracted Rate and the Cost Share Amount will be determined by HEALTH NET and communicated to PARTICIPATING PHARMACY via the on-line Point-of-Sale System described above, in paragraph number six (6) (the "Adjudicated Amount").

8. The difference, if any, between the Cost Share Amount and the amount owed to PARTICIPATING PHARMACY based on the terms of the Agreement, shall be paid by HEALTH NET to PARTICIPATING PHARMACY under the payment terms set forth in the Agreement.

9. PARTICIPATING PHARMACY agrees that in no event shall PARTICIPATING PHARMACY attempt to collect an amount greater than the Cost Share Amount or charge any additional fee to a Beneficiary in connection with the purchase of a Covered Pharmaceutical Service covered by HEALTH NET and the Program (a "**Qualified Prescription Drug**").

10. In accordance with Program requirements, PARTICIPATING PHARMACY shall, after a Qualified Prescription Drug is dispensed at the point-of-sale, inform each Beneficiary presenting a prescription for a Qualified Prescription Drug of any difference between the price of the prescribed drug and the lowest cost therapeutically equivalent and bio-equivalent generic drug available at the PARTICIPATING PHARMACY. HEALTH NET will provide the relative price information to PARTICIPATING PHARMACY via on-line messaging via the Point-of-Sale System.

11. Subject to Program requirements, PARTICIPATING PHARMACY agrees to provide patient counseling services in accordance with applicable state pharmacy laws and regulations.

12. In accordance with Program requirements, PARTICIPATING PHARMACY agrees to maintain Beneficiary demographic data and an information system capable of concurrent drug utilization review that is designed to ensure the performance of a review of the prescribed drug therapy before a prescription is dispensed to a Beneficiary. Such concurrent drug utilization review system shall include, but not be limited to, screening for potential drug therapy problems due to therapeutic duplication, age or gender related contraindications, over-utilization and under-utilization, drug-drug interactions, incorrect drug dosage or duration of drug therapy, drug-allergy contraindications, and clinical abuse/misuse.

13. PARTICIPATING PHARMACY agrees that is shall implement and maintain a system that supports the use of the electronic prescribing standards as required by the Program and in accordance with the implementation deadline that is established by CMS.

14. In accordance with the MMA regulation 42 C.F.R. Section 423.505 (i)(2), PARTICIPATING PHARMACY agrees that (i) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of PARTICIPATING PHARMACY involving transactions related to CMS' contract with HEALTH NET; and (ii) HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period exists through ten (10) years from the final date of the Program agreement between CMS and HEALTH NET or the date of audit completion, whichever is later.

15. If HEALTH NET delegates any of its Program contractual obligations with CMS to PARTICIPATING PHARMACY, such delegation shall only in a manner consistent with the following: (i) such delegation shall be in writing and shall specify delegated activities and reporting responsibilities; (ii) such delegation may be revoked by HEALTH NET in instances when CMS or HEALTH NET determine that PARTICIPATING PHARMACY has not performed satisfactorily; (iii) HEALTH NET shall monitor PARTICIPATING PHARMACY'S performance on an ongoing basis and HEALTH NET is ultimately responsible to CMS for the performance of all services; (iv) PARTICIPATING PHARMACY shall comply with all applicable federal laws, regulations and CMS instructions; and (v) HEALTH NET retains the right to approve, suspend or terminate any arrangement between PARTICIPATING PHARMACY and a subcontractor. Any subcontract or delegation by PARTICIPATING PHARMACY shall be subject to HEALTH NET's prior written approval and shall comply with and incorporate the CMS requirements set forth in this Exhibit.

16. PARTICIPATING PHARMACY hereby certifies (based on best knowledge, information and belief) to the accuracy, completeness, and truthfulness of any claims data generated by PARTICIPATING PHARMACY or a subcontractor. PARTICIPATING PHARMACY and any subcontractor acknowledge that claims data will be used for the purpose of obtaining federal reimbursement.

17. In accordance with Program requirements and on an ongoing basis, HEALTH NET has the unconditional right to monitor PARTICIPATING PHARMACY's performance under the Agreement on an ongoing basis, as further described in this Exhibit D. PARTICIPATING PHARMACY agrees to cooperate with such monitoring.

18. In accordance with Program requirements, PARTICIPATING PHARMACY acknowledges and agrees that HEALTH NET has the sole and exclusive right to revoke any Program activities performed by PARTICIPATING PHARMACY under the Agreement, as further described in this Exhibit D or associated reporting responsibilities if either HEALTH NET or CMS determines that PARTICIPATING PHARMACY has not performed satisfactorily.

19. PARTICIPATING PHARMACY hereby agrees that in no event, including, but not limited to, nonpayment by HEALTH NET, its corporate parent, any HEALTH NET subsidiary, affiliate or intermediary, or a Payor (each an "**Entity**") or the insolvency or breach of this Agreement by any Entity, shall PARTICIPATING PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Beneficiary or other person, other than HEALTH NET, acting on a Beneficiary's behalf, for Qualified Prescription Drug Coverage. This paragraph nineteen (19) shall not prohibit PARTICIPATING PHARMACY from collecting the Cost Share Amount for a non-Qualified Prescription Drug delivered on a fee-for-service basis to any Beneficiary, which has not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for Coordination of Benefits, from a Beneficiary in accordance with the terms of the Beneficiary's Benefit Program.

20. PARTICIPATING PHARMACY acknowledges that the Program requires that a Beneficiary has access to up to a ninety (90)-day supply of Qualified Prescription Drugs at network pharmacies. Accordingly, the reimbursement rate set forth in the Agreement, as further described in this Exhibit D, shall include the following rates for prescriptions of brand name Qualified Prescription Drugs that exceed a thirty (30) day supply:

    For brand name prescriptions that are equal to or higher than thirty-one (31) days, the Drug Acquisition Cost shall be the lower of:

    - AWP less 45%
    - The ingredient cost billed by PARTICIPATING PHARMACY

The Professional Dispensing Fees and the reimbursement rate for generic Qualified Prescription Drugs shall be as defined in the Agreement.

- ☐ Check here if Pharmacy will participate in the Program as a network pharmacy of Health Net, but will **not** dispense prescriptions that exceed a thirty (30) day supply.

The reimbursement rates stated above only apply to Clean Claims for Qualified Prescription Drugs that are filled and dispensed at a retail location. These rates do not apply to mail order, internet, home infusion, long term care, or "centralized refill" pharmacy locations.

21. PARTICIPATING PHARMACY acknowledges and agrees that the terms of this Exhibit D shall not apply to any Qualified Prescription Drugs that are provided in connection with the distribution of other third party offerings (e.g., home health, home infusion, mail order, durable medical equipment or long term care).

22. **Vaccine Administration.** If PARTICIPATING PHARMACY elects to administer "Part D Vaccines" (defined below), the following additional provisions shall apply:

22.1 **"Part D Vaccine"** means a specially prepared antigen, which upon administration to a person, will result in immunity, or any other definition that is required by applicable law, and: (i) must be administered by an "Immunizer" (defined below); (ii) the Part D Vaccine is administered to the Beneficiary at Participating Pharmacy's physical location; (iii) is for the benefit of a Beneficiary; (iv) is covered by the Beneficiary's Plan as communicated to PARTICIPATING PHARMACY by HEALTH NET or the claims processor through adjudication messaging or otherwise. Part D Vaccine's shall be deemed "Covered Pharmaceutical Services" under the Agreement, and that with respect to a Part D Vaccine, the term "dispense," as used in the Agreement, shall be interpreted to include the term "administer." Notwithstanding anything to the contrary in this Agreement, a Part D Vaccine shall not be deemed to be a Specialty Pharmaceutical, as such term is defined herein.

22.2 **"Immunizer"** means a Licensed Prescriber or other health care professional who is duly licensed and qualified under the laws of the jurisdiction in which the Part D Vaccine is administered, and who may, in the usual course of their practice, legally administer the Part D Vaccine to and: (i) who is employed by the Participating Pharmacy, or (ii) with whom the Participating Pharmacy has an established relationship facilitating the administration of the Part D Vaccine.

22.3 With respect to the administration of a Part D Vaccine, PARTICIPATING PHARMACY hereby represents, warrants and covenants to HEALTH NET that: (i) PARTICIPATING PHARMACY shall only submit Clean Claims for Part D Vaccines that have been directly administered to a Beneficiary by an Immunizer; (ii) that no one else is authorized or allowed to bill for or otherwise collect an "Administration Fee" (defined below) for administering the Part D Vaccine to a Beneficiary; and (iii) that any arrangements between PARTICIPATING PHARMACY and Immunizers to administer Part D Vaccines to Beneficiaries shall be subject to the terms and conditions of this Agreement and shall not violate the physician self-referral ("Stark") prohibition (section 1877 of the Social Security Act), the Federal anti-kickback statute (section 1128B(b) of the Social Security Act), or any other applicable Federal or State law or regulation.

22.4 PARTICIPATING PHARMACY acknowledges and agrees that the audit rights of HEALTH NET and any governmental agency set out in the Agreement, shall extend to the claims for reimbursement for Part D Vaccines, including without limitation the Administration Fee.

22.5 **"Administration Fee"** means the amount PARTICIPATING PHARMACY shall be entitled to for administering the Part D Vaccine to a Beneficiary. The Professional Dispensing Fees and the reimbursement rate for Part D Vaccines shall be as provided in Exhibit C of the Agreement and the Administration Fee shall be as follows:

❑ Administration Fee $19.33

22.6 The Administration Fee shall be submitted electronically in accordance with the provisions of the Agreement relating to submission of Clean Claims and any applicable CMS guidance and Health Net Policies pertaining to billing of Part D Vaccine administration costs. PARTICIPATING PHARMACY shall submit Clean Claims for both the Part D Vaccine and the Administration Fee using the NCPDP 5.1 standard. PARTICIPATING PHARMACY agrees to submit the Part D Vaccine and the Administration Fee as part of the same claim. PARTICIPATING PHARMACY shall prohibit any Immunizer administering Part D Vaccines hereunder from claiming separate reimbursement from HEALTH NET or any third party for any administration fees, dispense fees or ingredient costs for Part D Vaccines administered to Beneficiaries.

22.7 PARTICIPATING PHARMACY agrees to provide, at no additional charge to HEALTH NET, Payors and/or Beneficiaries any and all supplies and other materials as are necessary for the safe and proper administration of the Part D Vaccine, which supplies and materials may include, but not limited to syringes, gauze, band-aids, and alcohol prep pads.

22.8 HEALTH NET may, at its sole discretion, terminate this Section 22 of Exhibit D by providing PARTICIPATING PHARMACY with a ninety (90) day prior written notice of termination, and PARTICIPATING PHARMACY shall cease administering the Part D Vaccine to Beneficiaries within such ninety (90) day period. Termination of this Section 22 of Exhibit D, shall not affect any other term or condition of the Agreement, including Exhibit D, and all such remaining terms and conditions shall remain in full force and effect.

EXHIBIT E
CALIFORNIA ADDENDUM

1. **Scope and Application.** The terms and conditions set forth in this regulatory addendum (the "**Addendum**") shall amend and replace any inconsistent terms and conditions of the Agreement, the HEALTH NET policies and procedures, and/or other prior agreements between the parties whether oral or written, insofar as such agreements relate to business to be conducted by HEALTH NET Companies licensed in the State of California and to the extent that such provisions contradict any terms and conditions set forth in this Addendum. By way of explanation and not limitation of the foregoing, the terms and conditions set forth in this Addendum shall not apply to HEALTH NET business conducted outside the regulation of the State of California, or to entities other than Health Care Service Plans as defined in Cal. Health & Safety Code § 1345.

2. **Definitions and Meanings.** All capitalized terms used in this Addendum, if not herein defined, shall have the same meaning set forth in the Agreement.

   2.1 "**FDA**" means the United States Food and Drug Administration.

   2.2 Subsection 1.7 of the Agreement is amended by adding to the definition of "Clean Claim" the following:

   "For the purposes of this Agreement, a claim, or portion thereof, if separable, including: 1) a universal claim form and data set approved by the National Council on Prescription Drug Programs and any state-designated data requirements in statutes or regulations; 2) attachments and supplemental information or documentation, which provides the minimum amount of itemized, accurate and material information generated by or in the possession of PARTICIPATING PHARMACY related to the billed services and the minimum amount of material information in the possession of third parties related to PARTICIPATING PHARMACY's billed services that are required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of HEALTH NET's liability, if any, and to comply with any governmental information requirements."

   2.3 Subsection 1.20 of the Agreement, defining "**Payor**", is amended by the addition of the following sentence: "PARTICIPATING PHARMACY acknowledges that it has a received a payor summary of all Payors currently eligible to claim the contracted rates under this Agreement and may obtain an updated payor summary from HEALTH NET within 30 days of a written request therefore." (See Exhibit B of the Agreement for a list of current payors).

3. Subsection 2.0.2, "**Eligibility Verification**," is amended by adding the following provision at the end of the section: "Notwithstanding any other provision of this Agreement, HEALTH NET shall not rescind or modify a Prior Authorization after PARTICIPATING PHARMACY has filled a medical prescription in good faith through the Point of Sale System and pursuant to the Prior Authorization.

4. **Claims Processing.** The last sentence of Subsection 2.1.1.B, "**Manual Claims**," is deleted in its entirety and replaced by the following: "Any manually submitted claim must be submitted within ninety (90) days of the date of compounding and/or dispensing to a Beneficiary."

5. Subsection 2.1.13, "**Comply with All HEALTH NET Policies and Procedures**," is amended by adding the following paragraph thereto:

   "If HEALTH NET amends any material provision of Health Net Policies and procedures that apply to this Agreement, HEALTH NET shall give PARTICIPATING PHARMACY at least 45 working days

prior written notice of such amendment. If PARTICIPATING PHARMACY objects to the amendment, it may negotiate an acceptable change thereto or may give HEALTH NET notice of PARTICIPATING PHARMACY'S intent to terminate this Agreement before implementation of the change against PARTICIPATING PHARMACY. PARTICIPATING PHARMACY'S failure to object to any proposed amendment to a Health Net Policy and Procedure before it is implemented shall be deemed to constitute PARTICIPATING PHARMACY'S agreement thereto. Notwithstanding PARTICIPATING PHARMACY'S right to terminate this Agreement if it does not agree to any proposed amendment of Health Net Policies and procedures, PARTICIPATING PHARMACY shall not terminate this Agreement without providing HEALTH NET with at least ninety (90) days prior written notice of PARTICIPATING PHARMACY'S intent to terminate this Agreement."

6. Subsection 2.1.14, "**Non-Discrimination**," is amended by adding the following provision thereto:

"PARTICIPATING PHARMACY and its subcontractors: 1) shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40) or gender; 2) shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination; 3) shall comply with the provisions of the Fair Employment & Housing Act (Cal. Government Code § 12990, et seq.) and the applicable regulations promulgated thereunder (2 C.C.R. § 7285.0, et seq.)--the applicable regulations of the Fair Employment & Housing Commission implementing Cal. Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the C.C.R. are incorporated into this Agreement by reference and made a part hereof as if set forth in full; 4) shall meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds; 5) shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements."

7. The following Subsection 2.1.21, "**Surcharges and Copayments**" is added:

"**Reporting Surcharges and Copayments.** PARTICIPATING PHARMACY shall report to HEALTH NET in writing, or other electronic means, all Ancillary Charges, Copayments, Coinsurance or Deductibles and/or fees for non-Covered Pharmaceutical Services ("Surcharges") paid by Beneficiaries directly to PARTICIPATING PHARMACY. PARTICIPATING PHARMACY may not charge or collect from Beneficiaries any fees or monies for Covered Pharmaceutical Services other than those specifically permitted by this Agreement."

8. Subsection 2.2.1 of the Agreement, "**Records Maintenance**", the definition of "Claims record logs" is deleted and replaced with the following:

"**Claims records logs**" means "all books, records and papers relating to the pharmacy services provided to Beneficiaries, to the cost thereof, and to payments received by PARTICIPATING PHARMACY from Beneficiaries (or from others on their behalf), including but not limited to prescriptions received, claim forms, signatures logs, and invoices, for audit at any reasonable time for a period of six (6) years following the date of provision of Covered Pharmaceutical Services."

9. Subsection 2.2.3, "**Audit**," is amended by deleting the provisions that begin with the sentence, "When the audit or retrospective utilization review performed by HEALTH NET...discloses that PARTICIPATING PHARMACY has been overpaid....", and continuing to the end of the subsection; and replacing it with the following:

"When the audit or retrospective utilization review performed by HEALTH NET or its designated representatives discloses that PARTICIPATING PHARMACY has been overpaid under this

Agreement, PARTICIPATING PHARMACY shall reimburse HEALTH NET within 30 working days of the receipt by PARTICIPATING PHARMACY of any notice of overpayment of a claim ("Notice of Overpayment") that was originally paid within 365 days of the Notice of Overpayment or shall contest HEALTH NET'S Notice of Overpayment (The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider). HEALTH NET may, but shall not be required to, offset the amount of any uncontested overpayment against any current or future obligation to PARTICIPATING PHARMACY. PARTICIPATING PHARMACY may dispute findings by HEALTH NET made under this **Section 2.2.3** by submitting a written provider dispute to Health Net of California in accordance with Section 4.12 hereof. Such dispute must be made within thirty (30) working days following PARTICIPATING PHARMACY's receipt of the Notice of Overpayment. If after any such reconsideration HEALTH NET determines that an overpayment was in fact made, HEALTH NET may proceed to offset the amount of the overpayment against any current or future obligations to PARTICIPATING PHARMACY."

10. Subsection 4.5, "**Payment in Full**" is deleted in its entirety and replaced with the following:

"For Covered Pharmaceutical Services provided to Beneficiaries in accordance with this Agreement, the entity obligated to provide or arrange for Covered Pharmaceutical Services or compensation therefor under a Benefit Program, be it HNCA or another HEALTH NET Company or an applicable Payor (collectively, the "Risk Bearing Entity"), shall pay PARTICIPATING PHARMACY, either directly or through its claims processor, such compensation as is specified in **Exhibit C** attached hereto and incorporated herein by this reference. A check remittance detail shall be provided with each payment. Except as otherwise provided herein, PARTICIPATING PHARMACY shall accept such payment by the applicable Risk Bearing Entity in accordance with this Agreement as complete and full discharge of the liability of HEALTH NET, any HEALTH NET Company, Payor, and Beneficiaries for the rendering of Covered Pharmaceutical Services. PARTICIPATING PHARMACY agrees to look only to the applicable Risk Bearing Entity for reimbursement."

11. Subsection 4.7, "**Billing Requirements**" is deleted and replaced by the following:

"PARTICIPATING PHARMACY shall, within ninety (90) days of the date of compounding and/or dispensing a prescription to a Beneficiary (the "Claim Filing Deadline"), submit to HEALTH NET's designated claims processing agent a claim for payment via electronic Point-of-Sale System data transmission in a format acceptable to both parties. Transmission charges for claims shall be paid by PARTICIPATING PHARMACY and processing charges for claims shall be the responsibility of HEALTH NET. Time is of the essence with respect to the Claim Filing Deadline with respect to both paper and electronic claims. If PARTICIPATING PHARMACY fails to submit to HEALTH NET'S claim processor any claim for payment of Covered Pharmaceutical Services within the time frame set forth in this **Subsection 4.7**, then the Risk Bearing Entity (defined in Subsection 4.5) shall be under no further obligation to pay PARTICIPATING PHARMACY for such Covered Pharmaceutical Services included on any such claim, subject to limited exceptions for good cause and determined in HEALTH NET'S sole discretion. In no event shall PARTICIPATING PHARMACY seek payment from any Beneficiary in the event a Risk Bearing Entity denies liability for any claim that PARTICIPATING PHARMACY did not submit to HEALTH NET within the ninety (90) day time frame."

12. Subsection 4.10, "**Rates Revisions**," is amended by deleting two references to "thirty (30) days" and replacing these references with "forty-five (45) working days".

13. Subsection 4.11, "**Beneficiary Hold Harmless**" is amended by adding the following provision thereto:

"If HEALTH NET receives notice of any attempt to collect or the receipt of any such additional charges by PARTICIPATING PHARMACY, HEALTH NET shall take appropriate action.

PARTICIPATING PHARMACY shall promptly refund any payment deemed improper by HEALTH NET to the party who made the payment."

14. Subsection 4.12, "**Disputes**," is added to the Agreement as follows:

"PARTICIPATING PHARMACY may dispute any HEALTH NET action that adjusts, denies, or contests a claim, billing practice, or other contractual provision only if PARTICIPATING PHARMACY provides written notice of its dispute to HEALTH NET within three hundred sixty five (365) days of HEALTH NET'S action or in the case of inaction, within 365 days after the time for contesting or denying claims, as defined in section 1300.71(h) of Title 28 of the California Code of Regulations, has expired, and PARTICIPATING PHARMACY otherwise submits any notice of dispute to the following address:

Health Net of California
Provider Appeals
P.O. Box 10406
Van Nuys, CA 91410-0406.

For instructions, forms, and additional information on how to file a provider dispute, visit the provider section (California region) of Health Net's website at www.healthnet.com or call 1-800-641-7761

HEALTH NET shall issue a written determination stating the pertinent facts and explaining the reasons for its determination of PARTICIPATING PHARMACY'S dispute within 45 working days after the date of receipt of the dispute or amended dispute (if additional information is needed from PARTICIPATING PHARMACY to allow HEALTH NET to fairly review the disputed claim or issue)."

15. Subsection 10.7, "**Amendments**," is deleted in its entirety and replaced with the following:

"No amendment to this Agreement shall be effective unless in writing and signed by the parties or their respective authorized representatives. If HEALTH NET intends to amend a material term of this Agreement, it shall provide at least forty-five (45) working days advance written notice of the proposed amendment to PARTICIPATING PHARMACY. Any subsequent understanding between the parties, whether oral or written, not formally denominated and executed as an amendment to this Agreement, which authorizes or approves any course of performance deviating from the terms hereof, shall be presumed to be a temporary waiver, revocable at the will of either party and not an amendment to the provisions of this Agreement, regardless of the duration of such understanding."

Notwithstanding the foregoing, HEALTH NET may amend this Agreement to the extent necessary to comply with applicable Federal and State law, regulatory requirements, accreditation standards or licensing guidelines or rules. Any such amendment shall be effective no sooner than forty five (45) working days after HEALTH NET gives notice of the amendment to PARTICIPATING PHARMACY unless the applicable law, regulatory requirement, accreditation standard or licensing guidelines or rules require a shorter time frame for compliance.

EXHIBIT E
OREGON REGULATORY ADDENDUM

1. **Scope and Application.** The terms and conditions set forth in this regulatory addendum (the "**Addendum**") shall amend and replace any inconsistent terms and conditions of the Agreement, the HEALTH NET policies and procedures, and/or other prior agreements between the parties whether oral or written, insofar as such agreements relate to business to be conducted by HEALTH NET Companies licensed in the State of Oregon and to the extent that such provisions contradict any terms and conditions set forth in this Addendum. By way of explanation and not limitation of the foregoing, the terms and conditions set forth in this Addendum shall not apply to HEALTH NET business conducted outside the regulation of the State of Oregon, and shall only apply to Managed Health Insurance as defined in O.R.S. 743.801(9).

2. **Definitions and Meanings.** All capitalized terms used in this Addendum, if not herein defined, shall have the same meaning set forth in the Agreement.

3. Section 8.2 of the Agreement, **"Termination,"** shall be amended by adding new Subsection 8.2(I) as follows:

   If HEALTH NET intends to terminate or nonrenew this Agreement due to issues relating to quality of patient care rendered by the PARTICIPATING PHARMACY, HEALTH NET shall grant to a PARTICIPATING PHARMACY the opportunity to cure any such quality of care issues within thirty (30) days under procedures determined by HEALTH NET to be fair under the circumstances, taking into account any patient-safety related concerns.

4. **Right to Accounting.** Upon request by a PARTICIPATING PHARMACY, HEALTH NET shall provide an annual accounting accurately summarizing the financial transactions between the parties to this Agreement for the previous contract year.

5. **Withdrawal.** HEALTH NET shall allow a PARTICIPATING PHARMACY to withdraw from the care of a Beneficiary when, in the professional judgment of a PARTICIPATING PHARMACY, it is in the best interest of the Beneficiary to do so.

6. **Continuity of Care.** In the event of termination of this Agreement for any reason other than those included in O.R.S. 743.854 (5)(a), Provider shall continue to provide services to a specific Beneficiary under the following circumstances:

   6.1 The Beneficiary is undergoing an active course of treatment with Provider on the date this Agreement would otherwise terminate; and

   6.2 The benefits related to that course of treatment under the Beneficiary's Benefit Program would either be eliminated or reduced below out-of-network levels if the Beneficiary continued to receive services from Provider for that course of treatment; and

   6.3 The Beneficiary and Provider must agree that continuing that course of the treatment with the Provider is in the best interests of the Beneficiary; and

   6.4 Provider agrees to deliver such services according to the terms and provisions of this Agreement, including payment rates set forth in this Agreement, as if this Agreement had not terminated.

If all of the above are true, this Agreement will continue to apply to such course of treatment for that Beneficiary, for the duration allowed under Oregon statute. Once the period of continuation ends, the provisions of this Section will cease to apply and any further services the Beneficiary receives from Provider will be treated as if this Agreement does not exist.

EXHIBIT E
WASHINGTON REGULATORY ADDENDUM

1. **Scope and Application.** The terms and conditions set forth in this regulatory addendum (the "**Addendum**") shall amend and replace any inconsistent terms and conditions of the Agreement, the HEALTH NET policies and procedures, and/or other prior agreements between the parties whether oral or written, insofar as such agreements relate to business to be conducted by HEALTH NET Companies licensed in the State of Washington and to the extent that such provisions contradict any terms and conditions set forth in this Addendum. By way of explanation and not limitation of the foregoing, the terms and conditions set forth in this Addendum shall not apply to HEALTH NET business conducted outside the regulation of the State of Washington, or to entities other than Health Carriers as defined in W.A.C. 284-43-130.

2. Definitions and Meanings. All capitalized terms used in this Addendum, if not herein defined, shall have the same meaning set forth in the Agreement.

3. Section 4.6, **"Prompt Payment,"** is amended deleted and replaced with the following:

4.6 **Prompt Payment.**

A. For all compensation due to PARTICIPATING PHARMACY under this Agreement, HEALTH NET shall pay in accordance with the following minimum standard:

i. Ninety-five percent (95%) of the monthly volume of Clean Claims ("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") shall be paid within thirty (30) days of receipt by HEALTH NET or its billing agent; and

ii. Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt by HEALTH NET or its billing agent, except as agreed to in writing by the parties on a claim-by-claim basis.

B. The receipt date of a claim is the date HEALTH NET or its billing agent receives either written or electronic notice of the claim.

C. HEALTH NET has established reasonable methods for confirming receipt of claims and responding to PARTICIPATING PHARMACY inquiries about claims.

D. HEALTH NET shall pay interest on undenied claims failed to be paid as established in this Section and unpaid Clean Claims more than sixty-one (61) days old until HEALTH NET 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. HEALTH NET shall add the interest payable to the amount of the unpaid claim without the necessity of PARTICIPATING PHARMACY submitting an additional claim. Any interest paid under this Section shall not be applied by HEALTH NET to a HEALTH NET Beneficiary's deductible, copayment, coinsurance, or any similar obligation.

E. HEALTH NET shall communicate denial of a claim to PARTICIPATING PHARMACY, including the specific reason why HEALTH NET denied the claim. If the denial is based upon medical necessity or similar grounds, then HEALTH NET, upon request of PARTICIPATING PHARMACY, must also promptly disclose the supporting basis for the decision.

F. The requirements of this Section shall not apply to claims about which there is substantial evidence of fraud or misrepresentation by PARTICIPATING PHARMACY or instances where HEALTH NET has not been granted reasonable access to information.

G. The parties are not required to comply with this Section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

4. Amend Section 4.11, **"Beneficiary Hold Harmless,"** by deleting paragraph B, redesignating the current Paragraph C to Paragraph G and inserting the following:

B. PARTICIPATING PHARMACY agrees, in the event of HEALTH NET'S insolvency, to continue to provide the Covered Pharmaceutical Services to HEALTH NET for the duration of the period for which premiums on behalf of the Beneficiary were paid to HEALTH NET or until the Beneficiary's discharge from inpatient facilities, whichever time is greater

C. Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the HEALTH NET Beneficiary's health plan.

D. PARTICIPATING PHARMACY may not bill the HEALTH NET Beneficiary for covered services (except for deductibles, copayments, ancillary charges or coinsurance) where HEALTH NET denies payments because PARTICIPATING PHARMACY has failed to comply with the terms or conditions of this contract.

E. If PARTICIPATING PHARMACY contracts with other providers or facilities who agree to provide Covered Pharmaceutical Services to HEATLH NET Beneficiaries with the expectation of receiving payment directly or indirectly from HEALTH NET, such providers or facilities must agree to abide by the provisions of Section 4.11.

F. In accordance with Washington state law, PARTICIPATING PHARMACY and its subcontractors are hereby notified that willfully collecting or attempting to collect an amount from a HEALTH NET Beneficiary knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

5. Section 9.3 is deleted and replaced with the following:

9.3 Non-Binding Obligation.

A. Each party agrees to notify the other at the earliest possible reasonable time in the event of any dispute which is potentially arbitratable, or in the event that either party becomes aware of facts or circumstances which indicate that a reasonable possibility of litigation with any third party relating to any rights, duties, or obligations provided for under this Agreement may be forthcoming. Prior to invoking arbitration, the parties agree to make a reasonable effort to settle any dispute in an informal and expeditious manner and in accordance with any procedures set forth by HEALTH NET. The parties separately and specifically agree that if either shall contend that this Agreement is invalid or that grounds exist for its recession or cancellation, that any dispute concerning such contention shall be submitted to arbitration in the manner provided in this section. Each party shall bear its own attorneys' fees in any arbitration proceeding; however, if either party commences an action in court to compel arbitration, enforce an arbitration award, or otherwise seek by judicial means

to secure compliance with the arbitration provisions of this Agreement, then the prevailing party shall be entitled to recover from the losing party the prevailing party's reasonable attorneys' fees and costs of suit incurred for such purposes.

B. Any material breach of this Agreement, other than a deliberate refusal to provide Covered Pharmaceutical Services as set forth in **Section 8.2(D)**, shall give rise to all causes of actions and remedies allowable by law. To expedite resolution of any dispute arising under this Agreement, the parties hereby agree to submit such disputes to non-binding arbitration as follows:

C. Any dispute arising over the terms and conditions of this Agreement or in any other matter related to this Agreement, including, but not limited to, the calculation of compensation hereunder, whether in contract or in tort, which the parties are unable to resolve between themselves shall be submitted, upon the motion or written request of either party, to arbitration under the appropriate rules of the American Arbitration Association ("**AAA**").

D. The parties agree that the decision of the arbitrator shall not be final or binding as to each of them. The AAA administrative fee shall be advanced by the initiating party subject to final apportionment by the arbitrator. The administrative fee, costs of the arbitration, and the arbitrator's fee shall be shared as allocated by the arbitrator.

E. This arbitration clause shall not deprive either party of its right to seek judicial remedies; however, PARTICIPATING PHARMACY may not seek judicial remedy prior to a good faith effort to participate in and complete an alternative dispute resolution process.

RX AMERICA
221 N Charles Lindbergh Drive
Salt Lake City, Utah 84116

AMENDMENT TO PHARMACY NETWORK AGREEMENT

This Amendment (the "Amendment") to the Pharmacy Network Agreement between RxAmerica LLC ("ADMINISTRATOR") and _____ ("PHARMACY") is effective July 21, 2008.

WHEREAS ADMINISTRATOR and PHARMACY have previously entered into a Pharmacy Network Agreement under which PHARMACY participates in ADMINISTRATOR's pharmacy network and dispenses Covered Drugs to Eligible Persons enrolled in Benefit Plans administered by ADMINISTRATOR;

WHEREAS ADMINISTRATOR and PHARMACY have previously entered into one or more a Medicare Amendments to Pharmacy Network Agreement (the "Medicare Amendments") under which PHARMACY dispenses Covered Drugs to Beneficiaries of (1) Medicare Prescription Drug Plans ("PDPs") sponsored by ADMINISTRATOR, or (2) Medicare Advantage Prescription Drug plans ("MA-PDs") administered by ADMINISTRATOR (the Pharmacy Network Agreement between ADMINISTRATOR and PHARMACY, as amended, is hereinafter referred to as the "Agreement");

WHEREAS Section 2(d) of the Agreement provides that ADMINISTRATOR may make available to PHARMACY the opportunity to participate as a provider for a Benefit Plan which may be limited by geographic region or provide for reimbursement rates or contractual terms which differ from those provided in the Agreement;

WHEREAS Section 5(d) of the Agreement provides that ADMINISTRATOR may modify the Prescription Charge set forth in the Agreement by giving PHARMACY thirty (30) days prior notice of such modification;

WHEREAS Section 15 of the Agreement provides that ADMINISTRATOR may amend the Agreement or its Exhibits by giving prior written notice of an amendment to PHARMACY; and,

WHEREAS ADMINISTRATOR desires to make available to PHARMACY the opportunity to participate as a provider for PDPs sponsored by RxAMERICA and to modify the Prescription Charge with respect to such PDPs and the Agreement as set forth herein.

NOW, THEREFORE, ADMINISTRATOR hereby amends the Agreement as follows:

Article I. Definitions

Unless otherwise specified herein, capitalized terms in this Amendment have the same meaning as set forth in the Agreement.

Article II. Amendment of Agreement

2.1 Section 1(h) of the Agreement is hereby deleted in its entirety and replaced with the following provision:

> "(h) "MAXIMUM ALLOWABLE COST LIST" or "MAC LIST" means the list of Covered Drugs adopted by an Eligible Person's Benefit Plan that will be reimbursed to PHARMACY at the compensation level established by ADMINISTATOR. The MAC LIST is subject to periodic review and modification by ADMINISTRATOR."

2.2. The following provision is hereby added as Section 2.6 of the Medicare Amendments:

> "2.6 "SPECIALTY DRUGS" means those drugs set forth in Schedule 1 to Attachment A-2 to this Amendment."

2.3 The Medicare Amendments are hereby amended to add Attachment A-2 to this Amendment.

III. Effect on Agreement

3.1 Except as otherwise expressly provided in this Amendment, all terms and conditions of the Agreement remain in full force and effect.

3.2 Governing Law; Dispute Resolution; Adjustments.

(a) This Amendment shall be governed by and construed in accordance with the laws of the State of Utah without regard to choice of law provisions. The parties further agree that the exclusive venue for any dispute pertaining to this Amendment shall be courts sitting in the State of Utah, County of Salt Lake. In the event this Section 3.2(a) is inconsistent with Article 16 of the Agreement, Article 16 of the Agreement shall control.

(b) All disputes arising out of this Amendment that are not resolved by ADMINISTRATOR and PHARMACY shall be resolved exclusively by a court of competent jurisdiction, sitting without jury. THE PARTIES HEREBY WAIVE ANY RIGHT TO TRIAL BY JURY IN ANY PROCEEDING ARISING OUT OF OR RELATING TO THIS AMENDMENT, WHETHER NOW EXISTING OR HEREAFTER ARISING, AND WHETHER SOUNDING IN CONTRACT, TORT OR OTHERWISE. THE PARTIES AGREE THAT ANY OF THEM MAY FILE A COPY OF THIS PARAGRAPH WITH ANY COURT AS WRITTEN EVIDENCE OF THE KNOWING, VOLUNTARY AND

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BARGAINED-FOR AGREEMENT AMONG THE PARTIES IRREVOCABLY TO WAIVE TRIAL BY JURY AND THAT ANY PROCEEDING WHATSOEVER BETWEEN THEM RELATING TO THIS AMENDMENT SHALL INSTEAD BE TRIED IN A COURT OF COMPETENT JURISDICTION BY A JUDGE SITTING WITHOUT A JURY.

(c) If any proceeding is brought for the enforcement of this Amendment, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Amendment, the successful or prevailing party shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it may be entitled.

3.3 Headings. The headings contained in this Amendment are for reference purposes only and shall not affect in any way the meaning or interpretation of this Amendment.

3.4 Severability. The invalidity of any term or terms of this Amendment shall not affect any other term of this Amendment, which shall remain in full force and effect.

IN WITNESS WHEREOF, ADMINISTRATOR has executed this Amendment as set forth below.

ADMINISTRATOR RxAmerica L.L.C.		PHARMACY	
By:	_____ Signature	By:	_____ Signature
	Todd Meek Name		_____ Name
	V.P. Insurance Based Operations Title		_____ Title
Address:	221 N Charles Lindbergh Dr. Salt Lake City, UT 84116-2902	Address:	_____ _____
Email:	Network.contracts@rxamerica.com	Phone:	_____
Fax :	(801) 961-6336	Fax :	_____
		Chain Code(s):	_____
		NABP#(s):	_____
		NPI#(s):	_____

ATTACHMENT A-2

TO

MEDICARE AMENDMENT TO PHARMACY NETWORK AGREEMENT

SELECTED PAYOR PHARMACY COMPENSATION

For each Covered Drug provided to an Eligible Person, as defined in the Medicare Amendments, of a payor identified on Schedule 2 of this Attachment A-2, ADMINISTRATOR shall pay PHARMACY the applicable Prescription Charge set forth below, less any applicable Copayment:

RETAIL PHARMACY.

1 -34 Day Supply
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 16%, plus a $1.50 dispensing fee;
- MAC List price, plus a $2.00 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 25%, plus a $2.00 dispensing fee;
- MAC List price, plus a $2.00 dispensing fee; or,
- Usual and Customary Charge.

35 – 74 Day Supply
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 18%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 60%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

75 Day Supply of Greater
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 21%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 60%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Specialty Drugs: The applicable rate set forth in Schedule 1 to this Attachment A-2.

SCHEDULE 1
TO ATTACHMENT A-2

TO

MEDICARE AMENDMENT TO PHARMACY NETWORK AGREEMENT

SELECTED PAYOR PHARMACY COMPENSATION

ADMINISTRATOR shall pay PHARMACY the applicable rate set forth herein for each Covered Drug set forth below provided to an Eligible Member, as defined in the Medicare Amendments, of a payor identified on Schedule 2 of this Attachment A-2. ADMINISTRATOR may modify this Schedule 1 from time-to-time as provided for in the Agreement

GPI	Discount	GPI	Discount	GPI	Discount
12102530006420	-18	21100028002120	-13	21200055001310	-18
12108085002020	-17	21100028002130	-13	21300003001920	-18
12353040102220	-18	21100040002105	-18	21300005000320	-18
12353060052020	-18	21101020000305	-22	21300007002010	-22
12353060056420	-18	21101020000310	-22	21300010002010	-22
12353060056440	-18	21101020002120	-22	21300010002040	-22
12353060106416	-18	21101020002125	-22	21300010002105	-22
12353060106424	-18	21101020002130	-22	21300010002110	-22
12353060106430	-18	21101020002155	-22	21300010002115	-22
12353070000120	-18	21101020002160	-22	21300010002120	-22
12353070000320	-19	21101020002165	-22	21300020002105	-22
12353070000340	-34	21101020002170	-22	21300025102020	-17
12353070000360	-33	21101025002020	-22	21300025102120	-17
12353070002020	-18	21101025002110	-22	21300030002010	-25
12353070006320	-32	21101025002130	-22	21300034102110	-18
12995002606410	-18	21101030102105	-18	21300034102140	-18
12995002606420	-18	21101040000305	-18	21300053102110	-18
12995002606430	-18	21102030002105	-18	21300053102120	-18
16403070102110	-18	21104070000110	-18	21353010002020	-18
19100005002200	-17	21104070000120	-18	21353010002040	-18
19100020102005	-17	21104070000140	-18	21353025002020	-18
19100020102010	-18	21104070000143	-18	21353060001310	-18
19100020102113	-18	21104070000147	-18	21353070002120	-18
19100020102115	-18	21104070000150	-18	21355030202120	-18
19100020102117	-17	21200010102105	-22	21358070001320	-13
19100020102120	-18	21200010102115	-22	21403530002020	-18
19100020102125	-18	21200030102105	-22	21405005102310	-19
19100020102130	-18	21200030102120	-22	21405005102330	-19
19100020102210	-30	21200030102210	-22	21405010102005	-18
19100050002220	-17	21200040102010	-21	21405010106405	-18
21100010002020	-13	21200040102105	-21	21405010106407	-18
21100015002025	-22	21200040102110	-21	21405010106410	-18
21100015002110	-22	21200040102115	-21	21405010106415	-18
21100015002120	-22	21200042102020	-18	21405010106450	-18
21100015002140	-22	21200045102020	-22	21405010106455	-18
21100020002010	-22	21200050002105	-22	21405010106460	-18
21100028002020	-13	21200050002110	-22	21405010106480	-18

GPI	Discount	GPI	Discount	GPI	Discount
21405010156420	-18	21758050000320	-22	30201010102060	-18
21405010156430	-18	21758050002010	-22	30905070000110	-18
21405010156432	-18	21764065002120	-18	30905070002020	-18
21405010206430	-18	21764065002140	-18	30906550002020	-18
21405010206435	-18	21990002406440	-22	40143060100320	-18
21405010256445	-18	21990002406470	-22	40170060002020	-18
21405515001920	-18	22100010002010	-21	40180050002120	-6
21500005001320	-18	22109902101810	-21	45100010102108	-18
21500010002020	-18	30042090001320	-18	45100010102110	-18
21500012001320	-18	30043020002020	-19	45100010102118	-18
21500015002020	-18	30043020002080	-19	45100010102120	-18
21500020102005	-18	30044070002020	-18	45304020002010	-17
21500030102020	-18	30062020002140	-17	50250035102001	-18
21500050802020	-18	30062022052220	-18	50250035102010	-18
21533070300120	-18	30062030052020	-20	50250065002020	-18
21533070300130	-18	30062030052110	-20	50280020006320	-18
21533070300140	-18	30062030052115	-20	52505040002120	-18
21534020000320	-18	30062030052130	-20	56500010002010	-30
21534020000340	-18	30062030052140	-20	59157060002120	-13
21534020000350	-18	30062030052150	-20	62400030106420	-18
21534025000320	-18	30062030056420	-20	62403060452020	-18
21534025000340	-18	30062030102003	-20	62403060452040	-18
21534025000360	-18	30062030102006	-20	62403060452060	-18
21534035100320	-18	30062030102020	-20	62403060456420	-18
21534035100340	-18	30062030102030	-20	62403060456430	-18
21536015002120	-18	30062030102040	-20	62403060502120	-18
21550040102020	-18	30062030102115	-20	66200030002015	-18
21600040002220	-18	30062050002105	-25	66260010002020	-18
21600040002240	-18	30062050002155	-25	66270015006420	-18
21700008102020	-18	30100010002120	-19	66290030002020	-18
21700013001940	-22	30100020002020	-18	66290030006420	-18
21700020002105	-22	30100020002056	-17	7000070002520	-18
21700020002110	-22	30100020002062	-17	74400020052120	-18
21700045002120	-18	30100020002120	-17	74400020102020	-18
21700060106420	-18	30100020002121	-19	74503070000320	-18
21700060106430	-18	30100020002123	-19	75800040002220	-18
21700060106440	-18	30100020002125	-19	75800060002020	-18
21700060202022	-18	30100020002132	-19	75800070102020	-18
21700060202030	-18	30100020002134	-19	82300040002010	-18
21700060202120	-18	30100020002168	-19	82300048002020	-18
21700060202130	-18	30100020002170	-19	82401015112010	-18
21700060202135	-18	30100020002174	-19	82401015112020	-18
21700060202140	-18	30100020002176	-19	82401015112050	-18
21700060202160	-18	30100020002180	-19	82401015112075	-18
21700060206420	-18	30100020002182	-19	82401020002010	-18
21700060206440	-18	30100020002184	-19	82401020002015	-18
21700060206450	-18	30100020006430	-19	82401020002020	-18
21700060206460	-18	30100020102132	-19	82401020002040	-18
21700060206470	-18	30150080102130	-18	82401020002050	-18
21703020002120	-18	30150080102140	-18	82401020002060	-18
21707070102140	-18	30170070102005	-18	82401520002010	-18
21754040002120	-18	30201010102015	-18	82401520002020	-18
21754040002140	-18	30201010102030	-18	82401570002020	-18

GPI	Discount	GPI	Discount	GPI	Discount
82402050002025	-18	85100010006475	-25	90372030002020	-22
82402050002030	-18	85100010102120	-18	90372030002050	-22
82402050002120	-18	85100010206420	-31	93000020102110	-18
82403060002120	-18	85100010206450	-18	93000020102130	-21
83101010102215	-18	85100015102120	-18	94200087102120	-18
83101010102220	-18	85100015102122	-18	94200090102120	-18
83101010102240	-18	85100015102130	-18	96900010002900	-22
83101020102010	-18	85100015102132	-18	99402020000110	-18
83101020102020	-18	85100015102140	-18	99402020000140	-18
83101080102040	-18	85100015102144	-18	99402020002005	-18
83103030102030	-18	85100015102160	-25	99402020002010	-18
83334050102120	-13	85100015102170	-25	99402540102220	-13
85100010002109	-25	85100015102180	-25	99402540302120	-18
85100010002110	-25	85100015102190	-25	99403030100120	-13
85100010002112	-25	85100020002100	-20	99403030100330	-13
85100010002125	-25	85100026202140	-25	99404070000320	-17
85100010002130	-25	85100028002125	-25	99404070000330	-17
85100010002139	-25	85100028002160	-25	99404070002020	-17
85100010002140	-25	85100028002170	-25	99404080000105	-18
85100010002143	-25	85100028002180	-25	99404080000110	-19
85100010002147	-25	85100030002105	-20	99404080000120	-20
85100010006410	-25	85100030002170	-30	99405015002110	-13
85100010006430	-25	85100030002180	-20	99405030001320	-17
85100010006460	-25	85400010002015	-17		

SCHEDULE 2
TO ATTACHMENT A-2

TO

MEDICARE AMENDMENT TO PHARMACY NETWORK AGREEMENT

SELECTED PAYOR PHARMACY COMPENSATION

The Prescription Charges set forth in Attachment A-2 shall apply to each Covered Drug provided to an Eligible Member, as defined in the Medicare Amendments, of a payor identified below. ADMINISTRATOR may modify this Schedule 2 from time-to-time as provided for in the Agreement.

PDPs sponsored by ADMINISTRATOR

RX AMERICA
221 N Charles Lindbergh Drive
Salt Lake City, Utah 84116

AMENDMENT TO PHARMACY NETWORK AGREEMENT

This Amendment (the "Amendment") to the Pharmacy Network Agreement between RxAmerica LLC ("ADMINISTRATOR") and _____ ("PHARMACY") is effective July 21, 2008.

WHEREAS ADMINISTRATOR and PHARMACY have previously entered into a Pharmacy Network Agreement under which PHARMACY participates in ADMINISTRATOR's pharmacy network and dispenses Covered Drugs to Eligible Persons enrolled in Benefit Plans administered by ADMINISTRATOR;

WHEREAS Section 5(d) of the Agreement provides that ADMINISTRATOR may modify the Prescription Charge set forth in the Agreement by giving PHARMACY thirty (30) days prior notice of such modification;

WHEREAS Section 15 of the Agreement provides that ADMINISTRATOR may amend the Agreement or its Exhibits by giving prior written notice of an amendment to PHARMACY; and,

WHEREAS ADMINISTRATOR desires to modify the Prescription Charge and to amend the Agreement as set forth herein.

NOW, THEREFORE, ADMINISTRATOR hereby amends the Agreement as follows:

Article I. Definitions

Unless otherwise specified herein, capitalized terms in this Amendment have the same meaning as set forth in the Agreement.

Article II. Amendment of Agreement

2.1 Section 1(h) of the Agreement is hereby deleted in its entirety and replaced with the following provision:

> "(h) "MAXIMUM ALLOWABLE COST LIST" or "MAC LIST" means the list of Covered Drugs adopted by an Eligible Person's Benefit Plan that will be reimbursed to PHARMACY at the compensation level established by

ADMINISTATOR. The MAC LIST is subject to periodic review and modification by ADMINISTRATOR."

2.2. The following provision is hereby added as Section 1(o) of the Agreement:

"(o) "SPECIALTY DRUGS" means those drugs set forth in Schedule A to Exhibit 1 to this Agreement."

2.3 The Agreement is hereby amended to add Exhibit 1 to this Amendment.

III. Effect on Agreement

3.1 Except as otherwise expressly provided in this Amendment, all terms and conditions of the Agreement remain in full force and effect. Without limiting the foregoing sentence, this Amendment does not modify the Prescription Charge set forth in the Medicare Amendment to Pharmacy Network Agreement, nor any Prescription Charge applicable to particular Benefit Plans as specified under the terms of a prior amendment to the Agreement.

3.2 Governing Law; Dispute Resolution; Adjustments.

(a) This Amendment shall be governed by and construed in accordance with the laws of the State of Utah without regard to choice of law provisions. The parties further agree that the exclusive venue for any dispute pertaining to this Amendment shall be courts sitting in the State of Utah, County of Salt Lake. In the event this Section 3.2(a) is inconsistent with Article 16 of the Agreement, Article 16 of the Agreement shall control.

(b) All disputes arising out of this Amendment that are not resolved by ADMINISTRATOR and PHARMACY shall be resolved exclusively by a court of competent jurisdiction, sitting without jury. THE PARTIES HEREBY WAIVE ANY RIGHT TO TRIAL BY JURY IN ANY PROCEEDING ARISING OUT OF OR RELATING TO THIS AMENDMENT, WHETHER NOW EXISTING OR HEREAFTER ARISING, AND WHETHER SOUNDING IN CONTRACT, TORT OR OTHERWISE. THE PARTIES AGREE THAT ANY OF THEM MAY FILE A COPY OF THIS PARAGRAPH WITH ANY COURT AS WRITTEN EVIDENCE OF THE KNOWING, VOLUNTARY AND BARGAINED-FOR AGREEMENT AMONG THE PARTIES IRREVOCABLY TO WAIVE TRIAL BY JURY AND THAT ANY PROCEEDING WHATSOEVER BETWEEN THEM RELATING TO THIS AMENDMENT SHALL INSTEAD BE TRIED IN A COURT OF COMPETENT JURISDICTION BY A JUDGE SITTING WITHOUT A JURY.

(c) If any proceeding is brought for the enforcement of this Amendment, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Amendment, the successful or prevailing party shall be entitled to recover reasonable attorneys'

fees and other costs incurred in that action or proceeding, in addition to any other relief to which it may be entitled.

3.3 Headings. The headings contained in this Amendment are for reference purposes only and shall not affect in any way the meaning or interpretation of this Amendment.

3.4 Severability. The invalidity of any term or terms of this Amendment shall not affect any other term of this Amendment, which shall remain in full force and effect.

IN WITNESS WHEREOF, ADMINISTRATOR has executed this Amendment as set forth below.

ADMINISTRATOR RxAmerica L.L.C.		PHARMACY	
By:	_____ Signature	By:	_____ Signature
	Todd Meek Name		_____ Name
	V.P. Insurance Based Operations Title		_____ Title
Address:	221 N Charles Lindbergh Dr. Salt Lake City, UT 84116-2902	Address:	_____ _____
Email:	Network.contracts@rxamerica.com	Phone:	_____
Fax :	(801) 961-6336	Fax :	_____
		Chain Code(s):	_____
		NABP#(s):	_____
		NPI#(s):	_____

EXHIBIT 1

TO

AMENDMENT TO PHARMACY NETWORK AGREEMENT

PHARMACY COMPENSATION

For each Covered Drug provided to an Eligible Person, ADMINISTRATOR shall pay PHARMACY the applicable Prescription Charge set forth below, less any applicable Copayment:

RETAIL PHARMACY NETWORK

1 – 34 Day Supply
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 16%, plus a $1.50 dispensing fee;
- MAC List price, plus a $1.75 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 16%, plus a $1.75 dispensing fee;
- MAC List price, plus a $1.75 dispensing fee; or,
- Usual and Customary Charge.

35 – 74 Day Supply
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 18%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 60%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

75 Day Supply or Greater
Brand Name Drugs: The lesser of:

- AWP of the package size used for the drug minus 21%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Generic Drugs: The lesser of:

- AWP of the package size used for the drug minus 60%, plus a $0.00 dispensing fee; or,
- Usual and Customary Charge.

Specialty Drugs: The applicable rate set forth in Schedule A to this Exhibit 1.

SCHEDULE A
TO EXHIBIT 1

TO

AMENDMENT TO PHARMACY NETWORK AGREEMENT

PHARMACY COMPENSATION

ADMINISTRATOR shall pay PHARMACY the applicable rate set forth herein for each Covered Drug set forth below provided to an Eligible Person. ADMINISTRATOR may modify this Schedule A from time-to-time as provided for in the Agreement.

GPI	Discount	GPI	Discount	GPI	Discount
12102530006420	-18	21100028002120	-13	21200055001310	-18
12108085002020	-17	21100028002130	-13	21300003001920	-18
12353040102220	-18	21100040002105	-18	21300005000320	-18
12353060052020	-18	21101020000305	-22	21300007002010	-22
12353060056420	-18	21101020000310	-22	21300010002010	-22
12353060056440	-18	21101020002120	-22	21300010002040	-22
12353060106416	-18	21101020002125	-22	21300010002105	-22
12353060106424	-18	21101020002130	-22	21300010002110	-22
12353060106430	-18	21101020002155	-22	21300010002115	-22
12353070000120	-18	21101020002160	-22	21300010002120	-22
12353070000320	-19	21101020002165	-22	21300020002105	-22
12353070000340	-34	21101020002170	-22	21300025102020	-17
12353070000360	-33	21101025002020	-22	21300025102120	-17
12353070002020	-18	21101025002110	-22	21300030002010	-25
12353070006320	-32	21101025002130	-22	21300034102110	-18
12995002606410	-18	21101030102105	-18	21300034102140	-18
12995002606420	-18	21101040000305	-18	21300053102110	-18
12995002606430	-18	21102030002105	-18	21300053102120	-18
16403070102110	-18	21104070000110	-18	21353010002020	-18
19100005002200	-17	21104070000120	-18	21353010002040	-18
19100020102005	-17	21104070000140	-18	21353025002020	-18
19100020102010	-18	21104070000143	-18	21353060001310	-18
19100020102113	-18	21104070000147	-18	21353070002120	-18
19100020102115	-18	21104070000150	-18	21355030202120	-18
19100020102117	-17	21200010102105	-22	21358070001320	-13
19100020102120	-18	21200010102115	-22	21403530002020	-18
19100020102125	-18	21200030102105	-22	21405005102310	-19
19100020102130	-18	21200030102120	-22	21405005102330	-19
19100020102210	-30	21200030102210	-22	21405010102005	-18
19100050002220	-17	21200040102010	-21	21405010106405	-18
21100010002020	-13	21200040102105	-21	21405010106407	-18
21100015002025	-22	21200040102110	-21	21405010106410	-18
21100015002110	-22	21200040102115	-21	21405010106415	-18
21100015002120	-22	21200042102020	-18	21405010106450	-18
21100015002140	-22	21200045102020	-22	21405010106455	-18
21100020002010	-22	21200050002105	-22	21405010106460	-18
21100028002020	-13	21200050002110	-22	21405010106480	-18

GPI	Discount	GPI	Discount	GPI	Discount
21405010156420	-18	21758050000320	-22	30201010102060	-18
21405010156430	-18	21758050002010	-22	30905070000110	-18
21405010156432	-18	21764065002120	-18	30905070002020	-18
21405010206430	-18	21764065002140	-18	30906550002020	-18
21405010206435	-18	21990002406440	-22	40143060100320	-18
21405010256445	-18	21990002406470	-22	40170060002020	-18
21405515001920	-18	22100010002010	-21	40180050002120	-6
21500005001320	-18	22109902101810	-21	45100010102108	-18
21500010002020	-18	30042090001320	-18	45100010102110	-18
21500012001320	-18	30043020002020	-19	45100010102118	-18
21500015002020	-18	30043020002080	-19	45100010102120	-18
21500020102005	-18	30044070002020	-18	45304020002010	-17
21500030102020	-18	30062020002140	-17	50250035102001	-18
21500050802020	-18	30062022052220	-18	50250035102010	-18
21533070300120	-18	30062030052020	-20	50250065002020	-18
21533070300130	-18	30062030052110	-20	50280020006320	-18
21533070300140	-18	30062030052115	-20	52505040002120	-18
21534020000320	-18	30062030052130	-20	56500010002010	-30
21534020000340	-18	30062030052140	-20	59157060002120	-13
21534020000350	-18	30062030052150	-20	62400030106420	-18
21534025000320	-18	30062030056420	-20	62403060452020	-18
21534025000340	-18	30062030102003	-20	62403060452040	-18
21534025000360	-18	30062030102006	-20	62403060452060	-18
21534035100320	-18	30062030102020	-20	62403060456420	-18
21534035100340	-18	30062030102030	-20	62403060456430	-18
21536015002120	-18	30062030102040	-20	62403060502120	-18
21550040102020	-18	30062030102115	-20	66200030002015	-18
21600040002220	-18	30062050002105	-25	66260010002020	-18
21600040002240	-18	30062050002155	-25	66270015006420	-18
21700008102020	-18	30100010002120	-19	66290030002020	-18
21700013001940	-22	30100020002020	-18	66290030006420	-18
21700020002105	-22	30100020002056	-17	7000070002520	-18
21700020002110	-22	30100020002062	-17	74400020052120	-18
21700045002120	-18	30100020002120	-17	74400020102020	-18
21700060106420	-18	30100020002121	-19	74503070000320	-18
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21700060106440	-18	30100020002125	-19	75800060002020	-18
21700060202022	-18	30100020002132	-19	75800070102020	-18
21700060202030	-18	30100020002134	-19	82300040002010	-18
21700060202120	-18	30100020002168	-19	82300048002020	-18
21700060202130	-18	30100020002170	-19	82401015112010	-18
21700060202135	-18	30100020002174	-19	82401015112020	-18
21700060202140	-18	30100020002176	-19	82401015112050	-18
21700060202160	-18	30100020002180	-19	82401015112075	-18
21700060206420	-18	30100020002182	-19	82401020002010	-18
21700060206440	-18	30100020002184	-19	82401020002015	-18
21700060206450	-18	30100020006430	-19	82401020002020	-18
21700060206460	-18	30100020102132	-19	82401020002040	-18
21700060206470	-18	30150080102130	-18	82401020002050	-18
21703020002120	-18	30150080102140	-18	82401020002060	-18
21707070102140	-18	30170070102005	-18	82401520002010	-18
21754040002120	-18	30201010102015	-18	82401520002020	-18
21754040002140	-18	30201010102030	-18	82401570002020	-18

GPI	Discount	GPI	Discount	GPI	Discount
82402050002025	-18	85100010006475	-25	90372030002020	-22
82402050002030	-18	85100010102120	-18	90372030002050	-22
82402050002120	-18	85100010206420	-31	93000020102110	-18
82403060002120	-18	85100010206450	-18	93000020102130	-21
83101010102215	-18	85100015102120	-18	94200087102120	-18
83101010102220	-18	85100015102122	-18	94200090102120	-18
83101010102240	-18	85100015102130	-18	96900010002900	-22
83101020102010	-18	85100015102132	-18	99402020000110	-18
83101020102020	-18	85100015102140	-18	99402020000140	-18
83101080102040	-18	85100015102144	-18	99402020002005	-18
83103030102030	-18	85100015102160	-25	99402020002010	-18
83334050102120	-13	85100015102170	-25	99402540102220	-13
85100010002109	-25	85100015102180	-25	99402540302120	-18
85100010002110	-25	85100015102190	-25	99403030100120	-13
85100010002112	-25	85100020002100	-20	99403030100330	-13
85100010002125	-25	85100026202140	-25	99404070000320	-17
85100010002130	-25	85100028002125	-25	99404070000330	-17
85100010002139	-25	85100028002160	-25	99404070002020	-17
85100010002140	-25	85100028002170	-25	99404080000105	-18
85100010002143	-25	85100028002180	-25	99404080000110	-19
85100010002147	-25	85100030002105	-20	99404080000120	-20
85100010006410	-25	85100030002170	-30	99405015002110	-13
85100010006430	-25	85100030002180	-20	99405030001320	-17
85100010006460	-25	85400010002015	-17		

Walgreen Health Initiative
EXHIBIT IV

MEDICARE PART D PRESCRIPTION DRUG AMENDMENT
340B RATE SHEET A-1

1. PBM will reimburse Pharmacy for each Prescription Order dispensed to Medicare Enrollees who are enrolled with WHI Part D Plan Sponsors (other than the WHI Part D Plan Sponsor set forth on Rate Sheet U-1), as follows, reduced by any applicable Cost Sharing Amount received:

	RATES	
	Single-Source & Multi-Source Brands and Generic Drugs without a MAC**	Generic Drugs and Multi-Source Brands with a MAC**
Network Reimbursement Rate	Brand: AWP –38% + $5.00 Generic: AWP –38% + $5.00	WHI MAC + $5.00
Extended Days Supply Reimbursement Rate* ☐ *Initial Here*	Brand: AWP –38% + $5.00 Generic: AWP –38% + $5.00	WHI MAC + $5.00

*If client chooses a benefit design that covers extended days supply, then the *Extended Days Supply Reimbursement Rate covers 84-90 days supply.* Please initial the box where indicated demonstrating your acceptance to such terms.
** "MAC" means the maximum allowable cost for such drugs determined by WHI. The items and their prices will be updated by WHI from time to time at its sole discretion.

2. If the total of the discounted AWP in paragraph 1, above or MAC (from the MAC list) plus the dispensing fee ("Rate") is less than the Cost Sharing Amount, Pharmacy will receive the lesser of the Rate or the dispensing pharmacy's Usual and Customary Charge. Pharmacy will submit Usual and Customary Charges with each claim.

3. Regardless of the amount billed by the dispensing pharmacy as the dispensing fee, Pharmacy will be reimbursed the dispensing fee referenced in paragraph 1 of this Rate Sheet A-1 with the exception of when the Usual and Customary Charge is used for full reimbursement.

4. If Payor is required to reimburse PBM, PBM will be responsible (a) for any wholesale distributor tax or any other excise or value added tax based upon purchases at wholesale; and (b) to reimburse Pharmacy any applicable federal, state or local sales tax liability for prescriptions dispensed or goods and services provided to the Payor or its Eligible Members. Payor is defined as the Federal Government or agent thereof in administering Medicare Part D program. Sales tax is defined as an excise tax based on consumer retail sales or gross revenues whether designated a sales tax, gross receipts tax, retail occupation tax, value added tax, health care provider tax or tax otherwise titled or styled. It includes any tax in existence or hereafter created whether or not the bearer of the tax is the retailer or consumer. In all other situations including direct reimbursements by patients Pharmacy agrees to remit sales tax directly to the appropriate governmental entity and PBM has no responsibility to reimburse Pharmacy.

_____ PHARMACY	WALGREENS HEALTH INITIATIVES, INC.
_____ Signature	_____ Signature
_____ Printed Name	Karen England Printed Name
_____ Title	Vice President of Operations Title
_____ Date	_____ Date
_____ NCPDP Number (s)	

SAFETY NET PHARMACY ADDENDUM TO THE MEDICARE PART D PRESCRIPTION DRUG AMENDMENT TO THE PHARMACY NETWORK AGREEMENT

This Safety Net Pharmacy Addendum to the Medicare Part D Prescription Drug Amendment ("MPD Amendment") to the Pharmacy Network Agreement ("Agreement") between Walgreens Health Initiatives, Inc. ("WHI") and _____ ("Provider") is entered into as of _____, 2006 (the "Effective Date").

1. Purpose of Safety Net Pharmacy Addendum.
The purpose of this Safety Net Pharmacy Addendum ("Addendum") is to apply special terms and conditions to the Agreement by and between WHI and Provider for the administration of Medicare Prescription Drug Benefit program at pharmacies and dispensaries of Provider authorized by Part D of Title XVIII of the Social Security Act, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, and implementing regulations in Parts 403, 411, 417, 422 and 423 of Title 42, Code of Federal Regulations. To the extent that any provision of the pharmacy contract between WHI and Provider is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such pharmacy contract provisions.

2. Definitions.
For purposes of the pharmacy contract between WHI and Provider and this Addendum, the following terms and definitions shall apply:

(a) The term "Part D Plan Sponsor" has the same definition as in 42 C.F.R. § 423.4, and is contracted with WHI for WHI to provide pharmacy benefit management services for its Part D Plan;

(b) The term "Part D Plan" has the same definition as in 42 C.F.R. § 423.4;

(c) The term "Provider" means an entity identified by name in Section 1 of this Safety Net Pharmacy Addendum that is: a Federally Qualified Health Center (FQHC), 340B covered entity, free-standing site that utilizes National Health Service Corps Providers, Rural Health Clinic (RHC), or other safety-net provider, which operates or contracts for pharmacy services from one or more pharmacies or dispensaries;

(d) The term "Safety-Net Provider" means a provider that by mandate or mission organizes and delivers a significant level of healthcare and other health-related services to the uninsured, Medicaid, and other vulnerable populations.

(e) The term "pharmacy contract between WHI and Provider" means the Agreement, the MPD Amendment, as well as any other amendments or addenda thereto, to which this Addendum is appended;

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

(g) For the purposes of this Addendum, a Safety Net Pharmacy Provider refers to a pharmacy or dispensary that is owned or operated by a Provider or that a Provider contracts with for pharmacy services;

(h) The term Federally Qualified Health Center (FQHC) has the meaning given that term in §1905(l)(2)(B) of the Social Security Act as well as any implementing regulations;

(i) The term "340B Participating Provider" means a covered entity as defined in Section 340B(a)(4) of the Public Health Service Act [42 U.S.C. § 256b(a)(4)] that has enrolled in the 340B Drug Pricing Program;

(j) The term National Health Service Corps Provider has the meaning given to the term in §331(a) of the Public Health Service Act [42 U.S.C. §254d(a)];

(k) The term "Rural Health Clinic" (RHC) has the meaning given that term in §1861(aa)(2) of the Social Security Act;

(l) The term "dispensary" means a clinic where medicine is dispensed by a prescribing physician or other practitioner;

(m) The term "340B Drug Pricing Program" refers to the federal drug discount program established under Section 340B of the Public Health Service Act.

3. Persons Eligible for Services of Provider.

(a) The parties agree that the persons eligible for services of Provider shall be patients eligible for the Medicare prescription drug benefit under Part D of Title XVIII of the Social Security Act, as amended by the MMA, as well as under the implementing regulations in Part 423 of Title 42, Code of Federal Regulations;

(b) A Provider that participates in the 340B Drug Pricing Program may elect, but is not required, to provide pharmacy or dispensary services to persons who are not eligible under section 340B(a)(5)(B) of the Public Health Service Act and implementing guidelines; however, such Provider shall not dispense drugs purchased through the 340B Drug Pricing Program to such persons;

(c) Provider and either WHI and/or a Part D Plan Sponsor may establish a co-branded Part D drug benefit card that would be used exclusively by persons eligible for services of Provider at Provider's pharmacies;

(d) No clause, term or condition of the pharmacy contract between WHI and Provider shall be construed to change, reduce, expand or alter the eligibility of persons eligible for services of the Provider under this Section.

4. Governing Law.
For purposes of this Addendum, the Agreement, the MPD Amendment and all amendments and addenda thereto shall be governed and construed in accordance with Federal law. In the event of a conflict between such agreement and all addenda thereto and Federal law, Federal law shall prevail.

5. Pharmacy/Dispensary Participation.
The contract between WHI and Provider applies to all pharmacies and dispensaries operated by the Provider, as listed on this Addendum. A pharmacy is required to use a National Council for Prescription Drug Programs (NCPDP) provider number for reimbursement. To the extent a dispensary does not have a NCPDP provider number, it is required to use an NCPDP Alternate Site Enumeration Program (ASEP) number for reimbursement.

6. Use of Licensed Professionals.
Provider shall ensure that, if no licensed pharmacist is onsite, only individuals who are licensed to dispense under state law will dispense prescription medications under this Addendum. Provider will provide WHI and Part D Plan Sponsor(s) the names and DEA or National Provider Identifier ("NPI") numbers of such licensed individuals upon request. In addition, Provider shall have a consulting services contract with a licensed pharmacist who shall meet regularly with Provider's P&T Committee.

7. Acquisition of Pharmaceuticals.
Nothing in the pharmacy contract between WHI and Provider shall affect Provider's acquisition of pharmaceuticals from any source, including the Federal Supply Schedule and/or participation in the 340B Drug Pricing Program. Nor shall anything in such pharmacy contract between WHI and Provider require Provider to acquire drugs from WHI or from any other source.

8. Point of Sale Processing.
Where the Agreement contains provisions related to drug utilization review and/or generic equivalent substitution and Provider does not have the reasonable information technology capacity to comply with such provisions, then the provisions shall not apply to Provider.

9. Claims.
The Provider may submit claims to the WHI by telecommunication through an electronic billing system or through paper claims.

10. Hours of Service.
The hours of pharmacy services made available by the Provider shall be established by the Provider. At the request of the WHI, Provider shall provide written notification to WHI of its hours of service.

11. Limited Formularies.
Providers that do not maintain, as a regular practice of doing business, a full formulary as defined by WHI, shall not be held responsible for the provision of other formulary pharmaceuticals.

12. General Liability Insurance.
If the Provider currently has deemed status under the Federal Tort Claims Act, then such coverage for acts of the Provider shall be sufficient to satisfy the contract's malpractice liability insurance requirements and additional malpractice liability coverage shall not be required.

13. Terms.
This Addendum supplements and becomes a part of the MPD Amendment and the Agreement. Provider evidences its agreement to participate by signing below where indicated or by providing Covered Services in accordance herewith.

WALGREENS HEALTH INITIATIVES, INC.	PROVIDER:
	_____
By: _____	By: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

NCPDP #_____

PHARMACY BENEFIT MANAGEMENT

PHARMACY NETWORK AGREEMENT

THIS AGREEMENT is entered into by and between Walgreens Health Initiatives, Inc. ("PBM") and _____ ("Pharmacy").

RECITALS

WHEREAS, PBM manages prescription drug benefit plans and arranges for prescription and claim processing services for sponsors of benefit plans such as employer groups, health maintenance organizations, insurance companies, associations, unions, health and welfare trusts, and other organizations;

WHEREAS, Pharmacy operates community pharmacies in areas where such plan sponsors desire prescription services to be provided to their eligible members; and

WHEREAS, Pharmacy desires to participate in a network or networks upon the terms and conditions herein provided.

NOW, THEREFORE, in consideration of the covenants and agreements set forth herein, the parties agree as follows:

I. DEFINITIONS

A. "Ancillary Charge" in addition to the Copayment or Deductible, means an amount which an Eligible Member is required to pay to Pharmacy when an Eligible Member and/or a Physician requires that a Covered Drug be dispensed which is not in conformance with the Formulary or the MAC List.

B. "Average Wholesale Price" or "AWP" means the average wholesale price for a Covered Drug as set forth in the POS System, based on pricing files received by PBM from First Data Bank (or other nationally recognized price source selected by PBM), as updated generally within one week of PBM's receipt of such files.

C. "Benefit Plan" means the health care program, specifically pharmacy services, which an Eligible Member receives from a Plan Sponsor.

D. "Brand Name Drug" means a drug with a proprietary name or trademark assigned to it by the manufacturer or distributor.

E. "Copayment" means a dollar amount that the Benefit Plan requires an Eligible Member to pay to Pharmacy for a Covered Drug, limited by some Benefit Plans to a maximum dollar amount per year ("Deductible").

F. "Covered Drug" means a legend drug (whether a Brand Name Drug or Generic Drug) and any other drug or item when ordered by a Physician by means of a Prescription Order and which is eligible for compensation under the terms of a Benefit Plan.

G. "Eligible Member" means any person or eligible dependent who is covered under a Benefit Plan and whose enrollment, Copayment and benefit coverage is communicated by PBM to Pharmacy in accordance with the terms of this Agreement.

H. "Formulary" means the list of certain Covered Drugs adopted by a Benefit Plan and which may be dispensed by Pharmacy to an Eligible Member. A Formulary is subject to periodic review and modification by PBM.

I. "Generic Drug" means a drug identified by its chemical or non-proprietary name and included in a nationally recognized publication of drug information.

J. "Maximum Allowable Cost List" or "MAC List" shall refer to (unless otherwise expressly defined in any Exhibit or other attachment to this Agreement) PBM's Maximum Allowable Cost List of Generic Drugs that will be reimbursed to Pharmacy at the compensation levels established by PBM. Pharmacy acknowledges that the MAC List is subject to periodic review and modification by PBM.

K. "Payor" or "Plan Sponsor" means the person, group, organization, or other entity who is obligated to pay Pharmacy, through PBM, for Covered Drugs provided to Eligible Members.

L. "Pharmacy Manual" or "Manual" means the booklet which contains terms and conditions, including administrative policies and procedures, concerning the dispensing of a Covered Drug to an Eligible Member and claims submission and payment procedures. From time to time, PBM will update the Manual upon notice to Pharmacy.

M. "Physician" means a licensed medical doctor or other health care professional who is legally authorized to prescribe drugs in the state in which he/she is licensed.

N. "POS System" means the on-line or real time (point-of-sale) telecommunication system used to communicate information regarding Covered Drugs, Eligible Members, claims, drug utilization, Copayments, or other amounts to be collected from an Eligible Member by Pharmacy and the amounts payable to Pharmacy.

O. "Prescription Charge" means the total compensation payable to Pharmacy, as set forth in an exhibit or other attachment hereto, for a Prescription Order whether paid entirely by PBM or partly by PBM and partly by an Eligible Member as an Ancillary Charge, Copayment or Deductible.

P. "Prescription Order" means the request by a Physician to dispense medications, including refills.

Q. "Usual and Customary Charge" means the cash price, including all applicable customer discounts such as senior citizen or special customer discounts or coupons, which price a cash paying customer pays Pharmacy for a Prescription Order.

II. RESPONSIBILITIES OF PHARMACY

A. Pharmacy will dispense Covered Drugs to Eligible Members in accordance with the terms and conditions of this Agreement, including any exhibits and Manuals.

B. Before providing the Covered Drugs, Pharmacy will require each Eligible Member requesting a Covered Drug to present an identification card and/or other form of identification as referenced in the Manual.

C. Pharmacy will provide services hereunder at all locations operated by Pharmacy (unless otherwise restricted in an exhibit or other attachment hereto), which locations are listed on Exhibit 1. Pharmacy must provide all information requested on Exhibit 1 for each location to be enrolled in the network. Pharmacy must notify PBM in writing of any and all changes to Exhibit 1. All locations must submit claims for Covered Drugs using the POS System pursuant to the terms of the Manual. Claims submitted to PBM by means other than the POS System will be paid the rate(s) set forth in the Manual.

D. Pharmacy will provide services to Eligible Members in as timely a manner as provided to other customers and may not discriminate against an Eligible Member for any reason, including but not limited to, race, sex, religion, color, national origin, age, or physical or mental status.

E. Pharmacy will comply with the Formulary (to the extent it applies) and the MAC List in dispensing Covered Drugs, unless Pharmacy is (a) prohibited by state law; or (b) otherwise directed by PBM via the POS System.

F. Pharmacy will collect the applicable Copayment or Deductible, Ancillary Charge, and/or any other charges for a Covered Drug dispensed to an Eligible Member, as specified via the POS System or the Manual. Pharmacy may not discount, waive, rebate, or otherwise reduce the applicable Copayment, Deductible, and/or Ancillary Charge.

G. Pharmacy will cooperate with and support PBM's drug utilization review program. Pharmacy will review the current profile of Eligible Members and, using professional judgment, act upon drug utilization review information as provided by PBM.

H. Pharmacy will maintain a signature log at each of its pharmacy locations listing the Benefit Plan name, Prescription Order number, and date of receipt, and require an Eligible Member or representative who receives a Covered Drug to sign the log. If requested by Pharmacy, PBM will review other comparable systems or logs which provide documentation of receipt and compliance with this provision; provided, however, that acceptance of an alternate system by PBM must be in writing.

I. Pharmacy will exercise professional judgment in the dispensing of Covered Drugs and may refuse to dispense a Covered Drug to an Eligible Member based upon professional judgment.

J. Pharmacy will comply with the provisions of all applicable state, local, and federal laws and regulations and will obtain and maintain all federal, state, and local approvals, licenses, permits, and certifications required to operate as a pharmacy at each location listed on Exhibit 1. Pharmacy will notify PBM within two days of any suspension, revocation, condition, limitation, qualification, or other restriction on any such approval, license, permit, or certification which could impede Pharmacy in the performance of its obligations under this Agreement.

K. Pharmacy warrants and represents that neither Pharmacy nor any of its owners, directors, officers, employees, or contractors are subject to sanction under the Medicare/Medicaid program or debarment, suspension, or exclusion under any other federal or state agency or program, or otherwise are prohibited from providing services to Medicare or Medicaid beneficiaries. Pharmacy will notify PBM immediately of any change in such status.

L. Pharmacy will ensure that all pharmacists who are employed or subcontracted by Pharmacy and who dispense Covered Drugs to Eligible Members are properly licensed to practice and are appropriately insured. Pharmacy will also ensure that all its employees and subcontractors, including pharmacists, perform their duties in accordance with the applicable standards of professional ethics and practice.

M. Pharmacy will notify PBM as soon as possible of any claim or suit against Pharmacy and/or any pharmacist employed or subcontracted by Pharmacy arising from services provided to an Eligible Member. Pharmacy will provide such other information regarding the claim that might reasonably be requested as soon as possible and/or pursuant to the requirements of a Payor.

N. Pharmacy will maintain records and reports for prescriptions filled under this Agreement for a period of five years from the date of service or for the period

required by applicable law, whichever is longer. During normal working hours and upon written request, Pharmacy will allow PBM or its designee reasonable access to such records or reports required to be maintained, and also the right to make photocopies of such documents.

O. Pharmacy will make every effort to dispense Generic Drugs in lieu of prescribed Brand Name Drugs if commercially available and consistent with the pharmacist's professional judgment and state and federal law.

P. Pharmacy is responsible for the payment of any and all transaction charges or fees associated with the transmission of claims or claim information to PBM.

Q. Pharmacy will cooperate with Plan Sponsors and PBM in resolving any complaints received from Eligible Members.

III. RESPONSIBILITIES OF PBM

A. PBM will provide Pharmacy with Manuals and Formularies (including amendments) along with any other information or notices necessary for the administration of a Benefit Plan.

B. PBM will provide or arrange for the provision of identification cards to Eligible Members.

C. PBM is responsible to ensure the processing of Pharmacy's claims for Covered Drugs dispensed to Eligible Members and the payment of such POS System claims processing charges.

IV. COMPENSATION

A. PBM will pay Pharmacy and Pharmacy will accept the Prescription Charge for each Covered Drug dispensed to an Eligible Member and which is eligible for payment under the terms of this Agreement. If PBM has not received funding from a Payor, then PBM has no obligation to pay Pharmacy, nor will PBM incur any such payment liability whatsoever until such a time as a Payor makes funds available.

B. Claims submitted by Pharmacy for Covered Drugs will be processed twice monthly and paid within 30 days of PBM's receipt of funds from Payor(s).

C. In order to receive payment, Pharmacy must submit all original claims for payment on-line to PBM and/or its processor within five days of the date service is rendered to an Eligible Member. If any claim is rejected or suspended, or if additional information is required for further processing by PBM and/or its processor, Pharmacy must resubmit the claim for payment to PBM and/or its processor within 90 days of Pharmacy's receipt of such rejected claim. Claims submitted after the time periods described in this paragraph will not be eligible for payment.

D. PBM may obtain reimbursement for overpayments made to Pharmacy by offsetting such monies against future payments due or requiring reimbursement of such overpayments from Pharmacy, which Pharmacy will pay to WHI within 15 days of notice thereof. PBM or its delegate will provide Pharmacy with 30 days' notice prior to any such offsetting.

E. PBM may modify the Prescription Charge upon 60 days' prior notice to Pharmacy.

F. In no event, including, but not limited to, non-payment by PBM or Payors, PBM's insolvency, or breach of this Agreement, may Pharmacy bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any

recourse against an Eligible Member for Covered Drugs dispensed pursuant to this Agreement. This provision does not prohibit Pharmacy from collecting the applicable Ancillary Charge and/or Copayment or Deductible indicated via the POS System as payable by an Eligible Member. This Section IV.F will survive termination of this Agreement and will be construed to be for the benefit of an Eligible Member. This Section is not intended to apply to Covered Drugs dispensed after this Agreement has been terminated or drugs which are not Covered Drugs. This provision supersedes any oral or written agreement to the contrary now existing or hereinafter entered into between Pharmacy and an Eligible Member or persons acting on an Eligible Member's behalf.

V. TERM AND TERMINATION

This Agreement is effective on the date fully executed by the parties and will remain in effect thereafter, subject to any termination rights set forth in this Agreement, including the following:

A. Either party may terminate this Agreement without cause upon 90 days' prior notice to the other party.

B. PBM may terminate this Agreement immediately upon a material breach by Pharmacy by providing notice of such breach to Pharmacy. Material Breach by Pharmacy includes, but is not limited to, loss of Pharmacy's license or permit or any other license or permit necessary to provide services under this Agreement, or Pharmacy's sanction under the Medicare/Medicaid program or debarment, suspension, or exclusion under any other federal or state agency or program, or other prohibition from providing services to Medicare or Medicaid beneficiaries. Pharmacy may terminate this Agreement upon a material breach by PBM and such termination will be effective 15 days after written notice detailing the breach has been provided to PBM, unless such breach has been cured prior to the end of the 15 day period.

C. No waiver by either party with respect to any breach or default of any right or remedy and no course of dealing may be deemed to constitute a continuous waiver of any other breach or default or of any other right or remedy unless such waiver is expressed in writing by the party to be bound.

D. Termination has no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

E. In addition to termination rights contained elsewhere in this Agreement, any of the following acts or omissions by either party will be considered a default, and will give the nondefaulting party the rights herein contained: if either party to this Agreement voluntarily files a petition in or for bankruptcy, reorganization, or an arrangement with creditors; if either party makes a general assignment for the benefit of creditors; if either party fails to pay, or admits in writing its inability to pay, debts as they become due; if a trustee, receiver, or other custodian is appointed for either party; or, if any other case or proceeding under any bankruptcy is commenced in respect to either party, then the nondefaulting party may terminate this Agreement under Section V.B.

VI. INDEMNIFICATION AND LIABILITY

Pharmacy will indemnify and hold Plan Sponsors and PBM, its shareholders, directors, officers, employees, delegates, and representatives free and harmless from and against any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including, but not limited to, attorneys' fees), which may result or arise out of: (a) any actual or alleged malpractice, negligence or misconduct of Pharmacy in the performance or omission of any act or responsibility assumed by Pharmacy under this Agreement; or (b) the sale, compounding, dispensing, failure to sell, manufacture, or use of a Covered Drug dispensed to an Eligible Member pursuant to this Agreement. This Article VI will survive

termination of this Agreement. In no event will PBM be liable to Pharmacy for indirect, incidental, special, or consequential damages of any nature, loss of profit, punitive damages, injury to reputation, or loss of customer or business damages of any nature, notwithstanding PBM's notice of any such damages or losses. WHI's liability, if any, to Pharmacy under this Agreement will not exceed an amount equal to the total dispensing fees paid to Pharmacy by PBM over the most recently ascertainable one-year period immediately preceding the date on which the claim arose. PBM will have no liability for any claim asserted by Pharmacy or any third party more than one year after Pharmacy or such third party is or reasonably should have been aware of such claim.

VII. INSURANCE

Pharmacy will comply with either subsection A or B below.

A. Pharmacy will acquire and maintain throughout this Agreement, at Pharmacy's sole expense, druggist liability insurance with limits of no less than $1,000,000 for each claim and $3,000,000 in the aggregate (or such other amounts as PBM may agree to in writing), as well as comprehensive general liability insurance in amounts acceptable to PBM to insure against any claim for damages arising by reason of personal injury or death caused directly or indirectly by providing services pursuant to this Agreement. All insurance will be on an occurrence basis. Upon request, Pharmacy will provide PBM with a certificate of insurance evidencing such coverage. Pharmacy will notify PBM as soon as possible but in no event later than 15 days after any restriction on or denial, cancellation, modification, or termination of Pharmacy's general or professional liability insurance.

B. Pharmacy will self-insure for druggist liability, as well as comprehensive liability. On request, Pharmacy will provide a statement verified by a certified public accounting firm. Pharmacy will notify PBM within 15 days of any material change in Pharmacy's financial condition or status that affects its self-insurance. PBM may immediately terminate this Agreement upon notice to Pharmacy following the occurrence of any such change.

VIII. AUDITS

A. PBM or its delegate has the right to inspect, review, audit, and make copies of Pharmacy's prescription files, Usual and Customary Charges, and financial and administrative records related to the dispensing of Covered Drugs to Eligible Members hereunder for up to five years after the date a Covered Drug is dispensed. This Article VIII will survive the termination of this Agreement.

B. Pharmacy will maintain the confidentiality of all records and information relating to an Eligible Member in accordance with all applicable state and federal laws, rules, and regulations, including, without limitation, the federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Pharmacy will release such records and information only in accordance with this Agreement, subject to all applicable legal requirements.

IX. CONFIDENTIALITY.

The Pharmacy Manual, Formulary, MAC List and other documents provided by PBM to Pharmacy are considered proprietary and confidential to and will remain the sole property of PBM. This information may not be released to any third party without the written consent of PBM.

X. GENERAL TERMS

A. PBM will forward a copy of any proposed amendments to Pharmacy at least 30 days prior to the effective date of such amendment. The amendment will become effective on the date stipulated unless prior to the indicated effective date PBM receives a written objection from Pharmacy. All proposed amendments and objections will be communicated pursuant to Article XI of this Agreement. If Pharmacy objects to an amendment, the amendment will not go into effect, however, PBM at its discretion may terminate this Agreement pursuant to the terms of this Agreement. This provision does not apply to changes in the Prescription Charge, which changes will be made in accordance with Section IV.E.

B. The relationship between PBM and Pharmacy is that of independent contracting entities and nothing herein or otherwise may be construed to create an employer/employee relationship, a partnership, a joint venture relationship, an agency relationship, or any other legal relationship between the parties other than or in addition to that of independent contracting parties.

C. Any term or provision of this Agreement that is invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of such term or provision in any other situation or in any other jurisdiction.

D. The performance by either party hereunder is excused to the extent of circumstances beyond such party's reasonable control, such as flood, tornado, earthquake, or other natural disaster, epidemic, war, material destruction of facilities, fire, acts of God, etc. In such event, the parties will use their best efforts to resume performance as soon as reasonably possible under the circumstances giving rise to the party's failure to perform.

E. Neither party may assign this Agreement to a third party, except that either party may assign this Agreement to any direct or indirect parent, subsidiary, or affiliated company or to a successor company. Any permitted assignee will assume all obligations of its assignor under this Agreement. No assignment will relieve any party of responsibility for the performance of any obligations which have already occurred. This Agreement will inure to the benefit of and be binding upon each party, its respective successors, and permitted assignees.

F. Neither party may advertise or use any trademarks, service marks, and/or symbols of the other party without first receiving the written consent of the party owning the mark and/or symbol with the following exceptions. PBM may reference the name, addresses, and phone numbers, etc. of pharmacies in PBM's informational brochures or other publications or services PBM or Payors provide to Eligible Members, potential Eligible Members or the general public and Pharmacy may reference PBM's name, trademark, service mark and/or symbols to inform Eligible Members and the general public that Pharmacy is a participating provider to PBM.

G. This Agreement constitutes the entire and full agreement between the parties hereto and supersedes any previous contract and no changes, amendments (except as otherwise provided in Sections IV.E. and X.A., above) or alterations will be effective unless reduced to writing signed by both parties. Pharmacy acknowledges that its signature below represents an application to become a provider in PBM's pharmacy network(s) and that PBM's execution of this Agreement is evidence of PBM's acceptance thereof. Any prior agreements, documents, understandings, or representations relating to the subject matter of this Agreement not expressly set forth herein or referred to or incorporated herein by reference are of no force or effect. Attachments, lists, manuals, exhibits and/or appendices referred to in this Agreement are incorporated by reference as if fully set forth in this Agreement.

H. In the event of a conflict between the terms of this Agreement and any Pharmacy Manual, the terms of this Agreement will prevail.

I. This Agreement is governed by the laws of the State of Illinois, without regard to principles of conflict of laws.

J. Each party represents and warrants that the person signing this Agreement on its behalf is duly authorized to bind such party to all terms and conditions set forth herein.

XI. NOTICES: All notices provided for herein must be in writing and sent by certified mail to the parties at the addresses set forth below in this Article XI., or to such other address as a party may indicate by written notice to the other party. Notices will be deemed delivered upon receipt or upon refusal to accept delivery.

_____	WALGREENS HEALTH INITIATIVES, INC.
_____	PO BOX 545, MAIL STOP 9275
_____	DEERFIELD, IL 60015-0545
ATTN:_____	ATTN: PROVIDER RELATIONS

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized representatives as of the date written below.

_____	WALGREENS HEALTH INITIATIVES, INC.
PHARMACY NAME	
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE
_____	
NCPDP NUMBER	

WHI Pharmacy Network Agreement – EXHIBIT A
Provider Information

SERVICE INFORMATION

Pharmacy Name:_____

Physical Location Address:_____

City, State, Zip: _____

Pharmacy Phone #:_____ Fax #: _____

County:_____ Is this Location open 24 hours? Yes No

Pharmacy Classification (Check all that apply):

☐ Retail ☐ IHS ☐ LTC ☐ Hospital ☐ Home Infusion ☐ Other

IDENTIFICATION NUMBERS

NCPDP (NABP) #:_____ FEIN: _____

STATE OF LICENSE: _____ LICENSE NUMBER: _____

DEA NUMBER: _____ MEDICAID #: _____

MEDICARE #: _____ NPI#: _____

CONTACT AND PAYMENT INFORMATION

Pharmacy Manager: _____

Payment Contact: _____

Payment Center Code (if applicable): _____

Payment/Remit Address (Checks sent to): _____

City, State, Zip:_____

Payment Phone: _____ Fax#: _____

Policy/Process Notifications to: _____

Notification Email Address:_____

Notification Fax#: _____

WELLPOINT
nextRx

Wellpoint
EXHIBIT V

Dear Supervising Pharmacist:

Thank you for your interest in participating in the consolidated pharmacy network between Professional Claims Services, Inc. dba WellPoint Pharmacy Management, a New York corporation ("WellPoint"), and Anthem Prescription Management, LLC, an Ohio limited liability company ("Anthem") (collectively referred to as "PBM"), both of which are affiliates of WellPoint, Inc. These networks are recognized under **BIN# 610053 and BIN# 610575**. This agreement will give you access to both WellPoint and Anthem clients.

Please return both copies of your agreement in the enclosed postage paid envelope.

To become a participating pharmacy provider you can mail your agreement to:

WellPoint NextRx
Attn: Networks Department AF06
P.O. Box 4488
Woodland Hills CA 91365-9709
or
Fax the Signature Pages, Credentialing Survey, copy of your Pharmacy License and W-9 Form to:

818-313-5125

You do not have to fax the entire Agreement. Just fax the pages that need filling out, signature page, credentialing survey, copy of your Pharmacy License and W-9 form. The State Regulatory Requirements Manual is for your reference only and should not be returned. **Please note: If your pharmacy is located in Ohio, complete and return pages 82, 83, and 84 of the Regulatory Requirements Manual.**

If you have any questions or require further information, please do not hesitate to call Jason at (800) 962-7378 Extension 5109, Monday through Friday, 10AM to 6PM Pacific Standard Time.

Sincerely,

Debbie Uemura
Manager, Pharmacy Networks
WellPoint Pharmacy Management

WellPoint NextRx is a division of WellPoint, Inc. Services are provided by a WellPoint PBM (either Professional Claim Services Inc., doing business as WellPoint Pharmacy Management, or Anthem Prescription Management, LLC, as appropriate). WellPoint NextRx is a servicemark of WellPoint, Inc.

Revised 12 2006

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PHARMACY CHECK LIST

WELLPOINT PHARMACY MANAGEMENT
(BIN 610053 AND 610575)
CANNOT PROCESS YOUR AGREEMENT WITHOUT THE FOLLOWING INFORMATION AND DOCUMENTATION:

- ☐ SIGNED ORIGINAL SIGNATURE PAGE (PAGE 24) OF AGREEMENT *NO STAMPED SIGNATURES*
- ☐ PHARMACY NCPDP AND NPI# (PAGE 24)
- ☐ COMPLETED CREDENTIALING PAGES (25, 26, 27)
- ☐ COMPLETED WELLPOINT MEDICARE NETWORK PAGES 41 & 42
- ☐ PHOTOCOPY OF **CURRENT** RETAIL PHARMACY STATE LICENSE
- ☐ COMPLETED W-9 FORM (ENCLOSED IN PACKET)

NOTE* THE REGULATORY REQUIREMENTS MANUAL IS FOR YOUR REFERENCE FILES ONLY AND SHOULD NOT BE RETURNED.

CHECKLIST

TO INSURE THAT YOUR APPLICATION IS NOT UNNECESSARILY DELAYED, PLEASE BE CERTAIN THAT YOU HAVE COMPLETED AND ARE RETURNING THE FOLLOWING:

- ☐ PARTICIPATING PROVIDER AGREEMENT
- ☐ PHARMACY PROGRAM CONDITIONS
- ☐ MEDICARE PART D – RETAIL PHARMACY PROGRAM CONDITIONS
- ☐ CREDENTIALING SURVEY APPLICATION FOR INDEPENDENT PHARMACIES
- ☐ CURRENT STATE LICENSE COPY
- ☐ COMPLETED W-9

PLEASE BE SURE TO INCLUDE THESE WITH YOUR SIGNED AGREEMENT.

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__-_____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

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PARTICIPATING PHARMACY PROVIDER AGREEMENT

This PARTICIPATING PHARMACY PROVIDER AGREEMENT, together with all schedules, attachments, exhibits, Pharmacy Operations Manuals, Regulatory Requirements Manuals, and Pharmacy Program Conditions, (the "Agreement") is entered into by and between Professional Claims Services, Inc. dba WellPoint Pharmacy Management, a New York corporation ("WellPoint"), and Anthem Prescription Management, LLC, an Ohio limited liability company ("Anthem") (collectively referred to as "PBM"), both of which are affiliates of WellPoint, Inc., and the undersigned pharmacy ("Pharmacy"). This Agreement shall become effective as of the date set forth on the signature page hereto.

WHEREAS, PBM provides administrative services to, or manages prescription benefits for, certain groups, including, but not limited to, Blue Cross and/or Blue Shield plans, employers, insurance carriers, health care service plans, third party administrators, and other health related entities and/or payors;

WHEREAS, PBM provides networks of participating pharmacies as part of its prescription benefit administrative and management services;

WHEREAS, Pharmacy desires and is willing to participate in PBM's networks of participating pharmacy providers and to provide pharmacy services under the terms and conditions set forth in this Agreement; and

WHEREAS, PBM and Pharmacy recognize as a mutual objective continuing efforts toward the goal of access, cost containment, and the delivery of quality pharmacy services.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Affiliate.
The term "Affiliate" shall mean any entity which owns or controls or is owned or controlled by, PBM, directly or indirectly, and any entity which is under common ownership with PBM directly or indirectly.

1.2 Average Wholesale Price or AWP.
The terms "Average Wholesale Price" or "AWP" shall mean the average wholesale price of a Covered Service as established and reported by MediSpan, First DataBank, or other nationally recognized pricing source selected by PBM in its sole discretion. AWP shall be updated at least weekly or in accordance with reasonable industry standards with data received from the pricing source; provided, however, PBM receives usable and acceptable data from such pricing source, which if not received timely could result in delays. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources. In the event that the AWP pricing benchmark used by PBM hereunder is replaced with another benchmark calculation (such as ABP – average benchmark price), PBM may switch to such new pricing benchmark upon written notice to Pharmacy, and such notice will identify any new pricing terms, if any, required to maintain comparable pricing under the new benchmark.

1.3 Claim.
The term "Claim" shall mean the Pharmacy request for payment in the format prescribed by PBM of amounts due Pharmacy under this Agreement for providing Covered Services to Covered Individuals.

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1.4 Co-payment or Co-pay.
The terms "Co-payment" or "Co-pay" shall mean the payment due from a Covered Individual to the Pharmacy at the time the Covered Service is provided, according to the Covered Individual's Plan or as otherwise required by a Payor, which shall be deducted from Pharmacy's reimbursement hereunder. Co-payments may include, but are not limited to, flat or percentage dollar amounts, coinsurance, deductible, and preferred or formulary incentives.

1.5 Cognitive Services.
The term "Cognitive Services" shall mean certain services, agreed upon between PBM and Pharmacy that are not required by Law when providing Covered Services, but may be rendered by a Pharmacy.

1.6 Compound Prescriptions.
The term "Compound Prescriptions" shall mean a mixture of two or more ingredients when at least one of the ingredients in the preparation is a federal legend drug or state restricted drug in a therapeutic amount. It excludes the addition of only water or flavoring to any preparation. Further, "Compound Prescriptions" shall refer to a compound preparation not administered by infusion.

1.7 Covered Individual.
The term "Covered Individual" shall mean an individual who is eligible, as determined by Payors, to receive Covered Services under a Plan.

1.8 Covered Quantity.
The term "Covered Quantity" shall mean a quantity of a Covered Service as allowed by Law and the Plan and authorized by a prescriber.

1.9 Covered Refill.
The term "Covered Refill" shall mean refills of a Covered Quantity of a Covered Service as allowed by Law and the Plan and authorized by a prescriber and Covered Individual.

1.10 Covered Service or Covered Prescriptions.
The terms "Covered Service" or "Covered Prescriptions" shall mean any medically necessary drugs, devices, supplies, equipment, and other items (which may include insulin, disposable insulin syringes, and other diabetic supplies) dispensed to a Covered Individual for which such Covered Individual is entitled to receive in accordance with and subject to the terms and conditions (including any Covered Quantity, Covered Refill, or other limiting provisions) of the applicable Plan, including all services usually and customarily rendered by a pharmacy in the normal course of business, including but not limited to dispensing, counseling, and product consultation.

1.11 Dispense As Written or DAW Code.
The terms "Dispense As Written" or "DAW Code" shall mean the code promulgated by NCPDP to indicate the reason for dispensing a multi-source brand-named medication.

1.12 Dispensing Fee.
The term "Dispensing Fee" shall mean the amount paid to Pharmacy for professional services rendered by a licensed pharmacist for providing Covered Services to a Covered Individual.

1.13 Formulary.
The term "Formulary" shall mean a list of preferred drugs and medical supplies developed, published, and periodically revised by PBM and/or Payors. Formularies may be available to Pharmacy upon request or by electronic messaging via the online system.

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1.14 HIPAA.
The term "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any subsequent amendments or regulations promulgated thereunder.

1.15 Law.
The term "Law" shall mean any federal, state, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards, instructions, 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 local government or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

1.16 Maximum Allowable Cost or MAC.
The terms "Maximum Allowable Cost" or "MAC" shall mean the highest amount at which Pharmacy will be reimbursed for a Covered Service, which lists and pricing may be established and amended by PBM and/or Payor in its sole discretion.

1.17 MedicareAdvantage (formerly Medicare+Choice).
The terms "MedicareAdvantage" or "Medicare+Choice" shall mean a Plan providing managed health care services to Covered Individuals in accordance with the Balanced Budget Act of 1997 (BBA) (Publ.No 105-33) to Title XVIII of the Social Security Act, as then constituted or later amended.

1.18 NCPDP.
The term "NCPDP" shall mean the National Council for Prescription Drug Programs, which is a pharmaceutical-industry trade association.

1.19 NDC.
The term "NDC" shall mean the national drug code, which is an identifier published by the pharmaceutical industry for a prescription drug.

1.20 Network.
The term "Network" shall mean a group of pharmacies that have agreed to participate in a national, state, Payor, or other network under this Agreement or obtained by acquisition or otherwise.

1.21 Payor.
The term "Payor" shall mean the entity for which PBM provides prescription benefit administrative and/or management services, which may include, among others, Affiliates, Blue Cross and/or Blue Shield plans, employers, insurance carriers, health care service plans, third party administrators, self-administered or self-insured programs providing health care benefits, insurers, pharmacy benefit management companies, and other health related entities and/or other payors.

1.22 Pharmacy Operations Manual.
The term "Pharmacy Operations Manual" shall mean collectively the pharmacy operations manuals or provider manuals published by either PBM, Anthem, WellPoint, and/or their designees, as amended and/or supplemented by PBM or its designees from time to time, which are provided or made available to Pharmacy in written or electronic format to explain policies and procedures and other requirements required to be followed by Pharmacy in connection with this Agreement.

1.23 Pharmacy Program or Pharmacy Program Conditions and/or Pharmacy Program Requirements.
The terms "Pharmacy Program," "Pharmacy Program Conditions," "Pharmacy Program Requirements" or "Pharmacy Program Conditions/Requirements" shall mean that document or sets of documents which set forth the rules, guidelines, policies and procedures of PBM and/or Payor, and may include, without

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limitation, Network participation requirements, credentialing, audit, drug utilization evaluation activities, prior authorization requirements, quality of care review, and/or grievance resolution procedures, as may be amended from time to time by PBM.

1.24 Pharmacy Services Administration Organization or Affiliation or PSAO.
The terms "Pharmacy Services Administration Organization or Affiliation" or "PSAO" shall mean an entity that provides administrative services to pharmacies, including arranging for such pharmacies' participation in various pharmacy networks.

1.25 Plan.
The term "Plan" shall mean a contract, endorsement, or other agreement or program and any changes or additions thereto as may be made or amended from time to time which, by its terms, provides coverage for health care or pharmacy services and/or supplies or otherwise provides access to health care or pharmacy services and/or supplies pursuant to agreed upon terms, which may include but is not limited to document(s) describing the partially or wholly insured, underwritten and/or administered healthcare benefits or services program between a Payor and an employer or other entity or individual; in the case of a self-funded arrangement, the plan document, which describes the Covered Services for a Covered Individual(s); and/or discount programs for uninsured or underinsured.

1.26 Prescription Charge.
The term "Prescription Charge" shall mean the total compensation payable to Pharmacy for providing Covered Services to a Covered Individual. Such compensation shall be messaged to Pharmacy via PBM's electronic Claims submission system, and as more fully described in the applicable Pharmacy Program Condition(s) or Program Requirements. The Prescription Charge is limited to the quantity of the Covered Service as prescribed, up to, and including, a thirty (30) day supply, unless a Covered Individual's Plan and Program Conditions and/or Requirements permits a different supply. The Prescription Charge is based on the actual bottle size, package size, or container from which the applicable Covered Service was dispensed from Pharmacy's stock.

1.27 Prior Authorization.
The term "Prior Authorization" shall mean certain Covered Services, identified by PBM's online system, that are not payable unless certain criteria are satisfied.

1.28 Regulatory Requirements Manual.
The term "Regulatory Requirements Manual" shall mean the regulatory requirements manual(s) published by either PBM, Anthem, WellPoint, and/or their designees, as amended and/or supplemented from time to time by PBM or its designee, which are provided or made available to Pharmacy in written or electronic format, providing the specific, different and/or additional contractual provisions applicable to some of the Covered Services, Covered Individuals, Pharmacy, and/or Payors as required by various Laws.

1.29 Usual and Customary Charge or U&C.
The terms "Usual and Customary Charge" or "U&C" shall mean the lowest price the Pharmacy would charge to a cash-paying customer with no insurance for an identical pharmaceutical good or service on the date and at the location that the prescription is dispensed.

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ARTICLE 2
RELATIONSHIP OF THE PARTIES

2.1 Independent Entities.
PBM and Pharmacy are independent entities, and nothing in this Agreement shall be interpreted to create any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement. In the performance of the obligations of this Agreement, regarding any services rendered under this Agreement, by either party or its agents, servants, or employees, each party is at all times acting and performing as an independent contractor with respect to the other party, and no party shall have or exercise any control or direction over the method by which the other party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative, or employee of, or joint venture with, or fiduciary of, the other party. No provision of this Agreement or any part of any Plan shall be construed to require any pharmacist to dispense any medication or specific type of medication to any Covered Individual if, in the pharmacist's reasonable professional judgment, such medication should not be dispensed to such person.

2.2 Relationship Between Pharmacy And Covered Individuals.
The relationship between Pharmacy and Covered Individuals is that of pharmaceutical provider and patient. Pharmacy shall perform all professional and other services required to be provided under this Agreement and shall be free to exercise its own judgment on all questions of professional practice.

2.3 Other Payor Arrangements.
Pharmacy agrees that each arrangement by which Pharmacy performs services for Covered Individuals of an Affiliate or Payor that utilizes PBM's Network(s) shall constitute an independent legal relationship between Pharmacy and that Affiliate or Payor.

2.4 Non-Exclusivity.
The Agreement is non-exclusive, and Pharmacy may contract with other third party entities so long as its ability to perform its obligations under this Agreement is not impaired. Nothing in this Agreement shall in any way restrict the ability of PBM or Pharmacy to enter into any agreement of any kind relating to the subject matter of this Agreement.

2.5 No Third Party Beneficiaries.
This is an Agreement between PBM and Pharmacy only. It shall not be interpreted to create any rights or remedies in favor of any person or entity who is not a party to the Agreement, and no such person or entity shall have any right or cause of action under this Agreement, including any Covered Individual, except as otherwise provided herein.

ARTICLE 3
PARTICIPATION

3.1 General.
Pharmacy agrees to participate in: (a) all Pharmacy Programs and Networks in which Pharmacy participates in as of the date of execution of this Agreement; (b) all Networks and Pharmacy Programs designated herein or identified in the attached Schedules (Pharmacy Program Conditions/Requirements); and (c) all Networks Pharmacy agrees to participate in as evidenced by its provision of Covered Services to a Covered Individual of a Payor utilizing such Network(s). Participation in the Networks shall be in

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accordance with this Agreement, including the Pharmacy Operations Manual, the Regulatory Requirements Manual, and all Pharmacy Program Conditions, Pharmacy Program Requirements, and other rate sheets, exhibits, and addenda with respect thereto.

3.2 Other Pharmacy Programs.
Pharmacy may be included in additional Networks for Pharmacy Program(s), including but not limited to, insured programs, consumer discount card programs, and worker's compensation programs, upon thirty (30) calendar days advance written notice from PBM. In such event, Pharmacy may decline to participate in such additional Pharmacy Program(s) Networks by giving PBM written notification of its intent not to participate prior to the effective date of such Pharmacy Program(s) Network. Failure by the Pharmacy to provide written notification to PBM of its non-participation in the referenced additional Pharmacy Program(s) prior to the effective date of such Program(s) shall be deemed acceptance by the Pharmacy to participate in such additional Pharmacy Program(s).

3.3 Other Pharmacy Networks.
PBM reserves the right to establish other pharmacy networks or other pharmacy referral panels (hereinafter "Other Networks"), which have their own set of selection criteria. If Pharmacy does not meet the selection criteria, Pharmacy understands and agrees that it will cooperate in the transfer of the Covered Individual pharmacy information to a pharmacy within the Other Network. In the event Pharmacy renders Covered Services to the Covered Individual that should have been rendered by an Other Network pharmacy, then Pharmacy agrees that it will be deemed an out of network provider under the Covered Individual's Plan for the rendition of said services. PBM will give Pharmacy at least sixty (60) calendar days advance notice of the implementation of an Other Network.

3.4 Participation Exclusions/Restrictions.
To the extent not prohibited by Law, Pharmacy acknowledges and agrees that: (a) Payors may not utilize all pharmacies in a Network for their respective Plan networks or Pharmacy Programs; and (b) Payors may restrict or limit access to certain Covered Services (including, but not limited to, specialty medications, high cost medications, injectibles, medications with limited availability, etc.) to specified providers, which may or may not include Pharmacy.

ARTICLE 4
RESPONSIBILITIES AND OBLIGATIONS OF PHARMACY

4.1 Licensure and Other Requirements.
Pharmacy warrants and represents that Pharmacy and each pharmacist is in and shall maintain in good standing with all federal, state, and local regulatory bodies and has and shall maintain all federal, state and local approvals, licenses, and permits required to operate as a pharmacy at each location and to provide services under this Agreement. Pharmacy will notify PBM immediately of any revocation, suspension, limitation or other action, which could materially impair performance of its obligations under this Agreement. Pharmacy shall immediately notify PBM in writing if Pharmacy loses or voluntarily surrenders such licensure, accreditation, permits, authorizations or approvals, or no longer meets the PBM's standards, during the term of this Agreement.

4.2 Ineligibility To Participate.
Pharmacies sanctioned by the General Services Administration, Office of Inspector General, or other applicable regulatory body, who are not eligible to participate in Medicare, Medicaid, or other Federal health care programs are not eligible to participate in any Network. Pharmacy warrants and represents that at the time of execution of this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of

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Parties Excluded from Federal Programs and the HHS/OIG List of Excluded Individuals/Entities. In the event Pharmacy or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose ineligible person status, Pharmacy shall have an obligation to: (i) immediately notify PBM in writing of such ineligible person status, and (ii) within ten (10) calendar days of such notice, remove such individual, entity, or location that is responsible for, or involved with, Pharmacy's business operations related to this Agreement.

4.3 Other Pharmacy Qualifications.
Pharmacy acknowledges and agrees that Pharmacy: (i) has registered with the National Association of Boards of Pharmacy to dispense pharmaceuticals; and (ii) does not act as or provide services under this Agreement as a mail order pharmacy, internet pharmacy, long term care pharmacy, institutional pharmacy, 340B, or specialty pharmacy as identified by either the National Council of Prescription Drug Programs ("NCPDP") or PBM, unless specifically agreed to by PBM in writing.

4.4 Service Availability.
Pharmacy shall provide Covered Services to all Covered Individuals pursuant to the terms of this Agreement during regular hours of operation of Pharmacy and in the same manner, in accordance with the same standards, and with the same availability as that offered to other persons. Pharmacy shall use best efforts to maintain an adequate supply of drugs, devices, supplies, equipment, and other items to provide Covered Services.

4.5 Eligibility Verification.
Pharmacy agrees to determine, as a condition precedent to providing Covered Services, the eligibility of each Covered Individual by requesting a current PBM or Payor identification card or by requesting Covered Individual's identification number and verifying eligibility using the on-line electronic network. Pharmacy may not be paid for Covered Services provided to an individual whose eligibility was not correctly submitted to and verified by PBM.

4.6 Providing Covered Services.
Pharmacy will provide Covered Services to Covered Individuals subject to and in accordance with this Agreement, including but not limited to the Program Conditions and/or Requirements and the Pharmacy Operations Manual, the Regulatory Requirements Manual, the prescriber's directions, the Plan, Formulary, applicable Law, and the standard of practice of the community in which Pharmacy provides Covered Services and in a manner so as to assure the quality of such services in a culturally competent manner. Pharmacy agrees that all Covered Services provided to Covered Individuals under this Agreement shall be provided by a pharmacist or by a qualified person under a pharmacist's direction. Pharmacy shall have a licensed pharmacist or other designated licensed professional available during all business hours for patient consultations, which will be provided to Covered Individuals at no additional charge. Pharmacy shall not refuse to provide any Covered Service to a Covered Individual due to dissatisfaction with reimbursement under this Agreement for a particular Covered Service.

4.7 Collection From Covered Individuals.
Upon Covered Individual's receipt of each Covered Service, Pharmacy shall collect and retain from the Covered Individual the Co-payment for the Covered Service. Pharmacy shall have full responsibility for the collection of such Co-payment, as well as the collection of any other charge(s) designated as a Covered Individual's financial responsibility in accordance with the terms of the applicable Plan, and shall not seek to collect any Co-payment from PBM or Payors. Unless otherwise directed in writing by PBM, in no event shall Pharmacy collect any greater amount than that indicated via the online system. Pharmacy shall not discount, waive, reduce, or defer Covered Individual's Co-payment in whole or in part. Pharmacy shall not: (a) balance-bill a Covered Individual; (b) charge Covered Individuals any charges

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other than the Co-Payment related to the Covered Service; and/or (c) charge a fee to Covered Individuals as a condition to be part of Pharmacy's panel of patients.

4.8 Claims Submission.
In each instance when a Covered Service is provided to a Covered Individual, Pharmacy must submit a Claim to PBM or its designee. Each Claim submitted by Pharmacy will constitute a representation and certification by Pharmacy to PBM that the Covered Services were provided to the Covered Individual and that the information transmitted is accurate and complete.

Electronic Format. All Claims (including Compounds) for Covered Services must be submitted electronically to PBM or its designee via the online system in NCPDP format (then most current version) or in such other manner and format as directed by PBM or its designee. Failure to submit the Claim electronically when the online system is operational may be considered a material breach and grounds for termination of this Agreement and/or PBM may impose a reasonable handling fee per Claim in those situations in which Pharmacy submits Claims non-electronically. Pharmacy shall provide and maintain at its expense the equipment, software, and communications network transmission capabilities necessary to submit Claims and receive processing messages via the online system. Pharmacy shall be responsible to pay for its own electronic communication and/or switch charges incurred in the online delivery and receipt of Claims and processing messages.

Required Information. Claims must be submitted in accordance with Law, the Pharmacy Operations Manual, the Regulatory Requirements Manual, and as otherwise set forth in this Agreement, including the Pharmacy Program Conditions and/or Requirements and other attachments to this Agreement. Pharmacy must submit all required information for the Claim via the online system, which may include but not be limited to the following: Covered Individual's identification number; quantity of the medication dispensed; days supply dispensed; Pharmacy's NCPDP, Provider, or NPI number; the eleven (11) digit NDC of the item dispensed based on the bottle size from which the item was dispensed; the correct DAW Code; the prescriber's identification number; and the Pharmacy's U&C.

U&C. Pharmacy acknowledges and agrees that accurate submission of U&C is a material requirement of this Agreement and failure to electronically submit an accurate U&C with each Claim (including but not limited to Compounds) may be considered a material breach and grounds for termination of this Agreement.

DAW Codes. Pharmacy further acknowledges and agrees that Pharmacy must submit an accurate DAW Code in accordance with NCPDP specifications and that DAW Code submission may change the calculation of the Claim and/or Co-payment depending on Payor specifications. Pharmacy will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW Code. A Covered Individual's or Pharmacy's selection of a brand name multi-source product does not constitute medical necessity.

Prescriber Identification Number. Unless prohibited by Law, and in accordance with the other provisions of this Agreement, PBM has the right to terminate this Agreement for cause if PBM determines in its sole discretion that Pharmacy has submitted an unreasonable number of Claims with invalid prescriber identification and/or provider numbers ("Prescriber Number"). Prescriber Numbers shall be considered invalid when: (i) the Prescriber Number submitted by Pharmacy with the Claim is not the Prescriber Number listed on the prescription by the Prescriber; or (ii) no Prescriber Number is provided on the prescription, and the Prescriber Number submitted by the Pharmacy with the prescription Claim is not the "default" identification number provided by PBM; or (iii) the Prescriber Number submitted by the Pharmacy with the prescription Claim does not correspond to the actual prescriber of the prescription.

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This provision of the Agreement does not prohibit Pharmacy from submitting valid Prescriber Numbers that may be available to the Pharmacy through its prescription claims processing system.

Time for Submission. All Claims shall be submitted promptly after providing the Covered Service, and in no event later than thirty (30) calendar days after the date that Covered Service is rendered (or such longer period required by applicable Law). Failure to timely submit a Claim may result in non-payment of such Claim.

4.9 Claim Reversals.
All Covered Services not received by a Covered Individual must be reversed through the online system. Unless otherwise notified in writing by PBM, Pharmacy shall submit Claim reversals within ten (10) calendar days following the date the Claim was originally submitted. This includes (but is not limited to) reversals and resubmittals for partial fills, where the Covered Service is partially filled and the remainder is not retrieved by the Covered Individual in a reasonable period of time, in which case Pharmacy must electronically reverse and resubmit the actual quantity of a Covered Service received by a Covered Individual. In addition, this provision prohibits Pharmacy from submitting separate Claims for a Covered Service which should have been dispensed and covered as one Claim but due to inadequate supplies or other issues is dispensed and covered on different dates or at different times as multiple Claims.

4.10 Clinical, Quality, and Cost Containment Efforts.
In providing Covered Services to Covered Individuals, Pharmacy shall use its best efforts in supporting PBM and Payors in managing the cost and quality of Covered Services. Pharmacy shall use best efforts to cooperate with cost containment efforts such as Formularies, prior authorization programs, and drug utilization reviews which promote prescribing and dispensing of appropriate and cost-effective therapeutic alternatives, including but not limited to the following:

4.10.1 Lowest Cost Drugs.
Pharmacy agrees to dispense the lowest cost drug that Pharmacy then has in stock, consistent with the orders of the prescriber, the requirements of Law, and the professional judgment of Pharmacy.

4.10.2 Generic Substitution.
Pharmacy agrees to promote generic utilization and will provide Covered Services using generic medications whenever it is: (a) not specifically prohibited by prescriber or Law; (b) available at less cost than non-generic medications; and (c) in compliance with the applicable Plan and Formulary. Pharmacy shall maintain a record on the original prescription order of its attempt at achieving generic dispensing.

4.10.3 Mandatory Generic Programs.
Pharmacy shall use its best efforts to support PBM and Payor mandatory generic programs, including but not limited to, contacting the prescriber to encourage a change to a generic substitute when the prescription for the Covered Service contains a Dispense As Written signature for a multi-source brand medication. Pharmacy shall use best efforts to maintain an adequate supply of generic drugs.

4.10.4 Formulary Compliance.
Pharmacy shall dispense items on the Covered Individual's Formulary to the maximum extent permitted by Law. Pharmacy shall use best efforts to contact the prescriber to encourage Formulary compliance and request authorization to change to a therapeutic equivalent Formulary drug. Pharmacy shall maintain a record on the original prescription order of its attempt at achieving Formulary compliance.

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4.10.5 Prior Authorization.
Unless otherwise instructed in writing by PBM, if Pharmacy receives a system message that states "Prior Authorization Required" (or such other language to that effect) when submitting a Claim for a Covered Service, Pharmacy shall use best efforts to contact the prescriber and inform the prescriber of the Prior Authorization requirement or, where appropriate and permitted by the Plan, obtain additional information and contact the PBM or Payor (as applicable) prior authorization help desk to determine if the Plan Prior Authorization requirements have been satisfied. In those situations where Pharmacy must contact the prescriber and the prescriber is not available, Pharmacy shall notify Covered Individual and shall contact the PBM or Payor (as applicable) prior authorization help desk to obtain a one-time emergency authorization. If the applicable Payor's or PBM's prior authorization help desk is closed, to the extent required by Law, Pharmacy must provide an emergency supply, or, if not so required by Law, as otherwise instructed by PBM.

4.10.6 DUR.
Drug Utilization Review ("DUR") messages may appear in the online claim response. Pharmacy shall act upon all such messages subject to the professional judgment of the pharmacist. To the extent that PBM or its designee provides DUR information or messages to Pharmacy, Pharmacy acknowledges and agrees that: (a) information contained in DUR messages is derived from third party sources and is not independently developed by PBM; (b) the usefulness of DUR and other Formulary information is necessarily limited by the amount of patient information input into the online system as a result of Claims processing, the amount of information provided by Payors, and the thoroughness and accuracy of industry information and information provided by third parties; (c) DUR messages and Formulary information are intended as an aid to, and not a substitute for, the knowledge, expertise, skill, and judgment of prescribers, Pharmacy, pharmacists, and other healthcare professionals; (d) Pharmacy, prescribers, pharmacists, and other healthcare professionals are responsible for acting or not acting upon information generated and transmitted by PBM or its designee; (e) PBM does not control the healthcare decisions made or actions taken by Pharmacy, prescribers, pharmacists, other healthcare professionals, Payors, or Covered Individuals; (f) the DUR messages and Formulary information do not contain all currently available information on healthcare or pharmaceutical practices; (g) PBM and its designee are not responsible for failing to include information in a DUR message or in Formulary detail, for the actions or omissions of contributors of information to PBM or its designee, or for misstatements or inaccuracies in industry materials utilized by PBM or its designee; and (h) all warranty disclaimers and exclusions made by contributors of information or data to PBM or its designee shall apply to PBM hereunder.

4.11 PBM and Payor Programs and Initiatives.
Pharmacy agrees to provide Covered Services in accordance with any PBM and Payor programs and initiatives. This includes, but is not limited to, cooperating in good faith with, and participating in and complying with, any credentialing, utilization review, cognitive services, and quality assurance initiatives of PBM and/or Payors, as communicated to Pharmacy, as may be amended from time to time. Pharmacy practices that impact Covered Individuals that do not follow Formulary and other programs and initiatives are strictly prohibited.

4.12 Professional Judgment.
Nothing in this Agreement is intended to limit a pharmacist's professional judgment or violate applicable Law. Accordingly, notwithstanding anything to the contrary in this Agreement, Pharmacy and its pharmacists must exercise sound professional judgment at all times when providing Covered Services to

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Covered Individuals. Pharmacy or pharmacist may refuse to provide Covered Services to a Covered Individual based on that professional judgment, which must be documented. Pharmacy shall be solely responsible for its professional services rendered.

4.13 Covered Service Products.
All drug products utilized in providing Covered Services to Covered Individuals must be in compliance with applicable federal and state requirements including those of the Federal Food and Drug Administration ("FDA").

4.14 Rebates.
PBM, Payors, and/or their designees have and retain the right to submit all Claims for Covered Services for Covered Individuals to pharmaceutical companies in connection with rebate or other similar programs. Unless otherwise agreed to in writing, Pharmacy shall not submit any of the Claims for Covered Services for Covered Individuals to any pharmaceutical company for the purpose of receiving any rebates or discounts.

4.15 Grievance/Complaint Procedures.
Pharmacy agrees to cooperate fully with any applicable Covered Individual grievance, complaint, or similar procedure, including but not limited to, informing Covered Individuals of applicable grievance and/or complaint rights. Further, Pharmacy agrees to fully cooperate with, and provide information requested by PBM, to enable PBM and or Payors to conduct and resolve grievances that may be raised by Covered Individuals, Payors, or other providers regarding the provision of Covered Services by Pharmacy. Disputes of malpractice are outside the scope of this Agreement. This provision shall survive termination of this Agreement.

4.16 Appeals Procedures.
Pharmacy agrees to comply with any applicable Covered Individual appeal(s) procedures, including but not limited to, informing Covered Individuals of applicable Appeal rights. This provision shall survive termination of this Agreement.

4.17 Diversion of Covered Prescriptions to Non-Participating Pharmacy.
Pharmacy shall not undermine Usual and Customary Charges or compound pricing or otherwise undermine the intent of this Agreement, including but not limited to encouraging the use of, or diverting a Covered Prescription to, a non-participating pharmacy that is owned, operated by, or affiliated with Pharmacy. In the event PBM, at its sole discretion, determines that Pharmacy has taken actions to undermine Usual and Customary Charges or compound pricing or otherwise undermine the intent of this Agreement, PBM shall have the right to initiate termination process to remove the Pharmacy from all PBM networks upon written notice to Pharmacy.

4.18 Non-discrimination.
Pharmacy shall not discriminate or differentiate against any Covered Individual as a result of his or her enrollment in a particular plan, or because of race, color, creed, national origin, ancestry, religion, sex, sexual orientation, marital status, age, disability, payment source, state of health, need for health services, status as a Medicare or Medicaid beneficiary, or any other basis prohibited by Law.

4.19 Notification of Legal Action.
Pharmacy shall notify PBM or its designated agent of any legal or administrative claim made or action filed against Pharmacy arising from this Agreement, by a Covered Individual, or otherwise which could affect the ability of Pharmacy to carry out of this Agreement within ten (10) calendar days of receipt of such claim or action.

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4.20 Coordination of Benefits.
Pharmacy agrees to cooperate in good faith with PBM regarding coordination of benefits and to notify PBM promptly after receipt of information regarding any Covered Individual who may have a Claim involving coordination of benefits. When payor has been determined to be other than the primary payer, payment hereunder shall be based upon the Prescription Charge, reduced by the amount paid for the Covered Service by the primary and other tertiary plans. Pharmacy agrees to accept such amount as payment in full for the Covered Service. Notwithstanding the foregoing, this Section shall not be construed to require Pharmacy to waive coinsurance, indemnity balances and deductibles in contravention of any Medicare rule or regulation, nor shall this Section be construed to supersede any other Medicare Law.

4.21 Subrogation.
Pharmacy agrees to cooperate with PBM regarding subrogation and to notify PBM promptly after receipt of information regarding any Covered Individual who may have a Claim involving subrogation.

4.22 Program Conditions and/or Requirements and Pharmacy Operations Manuals.
Pharmacy agrees to comply with the Program Conditions and/or Requirements and the Pharmacy Operations Manual.

4.23 Compliance with Law and Regulatory Requirements Manual.
Pharmacy shall comply with, and operate its pharmacy in compliance with, all Laws, including HIPAA. Pharmacy acknowledges and agrees that various state and federal mandates may apply with respect to the Agreement and the Covered Services and/or Covered Individuals hereunder. Such mandates may provide specific, different, and/or additional contractual provisions applicable to some of the Covered Services, Covered Individuals, Plan, and/or Payors, and are set forth in the Regulatory Requirements Manual, which is incorporated herein by this reference as if fully set forth herein. The provisions in the Regulatory Requirements Manual only apply if they are required and then only as those provisions relate to Covered Individuals whose Plan, Pharmacy Program, or Payor is governed by the applicable provision. By executing this Agreement, Pharmacy acknowledges and agrees that it has received the Regulatory Requirements Manual, agrees to the provisions contained in the Regulatory Requirements Manual, and represents and warrants that it is, and shall remain, in compliance with all applicable provisions in the Regulatory Requirements Manual and all applicable Laws. Pharmacy agrees that by executing this Agreement, Pharmacy is executing any provisions in the Regulatory Requirements Manual requiring its signature and shall not require a separate signature in order to be effective. In the event of a direct conflict between this Agreement (including the Pharmacy Program Conditions and/or Requirements and the Pharmacy Operations Manual) and the applicable provisions of the Regulatory Requirements Manual, the applicable provisions of the Regulatory Requirements Manual shall control if required.

4.24 Compliance Program.
PBM maintains an effective Compliance Program and Standards of Business Conduct and requires its employees to act in accordance therewith. PBM will provide a copy of its then current Standards of Business Conduct to Pharmacy upon request.

4.25 Pharmacy Credentialing Application. Pharmacy acknowledges it has completed and reviewed the Pharmacy Credentialing Application attached hereto as Exhibit A and incorporated herein. Pharmacy shall update the Pharmacy Credentialing Application promptly upon any material changes in the information contained therein, and otherwise upon request of PBM.

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ARTICLE 5
COMPENSATION AND PAYMENT

5.1 Payment in Full.

Pharmacy will accept as payment in full for Covered Services rendered to Covered Individuals in accordance with this Agreement the amounts provided for in this Agreement, including the pricing Schedules hereto and any pricing Schedules, rate exhibits, amendments, or addenda entered into or agreed to by the parties prior to, on, or after the Effective Date of the Agreement (all of which are incorporated herein by this reference). Pharmacy shall not be paid for prescriptions and/or services that are not Covered Services under the Plan. Unless otherwise agreed to in writing, Claims will be paid at the lower of (i) Pharmacy's Usual and Customary Charge; (ii) the AWP discount plus the applicable Dispensing Fee; or (iii) MAC plus the applicable Dispensing Fee, minus, in all instances, any Covered Individual Co-payments and/or transmission fee(s). Notwithstanding the foregoing, when permitted by Law, the Plan, and the Payor, the Pharmacy may collect from the Covered Individual the lower of the Pharmacy's Usual and Customary Charge and the Covered Individual's Co-Payment when the contracted rate (i.e., applicable MAC or AWP discount and Dispensing Fee) is lower than the Pharmacy's Usual and Customary Charge and the Covered Individual's Co-Payment. In no case shall reimbursement to Pharmacy exceed Pharmacy's Usual and Customary Charge.

5.2 Payment Processing Cycles.

PBM shall process or arrange to process all Claims submitted for payment which are accurate, complete, and otherwise in compliance with this Agreement within thirty (30) calendar days of receipt. PBM shall issue or arrange to issue or require Payors to issue checks for payment of Claims at least twice a month. Pharmacy acknowledges and agrees that PBM operates only as an intermediary between Payors and Pharmacy with respect to payment under this Agreement and that Claim payment amounts due hereunder are the sole and exclusive responsibility of the Payor. In no event shall PBM be obligated to pay Pharmacy for Covered Services unless and until payment for such Covered Services is received from the Payor responsible for such payment. PBM has no liability to Pharmacy for nonpayment or for any delay in payment from a Payor. Pharmacy shall look solely to the Payor for payment.

5.3 Transmission Fees.

Pharmacy shall pay PBM the applicable transmission fee, which shall be deducted from the next remittance of amounts payable to Pharmacy. To the extent not prohibited by Law, a transmission means each claim, reversal, reject, resubmission, or other electronic communication sent to PBM through the online system.

5.4 Overpayments and Authorized Deductions.

Any amounts owed by Pharmacy to PBM (including but not limited to transmission fees and overpayments from Claim reversals, errors, inaccurate submissions, or otherwise) shall become immediately due and owing and shall be paid by Pharmacy to PBM upon request. Pharmacy agrees not to attempt to affect any accord or satisfaction through a payment instrument or accompanying written communication and not to conditionally or restrictively endorse any payment instrument; and PBM shall not be bound by any such attempt or endorsement. In the event of non-payment by Pharmacy or as otherwise authorized by this Agreement or at PBM's discretion, PBM may deduct or offset any overpayments or other amounts owed by Pharmacy to PBM from any amounts otherwise payable to Pharmacy. PBM further reserves the right, in its sole discretion, to require pharmacy to assign to PBM any collection rights Pharmacy may have against any person.

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5.5 Payment for Cognitive and/or Other Services.
PBM may, at its discretion and if Pharmacy agrees, make payments to Pharmacy with respect to Cognitive and/or other services provided to Covered Individuals. Such payments may result in different amounts payable to Pharmacy hereunder.

5.6 Taxes.
If any taxes, assessments, and/or similar fees ("taxes") are imposed on Pharmacy by a governmental authority for the provision of Covered Services to Covered Individuals, Pharmacy shall be responsible for such taxes and shall not pass such taxes on to Covered Individuals, Payors or PBM unless specifically required to do so under applicable Laws. In no event shall PBM be liable for any taxes or the determination of the amount of taxes.

5.7 Objection To Payment.
Pharmacy must promptly notify PBM in writing of any alleged error, miscalculation, discrepancy or basis for disputing the correctness or accuracy of any Claim (whether paid, denied, rejected, reversed, or otherwise) within one hundred eighty (180) calendar days after payment is due. Otherwise, Pharmacy will be deemed to have confirmed the correctness and accuracy of the Claims processed and/or paid during that financial cycle. In no event will PBM have liability above or beyond the aggregate amount of Claims during such one hundred eighty (180) calendar day period. To request an adjustment to a Claim payment, Pharmacy must timely submit to PBM sufficient documentation to evidence that the Claim was paid incorrectly. This objection and time limitation does not apply with respect to any overpayments that may be made to Pharmacy.

5.8 Covered Individual Held Harmless.
Pharmacy agrees that in no event, including but not limited to, nonpayment, insolvency, or bankruptcy of PBM or Payor, or breach of this Agreement, shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Individual for Covered Services. This does not prohibit collection of Co-payments in accordance with the terms of this Agreement. In the event Pharmacy violates this provision, Pharmacy shall promptly refund the amount collected in violation of this Agreement to Covered Individual, Payor, and/or PBM, as directed by PBM in writing. 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 Covered Individuals, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Pharmacy and Covered Individual(s).

ARTICLE 6
RECORD MAINTENANCE AND ACCESS

6.1 Maintenance of Records.
Pharmacy agrees to maintain records as is required by PBM, by Law, or by appropriate regulatory authorities as such relate to Covered Services to be provided in accordance with this Agreement for a period of no less than ten (10) years (or such longer period required by Law) following the termination of this Agreement. Without limiting the generality of the foregoing, Pharmacy shall maintain all pharmacy records and data relating to the provisions of Covered Services to Covered Individuals and its responsibilities under this Agreement in a manner consistent with appropriate pharmacy standards and Laws, including, without limitation, maintaining original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals. With respect to re-written prescription, re-written

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prescriptions for Covered Services must contain all appropriate documentation which was on the original prescription, including but not limited to DAW Code designations. PBM may withhold, deny, or chargeback payments where records and logs are not maintained as required hereunder.

6.2 Access to Records.
PBM, and any and all applicable governmental authorities, shall have access at all reasonable times to Pharmacy's books, records and other papers which relate to this Agreement and/or Covered Services, including, without limitation, original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals.

6.3 Survival of Termination.
The provision of this Article 6 shall survive the termination of this Agreement.

ARTICLE 7
AUDITS

7.1 Audit Procedures.
PBM, the Comptroller General of the United States ("Comptroller"), the Department of Health and Human Services ("DHHS"), the Centers for Medicare and Medicaid Services ("CMS"), and their respective duly authorized representatives or designees shall have the right, for the term of this Agreement and for three (3) years thereafter (or such longer period required by Law) to review, audit, examine, and reproduce any of Pharmacy's books, records, prescription files, and other documentation pertaining to Covered Services for Covered Individuals and/or Pharmacy's compliance with this Agreement. PBM will provide Pharmacy with fifteen (15) calendar days prior notice, or such lesser or greater time as is required by Law, of any onsite audit. In addition, Pharmacy shall provide records or copies of records requested by PBM, Comptroller, DHHS, CMS, or their third party authorized representatives or designees within ten (10) calendar days from the date of such written request or such shorter time required by Law. Pharmacy agrees to fully cooperate in good faith with such audits, regardless of the form of such audit, including but not limited to, onsite audits and audits by mail, in-house desk audits, drug utilization reviews and detection of Claim submission errors. In connection with such audits, Pharmacy agrees to allow PBM or its subcontractor to copy, photocopy, photograph, or use digital camera photography, for all prescriptions, profiles and other records relating to the dispensing of Covered Services to Covered Individuals. If PBM is denied admission to the Pharmacy or if Pharmacy does not timely present requested documentation and records, Pharmacy may be assessed a reasonable audit fee or PBM may deem 100% of the Claims to be audited as noncompliant and due and owing to PBM. In addition, where based on a sampling of audited Claims, PBM determines that Pharmacy has engaged in fraud or abuse or has made common errors in the submission of Claims, PBM has the right to extrapolate for purposes of determining the amount due and owing to PBM for noncompliant Claims to the extent not prohibited by Law.

7.2 Audit Discrepancies.
Audits of the Pharmacies will be conducted to determine non-compliant or discrepant Claims, which include, but are not limited to, the following: Pharmacy billed for brand, but dispensed generic; days' supply or quantity dispensed does not reflect the prescription order, ethical use, exceeds or is not in accordance with the Covered Individual's Plan; missing (or not timely produced) hard copy prescriptions; inaccurate Usual and Customary Charge submission; inaccurate DAW Code designations, including but not limited to prescriber Dispensed as Written ("DAW-1") not designated on prescription when billed as such and patient requests brand instead of generic drug ("DAW-2") is not documented on the prescription; reason not specified on prescription when refill too early message is over-ridden; inaccurate Prescriber Numbers submitted; Formulary non-compliance; NDC number billed not in accordance with

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NDC number dispensed; NDC number of product or number of units billed does not reflect Covered Service; Claim billed as a compound or is not written and designated as a compound preparation; non-compliance with quality, clinical, and cost containment programs.

7.3 Audit Recovery.
If it is determined by PBM or its designee that overpayments were made to Pharmacy, any such overpayment shall become immediately due and owing and shall be paid by Pharmacy to PBM upon notice to Pharmacy. PBM may, at its sole discretion, deduct or offset such amount of any overpayments made to Pharmacy from any amounts otherwise payable to Pharmacy.

7.4 Pharmacy Non-Compliance.
If Pharmacy is deemed non-compliant with the Agreement, certain penalties may apply, including, but not limited to, fees, interest, penalties, damages, or other charges imposed upon PBM by governmental entities, regulatory agencies, and/or Payors. PBM has the right to deduct any such amounts from any amounts payable to Pharmacy. PBM may report its audit findings to Payors, appropriate governmental entities, and/or regulatory agencies.

7.5 Survival of Termination.
The provisions of this Article 7 shall survive the termination of this Agreement.

ARTICLE 8
INSURANCE, INDEMNIFICATION AND ACCOUNTABILITY

8.1 Insurance.
Pharmacy, at its sole cost and expense, shall procure and maintain policies of general and professional liability insurance and such other insurance as shall be necessary to insure it and its employees against any claim or claims for damages arising out of, or related to, alleged personal injuries or death occasioned directly or indirectly in connection with the performance of Covered Services and activities of Pharmacy, and/or the use of any facilities, equipment or supplies provided by Pharmacy. Each of such policies shall be amounts of at least one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) annual aggregate, or such greater amount required by Law; or Pharmacy shall provide such other evidence of financial responsibility as may be acceptable to PBM. Pharmacy shall name as an additional insured PBM, its successors and assignees. Pharmacy shall immediately notify PBM in writing of any suspension, cancellation, or material change of insurance coverage. Pharmacy shall furnish PBM reasonable proof of such insurance as may be requested upon execution of this Agreement and/or at any reasonable time thereafter. Pharmacy acknowledges and agrees that failure to maintain the appropriate insurance policies will result in immediate termination of this Agreement. This provision shall survive the termination of this Agreement.

8.2 Indemnification.
All liability arising from the provision of Covered Services and any other services rendered by Pharmacy will be the sole responsibility of Pharmacy. Pharmacy will indemnify, defend, and hold harmless PBM, its designees, Payors, and their respective shareholders, directors, employees, agents, and representatives from and against any and all liabilities, losses, settlements, claims, injuries, damages, expenses, demands, penalties, or judgments of any kind (including reasonable costs, expenses, and attorneys' fees) that may result or arise out of: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Pharmacy in the performance or omission of any act or responsibility assumed by Pharmacy; (b) the provision of pharmacy services for the sale, compounding, dispensing, manufacturing, or use of a drug or

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device dispensed by Pharmacy; or (c) the breach or alleged breach by Pharmacy of any representation, warranty, or covenant of Pharmacy as set forth in this Agreement.

8.3 Data Processing Limitations.
Pharmacy acknowledge that PBM or its designee will provide electronic claims/data processing services (hereinafter the "Data Processor"). PBM MAKES NO EXPRESS WARRANTIES AS TO SUCH DATA PROCESSING SERVICES, AND NO WARRANTIES ARE TO BE IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT SHALL PBM, ITS SUBSIDIARIES OR AFFILIATES, OR ITS SUBCONTRACTORS, HAVE ANY LIABILITY WHATSOEVER TO PHARMACY ARISING OUT OF OR IN CONNECTION WITH SUPPLYING OR FAILING TO SUPPLY THE DATA PROCESSING SERVICES. Pharmacy acknowledges that Data Processor has expended substantial sums in creating and obtaining rights in the applications software programs used in the Pharmacy Program(s) (the "System") and has substantial proprietary interest and valuable trade secrets therein. At no time during the term of this Agreement or thereafter may Pharmacy assign, sell, license, let, duplicate, transfer, pledge or hypothecate the System or any portion thereof. Pharmacy shall utilize reasonable security controls to protect the System which are no less stringent than those Pharmacy uses to protect its own proprietary rights. Pharmacy agrees that all data submitted to the Data Processor for processing and all output provided by the Data Processor shall be delivered and transported to and from Pharmacy at its sole risk, cost and expense. Ownership rights to all data and information submitted to Data Processor or PBM in connection with this Agreement shall vest in the PBM.

8.4 Limitation of Liability.
Notwithstanding any other term of this Agreement, in no event shall PBM be liable to Pharmacy 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 PBM has been advised of or has foreseen the possibility of such damages).

ARTICLE 9
CONFIDENTIAL AND PROPRIETARY RIGHTS

9.1 Covered Individual Records.
Pharmacy and PBM agree that all Covered Individual records shall be treated as confidential so as to comply with all Laws regarding the confidentiality of Covered Individual records and/or is prudent in accordance with applicable industry standards. Pharmacy agrees never to provide Covered Individuals' information to others for Pharmacy's pecuniary gain. Nothing herein is meant, however, or shall be construed, to limit the rights of PBM, or the rights of governmental authorities, to inspect and copy any accounting, administrative, or Covered Individual records maintained by Pharmacy pursuant to Article 7 of this Agreement.

9.2 Confidential and Proprietary Information. Pharmacy agrees that all terms contained herein and within any other Agreement between PBM and Pharmacy, and all pricing, programs, services, business practices, and procedures of PBM are confidential and/or proprietary. Pharmacy agrees to maintain the confidential nature of such materials and not to disclose the terms and conditions contained herein or contained in any other Agreement with PBM or any pricing, programs, services, business practices, or procedures of PBM, without the express written consent of PBM, unless such information is already publicly available due to no fault of Pharmacy.

9.3 Remedies. Pharmacy shall promptly notify PBM if it becomes aware of any use of confidential information or data that is not authorized by PBM. Pharmacy acknowledges and agrees that any

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unauthorized disclosure or use of confidential and/or proprietary information or data obtained from or provided by PBM would cause PBM immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if Pharmacy fails to comply with this Article 9, PBM is entitled to seek and obtain injunctive relief, monetary remedies, and/or such other damages as available by Law against Pharmacy.

ARTICLE 10
MARKETING, ADVERTISING, AND PUBLICITY

10.1 Publish Pharmacy Information.
Pharmacy agrees to provide to PBM, and agrees that PBM may publish, Pharmacy's name, tax identification number or other provider identification number, address, telephone number, hours of operation and other similar descriptive information or information reasonably required for any advertisement, literature or publication produced for the marketing, administration and/or operation of a Pharmacy Program or Network. Pharmacy's use of the name or a symbol, trademark or service mark of PBM or its Affiliates or subsidiaries in any advertisement, literature, publication, pamphlet or sign Pharmacy uses, whether or not such use relates to Pharmacy's participation in the Pharmacy Program(s) or Network(s), shall be subject to the prior written consent of PBM. Notwithstanding such consent, nothing herein shall be deemed to grant Pharmacy any rights in such names, symbols, trademarks or service marks. Upon termination of this Agreement, Pharmacy agrees to immediately cease all such use.

10.2 Marketing and Promotion.
Pharmacy shall make reasonable efforts to assist PBM or Payors in marketing Plans. Pharmacy shall ensure that all Pharmacy facilities maintain reasonable PBM or Plan promotion, membership and marketing materials as reasonably requested by PBM or Payor, consistent with the signage visibility and marketing support granted to third parties other than PBM.

10.3 Direct Marketing.
Pharmacy shall not directly market to or solicit Covered Individuals without written authorization from PBM and the applicable Payor. Such marketing and soliciting activities to Covered Individuals shall include without limitation direct marketing campaigns and solicitations via mail, telephone, internet or any other means available.

10.4 Public Comments.
PBM and Pharmacy agree that, in the event of conflict involving the terms of this Agreement or termination of this Agreement, both PBM and Pharmacy will refrain from publicly disparaging the other.

ARTICLE 11
GOVERNING LAW AND DISPUTE RESOLUTION

11.1 Choice of Law.
This Agreement shall be construed, interpreted, and governed by the Laws of the State of Ohio. The operation of a pharmacy or the professional practice of pharmacy shall in all respects be governed by the laws of the state wherein the pharmacy is located and where the practice of pharmacy is performed.

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11.2 Dispute Resolution.
In the event that any dispute, claim or controversy relating to this Agreement arises between Pharmacy and PBM, except for disputes deemed by PBM to be related to termination without cause of this Agreement, both agree to meet and make a good faith effort to resolve the dispute. If such efforts are unsuccessful, either party may commence arbitration by filing an arbitration demand with the American Arbitration Association ("AAA") or American Health Lawyers Association ("AHLA") within thirty (30) calendar days of the meeting. The dispute will be resolved through arbitration to be conducted in Hamilton County, Ohio.

Any dispute subject to arbitration shall be settled by binding arbitration, strictly in accordance with this Agreement, except to the extent the dispute is required by Law to be resolved by a state or federal authority. The parties shall not have the right to participate as a member of any class of claimants pertaining to any dispute subject to arbitration hereunder, nor shall there be any authority for disputes arising hereunder to be arbitrated on a class action basis. Arbitration shall be limited only to disputes arising between Pharmacy and PBM and cannot be consolidated or joined with claims of other persons who may have similar claims.

The Commercial Arbitration Rules of the AAA or AHLA, as applicable, shall be employed, using a three (3) member panel of arbitrators. Any dispute under $500,000 shall be handled by expedited procedures under the AAA or AHLA. The panel shall consist of one (1) arbitrator selected by Pharmacy, one (1) arbitrator selected by PBM, and the third independent arbitrator shall be selected and agreed upon by the first two arbitrators. The parties may also use a single arbitrator, provided they mutually agree to do so and mutually agree on the choice of arbitrator. The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The cost of any arbitration proceeding under this Section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered and enforced in any court of competent jurisdiction. In the event the dispute is required by Law to be resolved by a state or federal authority, PBM and Pharmacy agree to be bound by the findings of such state or federal authority.

11.3 Survival of Termination.
This Article 11 shall survive termination of this Agreement.

ARTICLE 12
TERM AND TERMINATION

12.1 Term.
This Agreement shall be effective as of the Effective Date appearing on the signature page hereof and shall continue in effect for a one (1) year term, and shall automatically renew for successive one-year terms unless either party provides written notice of non-renewal to the other party at least sixty (60) calendar days' prior to the end of the initial term or any renewal term.

12.2 Termination.
This entire Agreement may be terminated as follows:

(a) Automatic Termination.
This Agreement will terminate automatically without notice with respect to any individual pharmacy location operated by Pharmacy as of the date on which such individual pharmacy

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location fails to maintain appropriate licensure, registration, certification, good standing, or insurance, as required under this Agreement and/or Law.

(b) Immediate Termination Rights.
PBM may terminate this Agreement immediately upon written notice to Pharmacy in the event of:
(i) Breach of any representation, warranty or covenant of Pharmacy in this Agreement;
(ii) The transfer of ownership of any of Pharmacy's pharmacy locations to a new owner, or if the right to control any aspect of Pharmacy's operations is transferred to another person or entity;
(iii) Pharmacy becomes insolvent, admits it is unable to pay its debts, an action is filed by or against Pharmacy under the Federal Bankruptcy Act or any other Law or act regarding insolvency, reorganization, arrangement, or extension for the relief of debtors, including any assignment for the benefit of creditors, the appointment of a receiver or trustee for transfer or sale of a material portion of Pharmacy's assets, or PBM's receipt of a writ of attachment, execution or garnishment;
(iv) Pharmacy or Pharmacy's employees act in an illegal, unethical, unscrupulous or immoral manner which adversely impacts the reputation of PBM, its Affiliates, or Payors;
(v) PBM has reason to believe in its sole discretion that the health or safety of a Covered Individual(s) may be in jeopardy; or
(vi) Pharmacy engages in any fraudulent activity related to the terms of the Agreement.

(c) Event of Default.
Either Party may terminate this Agreement at any time for material breach by the other party by giving at least thirty (30) days' written notice to the other party, or such longer period as required by Law, which termination shall become effective at the end of such notice period if such breach is not cured to the satisfaction of the non-breaching party by such date.

(d) Pharmacy Termination Right.
Pharmacy may terminate this Agreement in accordance with Section 13.2 in the event Pharmacy objects to any amendment made under Section 13.2 of this Agreement.

(e) Pharmacy Program and/or Network Termination.
PBM may terminate Pharmacy from participating in any specific Network or Pharmacy Program, including but not limited to any Network or Pharmacy Program as it relates to a specific Plan or Payor, without cause upon a sixty (60) day written notice to Pharmacy (or such longer period as required by Law).

(f) Mutual Right of Termination Without Cause
Either party may terminate this Agreement, without cause, provided one terminating party sends the other party written notice at least sixty (60) days prior to the effective date of termination.

12.3 Rights and Remedies in the Event of Termination or Breach.
In the event of termination or breach of this Agreement, in addition to all other rights and remedies PBM may have at Law, equity, or under this Agreement, PBM shall have the right, upon notice to Pharmacy, to: (i) deduct from any amounts owing to Pharmacy any amounts which Pharmacy owes PBM; (ii) impose reasonable investigation, collection, audit, and/or similar fees with respect to any breach of this Agreement; (iii) suspend performance of any and/or all of PBM's obligations under or in connection with this Agreement, including, without limitation, PBM's obligation to process claims; and/or (iv) suspend Pharmacy's performance of any and/or all of Pharmacy's obligations under or in connection with this Agreement.

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In the event this Agreement is terminated, Pharmacy shall submit all Claims for Covered Services dispensed before the date of termination within five (5) calendar days after the date of termination. Any rights to payment for any Claim submitted after such time, whether or not the same would qualify as a Claim, shall be deemed forfeited, and Pharmacy agrees to hold PBM, Affiliates, their subsidiaries, subcontractors, Payors, and each of their respective employees, shareholders, members, officers and directors and the Covered Individual receiving the Covered Service harmless for any expense associated therewith.

Upon termination of this Agreement, Pharmacy shall return, at its expense, any Pharmacy Operations Manuals, Regulatory Requirements Manuals, decals, participation identification materials and other documents or materials supplied to Pharmacy by PBM in connection with this Agreement and/or any Pharmacy Program or Network, including all confidential and proprietary information of PBM.

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. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to PBM under this Agreement.

ARTICLE 13
GENERAL PROVISIONS

13.1 Entire Agreement.
This Agreement together with all schedules, attachments, exhibits, Pharmacy Operations Manuals, Regulatory Requirements Manual, Pharmacy Program Conditions and/or Requirements, and addenda attached hereto or incorporated herein, contains the entire Agreement between PBM and Pharmacy, all of which are incorporated by referenced as if fully set forth herein and referred to collectively as the "Agreement". Any prior oral or written agreements, promises, negotiations, or representations concerning the subject matter covered by this Agreement are terminated and of no force and effect except that all existing pricing schedules, Pharmacy Program Conditions and/or Requirements, and addenda shall be incorporated into this Agreement, unless otherwise provided for in any attached Schedule to this Agreement. This Agreement will be effective and binding on the parties only if the duly authorized signatures of the parties are affixed hereto where indicated on the signature page.

13.2 Amendments/Modifications.
Except as otherwise set forth herein, this Agreement may be altered or amended only with the written consent of each party hereto; except that, PBM may amend any term, part or provision of this Agreement, including, without limitation, any exhibits, Pharmacy Programs Conditions and/or Requirements, Prescription Charge, schedules, amendment or addenda, by giving written notice to Pharmacy at least ten (10) calendar days (or such longer period required by Law) prior to the Effective Date of the amendment ("notice period"). If Pharmacy objects to any such amendment(s), Pharmacy may terminate this Agreement by giving PBM written notice of termination of the Agreement prior to the expiration of the notice period, which termination shall become effective thirty (30) days after the date of such notice of termination, or such other longer or shorter period required by Law. If Pharmacy does not provide written notice of termination of this Agreement to PBM within the notice period, then Pharmacy will be deemed to have accepted such amendment, and Pharmacy agrees that such amendment(s) shall not require a separate signature in order to be effective.

13.3 Replacement Agreement.
From time to time, PBM may issue a replacement agreement which restates the provisions of this Agreement, together with any amendments, addenda, attachments, appendices, exhibits, and schedules. The replacement agreement shall not contain any new provisions. Pharmacy agrees to execute the replacement agreement without re-opening negotiations.

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13.4 Assignment.
No part of this Agreement may be assigned by Pharmacy without PBM's prior written consent. Pharmacy acknowledges and agrees that PBM, without consent of the Pharmacy, may assign all or any part of this Agreement and/or PBM's rights, privileges or duties under this Agreement to any direct or indirect parent, subsidiary, or Affiliate or to a successor company.

13.5 Third Party Agreements/Subcontractors.
PBM may subcontract all or any part of its obligations under this Agreement to a third party provided that such subcontractor agrees to perform the services as set forth herein. Pharmacy will be advised of such subcontracting relationships when necessary to enable Pharmacy to perform its duties under this Agreement.

13.6 Lawful Interpretation.
This Agreement will be interpreted and performed in compliance with all Laws. If this Agreement or any part hereof is found not to be in compliance with any Law, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

13.7 Force Majeure.
The parties shall be excused, discharged, and released from performance under this Agreement to the extent that all or part of the Agreement cannot be performed due to causes which are outside the control of PBM and Pharmacy, and could not be avoided by the exercise of due care, including but not limited to acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive activity or sabotage, terrorist activity, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable Law. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement.

13.8 Severability.
In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

13.9 Waiver.
Neither the waiver by either of the parties of a breach or a default of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach or default of any of the provisions of this Agreement. A waiver by either party of strict compliance with the terms of this Agreement shall only be effective if in writing and signed by both parties hereto, and shall not be effective with respect to any prior or subsequent failure by either party to comply with any term of this Agreement.

13.10 Binding Effect.
Except as otherwise provided herein, this Agreement shall be binding upon and inure to the benefit of the parties, their agents, successors and permitted assigns unless otherwise set forth herein or agreed to in writing by the parties.

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13.11 Notices.
Any notice required to be given pursuant to this Agreement shall be in writing, postage prepaid, and shall be sent via facsimile transmission or by United States first class mail or by certified or registered mail to the parties at the addresses indicated on the signature page of this Agreement (or such other addresses that the parties may hereafter designate); provided however that any notice of dispute or termination by Pharmacy must be sent by certified or registered mail to PBM at the address indicated on the signature page of this Agreement, with a copy sent by certified or registered mail to the following (or such other address designated by written notice of PBM):

WellPoint, Inc.
1 WellPoint Way - CAT202-H006
Thousand Oaks, CA 91362
Attn: Legal Department

The notice shall be effective on the third business day after deposit in the U.S. Mail if sent by certified mail or on the date of electronic confirmation of facsimile receipt if sent by facsimile.

13.12 Headings.
The paragraph headings herein are for convenience purposes only and are not to be utilized in construction of the provisions of the Agreement.

ARTICLE 14
PHARMACY SERVICES ADMINISTRATION ORGANIZATION OR AFFILIATION

14.1 Applicability.
This Article 14 shall apply only when the entity executing this Agreement is a PSAO entering into this Agreement on behalf of one or more pharmacies.

14.2 PSAO Exhibit.
PSAO and Pharmacy agree to comply with and be bound by the provisions contained in Exhibit B attached hereto and incorporated herein by this reference.

-SIGNATURES ON NEXT PAGE-

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In Witness Whereof, the parties hereto have executed and delivered this Agreement, the day and year first written below.

PHARMACY

By: _____
Signature

_____
Print Name

_____
Title

_____
Pharmacy Name

_____
Pharmacy Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

_____
Email Address

_____
NCPDP Number

_____
NPI Number
Date: _____

Anthem Prescription Management, L.L.C.

By: _____
Signature

Keith A. Dostal, R.Ph.
Staff V.P. of Retail Pharmacy Networks

Post Office Box 4488
Woodland Hills, CA 91365-9709

_____
Date

_____
Effective Date

Professional Claim Services, Inc., d.b.a. WellPoint Pharmacy Management

By: _____
Signature

Keith A. Dostal, R.Ph.
Staff V.P. of Retail Pharmacy Networks

Post Office Box 4488
Woodland Hills, CA 91365-9709

_____
Date

_____
Effective Date

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EXHIBIT A

Credentialing Survey Application For Independent Pharmacies

1) General Information:

Pharmacy Legal Name			
D/B/A Name			
Name of Person Who Signs Third Party Contracts			
Pharmacist In Charge (PIC)		PIC License #	
Address 1 (No P.O. Boxes)			
Address 2			
City, State, Zip			
County			
Phone #			
Fax #			
E Mail Address			

NCPDP (formerly NABP)#			
NPI #			
Federal Tax ID #			
Pharmacy DEA #		Exp. Date	
State License # **(Provide current copy)**		Exp. Date	
Board of Equalization (Sellers Permit#)			
Medicaid #			
Medicare #			
Pharmacy Insurance $1M/$3M gen liability & gen aggregate per occurence	Amount of coverage:	Exp Date	
Insurance Company Name		Account #	

2) Payment Information

Name of Person Who Handles Payment	
Payment Address	
ity, State, Zip	
Phone #	
Fax #	
E Mail Address	

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Please note that failure to answer any of these questions will delay the processing of your application.

3) Patient Services

a. Pharmacy Type – Please indicate the approximate amount of business you do in each of the following:

Dispenser Type	Percent of Business
Retail	%
Mail Service	%
Long Term Care	%
Specialty	%
Compounding	%
IV Infusion	%
Internet	%

b. Hours of Pharmacy Operation

M-F _____ Sat._____ Sun._____

Yes	No	
		Patient counseling?
		Written literature about the prescription being dispensed?
		Compounding capability?
		Delivery Service?
		Separate charge for delivery service?
		Pharmacy language translation? List languages:
		Access for handicap customers?

c. Services Provided:

d. Other Questions:

Yes	No	
		Does your pharmacy have a store front with the name posted?
		Do members have access to walk in and get prescriptions filled while they wait?
		Has your pharmacy had any claims, settlements or judgments against it in the last 10 years?
		Has your pharmacy ever filed for bankruptcy, receivership or reorganization?

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Acknowledgment

The undersigned hereby acknowledges that the information provided in this document is, to the best of his/her knowledge, accurate and complete. The undersigned further understands that intentional submission of false or misleading information or the withholding of relevant information is grounds for termination by PBM. The undersigned hereby agrees to notify PBM of any changes in the above information.

_____
Name of Pharmacy

_____
Signature

_____
Printed Name and Title

_____
Date

Checklist
To insure that your application is not unnecessarily delayed, please be certain that you have completed and are returning the following:

- ❑ **Participating Provider Agreement**
- ❑ **Pharmacy Program Conditions**
- ❑ **Medicare Part D – Retail Pharmacy Program Conditions**
- ❑ **Credentialing Survey Application for Independent Pharmacies**
- ❑ **Current State License copy**
- ❑ **Completed W-9**

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EXHIBIT B

PHARMACY SERVICES ADMINISTRATION ORGANIZATION OR AFFILIATION AGREEMENT

By executing the Agreement, PSAO agrees as follows:

1. **Requirements for participation as a Pharmacy Services Administrative Organization.**

- PSAO must have a chain headquarters established.
- Chain headquarters must handle all communications to the pharmacy from the PBM.
- Chain headquarters must have a help desk for pharmacies to call for assistance with on-line claims processing.
- Chain headquarters must be able to assist pharmacy with payment issues.
- Chain headquarters must have a signed contract with the pharmacy enrolled with their PSAO that confirms the pharmacy agrees to the terms and conditions of the PBM contract..
- All pharmacies enrolled with the chain must agree to participate in all applicable PBM Networks.
- Pharmacy must agree to remain with current PSAO for no less than one month in our database.
- Updates will be done only once a month in accordance with the affiliation reported by NCPDP.
- All pharmacies must accept the PSAO rate.

2. **PSAO Representation of Pharmacies.**

By signing the Agreement, PSAO is entering into the Agreement on its own behalf and on behalf of the Pharmacies. PSAO represents and warrants that it has authority to enter into the Agreement on its own behalf and on behalf of the Pharmacies and, for the term of the Agreement and any renewals thereof, shall continue to possess the authority to individually bind each Pharmacy to the terms of the Agreement and any addenda or amendments thereto. Pharmacies shall be deemed to have accepted all terms and conditions of the Agreement. PSAO shall promptly provide to PBM upon PBM's written request evidence of such authority.

3. **PSAO Payments (Please check one).**

Check the appropriate box below:

☐ [Box 1] By checking this box, PSAO instructs PBM to send all amounts due and owing to Pharmacies under the Agreement to PSAO. PSAO represents and warrants that it has authority to collect any payments due under the Agreement on behalf of the Pharmacies and, for the term of the Agreement and any renewals thereof, shall continue to posses the authority to collect such payments on behalf of the Pharmacies. Based upon such representation, warranty, and instruction, PBM shall send one check to PSAO for all amounts due and owing to all Pharmacies under the Agreement, less any deductions or setoffs authorized under the Agreement.

☐ [Box 2] By checking this box, PSAO instructs PBM to send all amounts due and owing under the Agreement directly to the Participating Pharmacy, less any deductions or setoffs authorized under the Agreement.

If PSAO fails to check either box above or checks both boxes above, Box 1 will be deemed checked, and Pharmacy payments due under the Agreement will be sent to PSAO.

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4. **Pharmacy Notification.**

PSAO shall develop, implement and maintain efficient and accurate procedures for notifying Pharmacies of the Pharmacies' obligations under the Agreement and any amendments or addenda thereto.

5. **Indemnification.**

PSAO shall indemnify PBM, Affiliates, Payors, and their respective shareholders, officers, directors, employees, and agents, and their successors, representatives, and assigns thereof, and hold them harmless for, from, and against, any and all liability, loss, damage, settlement, claim, injury, demand, judgment, and expense, including attorneys' fees, arising directly or indirectly from: (a) PBM's response to subpoenas or other requests for PSAO or Pharmacy information, (b) failure of PSAO to act in accordance with its agreement with Pharmacy(ies), (c) any dispute between PSAO and Pharmacy(ies), and/or (d) any delay or failure by PSAO to pay Pharmacy(ies) upon receipt of payment from PBM.

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PHARMACY PROGRAM CONDITIONS/REQUIREMENTS
SCHEDULE 1

WELLPOINT NATIONAL NETWORK

These Pharmacy Program Conditions/Requirements are hereby made a part of and effective in accordance with the terms of this Participating Pharmacy Provider Agreement.

A. **Prescription Charge: With respect to networks that permit a 60 days supply or greater, Pharmacy will be compensated for dispensing a 60 day or greater supply of Covered Pharmaceuticals to Covered Individuals as follows:**

1. For those Brand Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 20% plus a Dispensing Fee of $1.00, or
   (b) The dispensing Pharmacy's Usual and Customary Charge
   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

2. For those Generic Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 20% plus a Dispensing Fee of $1.00 or
   (b) The dispensing Pharmacy's Usual and Customary Charge
   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

3. For those Covered Prescriptions, Covered Refills and Covered Service which include drugs and products found on PBM's MAC list, the lesser of:

   (a) MAC plus a Dispensing Fee of $1.00 or
   (b) AWP minus 20% plus a Dispensing Fee of $1.00 or
   (c) The dispensing Pharmacy's Usual and Customary Charge
   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

Pharmacy will be compensated for dispensing less than or equal to a 59 day supply of Covered Pharmaceuticals to Covered Individuals as follows:

1. For those Brand Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 17% plus a Dispensing Fee of $1.50, or
   (b) The dispensing Pharmacy's Usual and Customary Charge
   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

2. For those Generic Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

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(a) AWP minus 17% plus a Dispensing Fee of $1.75 or
(b) The dispensing Pharmacy's Usual and Customary Charge
less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

3. For those Covered Prescriptions, Covered Refills and Covered Service which include drugs and products found on PBM's MAC list, the lesser of:

(a) MAC plus a Dispensing Fee of $1.75 or
(b) AWP minus 17% plus a Dispensing Fee of $1.75 or
(c) The dispensing Pharmacy's Usual and Customary Charge
less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

B. Unless prohibited by Plan, when the applicable contracted AWP discount plus dispensing fee or MAC plus dispensing fee ("Contracted Rate") is less than the Pharmacy's Usual and Customary Charge and the member's copayment, the Contracted Rate will not apply and the member will pay the lesser of the Pharmacy's Usual and Customary Charge or the member's copayment, which amount PBM will identify for Pharmacy via the online claims adjudication system as the amount to collect from the member.

C. In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

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PHARMACY PROGRAM CONDITIONS/REQUIREMENTS
SCHEDULE 2

100% CO-PAY PROGRAM
DISCOUNT CARD PROGRAM

These Pharmacy Program Conditions/Requirements are hereby made a part of and effective in accordance with the terms of this Participating Pharmacy Provider Agreement.

Prescription Charge. Subject to the terms of the attached Agreement, Pharmacy will be compensated for dispensing Covered Prescriptions, Covered Refills and Covered Services to Covered Individuals as follows:

1. For those Brand Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 13% plus a Dispensing Fee of $2.75, or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

2. For those Generic Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 13% plus a Dispensing Fee of $3.50, or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

3. For those Covered Prescriptions, Covered Refills and Covered Service which include drugs and products found on PBM's MAC list, the lesser of:

   (a) MAC plus a Dispensing Fee of $3.50, or
   (b) AWP minus 13% plus a Dispensing Fee of $3.50, or
   (c) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

Pharmacy agrees to accept the applicable rates as payment in full for all Covered Services. Pharmacy shall not bill a 100% Co-pay program participant any amount that results in compensation to Pharmacy exceeding the amounts as set forth hereunder.

Verify that the individual who presents a 100% Co-pay program card is the 100% Co-pay program participant whose name is set forth on the card, and shall confirm such individual's 100% Co-pay program membership through the on-line computer system.

Look solely to the 100% Co-pay program participant for payment for all Covered Services which are provided to such 100% Co-pay program participant pursuant to this Agreement. Pharmacy understands and agrees that neither PBM, nor any Affiliate of PBM, including but not limited to WellPoint, Inc., shall have any financial

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responsibility for Covered Services provided by Pharmacy to a 100% Co-pay program participant pursuant to this Agreement.

In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

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PHARMACY PROGRAM CONDITIONS/REQUIREMENTS
SCHEDULE 3

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND NETWORK

These Pharmacy Program Conditions/Requirements are hereby made a part of and effective in accordance with the terms of this Participating Pharmacy Provider Agreement.

Prescription Charge. Subject to the terms of the attached Agreement, Pharmacy will be compensated for dispensing Covered Prescriptions, Covered Refills and Covered Services to Covered Individuals as follows:

1. For those Brand Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 17% plus a Dispensing Fee of $1.50, or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

2. For those Generic Covered Prescriptions, Covered Refills and Covered Service which include drugs and products not found on PBM's MAC list, the lesser of:

   (a) AWP minus 17% plus a Dispensing Fee of $1.75, or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

3. For those Covered Prescriptions, Covered Refills and Covered Service which include drugs and products found on PBM's MAC list, the lesser of:

   (a) MAC plus a Dispensing Fee of $1.75, or
   (b) AWP minus 17% plus a Dispensing Fee of $1.75, or
   (c) The dispensing Pharmacy's Usual and Customary Charge

   less any applicable discount and less any Co-payment (all as calculated via the electronic Claim submission system).

In addition to Pharmacy's receipt of the base compensation described above, Pharmacy shall be entitled to retain any Co-payment amounts which exceed the above base compensation amount.

Pharmacy agrees that the above schedule shall also apply to prescriptions filled for eligible Covered Individuals of Blue Cross & Blue Shield of Rhode Island (BCBSRI) after such Covered Individuals have exhausted their prescription coverage under those plans, provided that (1) the Covered Individual is still otherwise covered by the BCBSRI Plan and (2) the prescription would have been a Covered Prescription but for the Covered Individual's exhaustion of the prescription drug benefit.

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PBM will have a claim adjudication process that differentiates a workers' compensation claim from a standard claim during the adjudication process for those BCBSRI contracts that hold a dual contract for BCBSRI traditional health benefits coverage and work-related injury coverage. Pharmacy will direct all claims pertaining to workers' compensation programs in which BCBSRI participates to PBM and PBM will process all such claims.

Pharmacy agrees to only charge the Prescription Charge for Covered Prescriptions filled for Covered Individuals subject to this Schedule after such Covered Individuals have exhausted their prescription coverage under their plans provided that (1) the Covered Individual is still otherwise covered by such plans and (2) the prescription would have been a Covered Prescription but for the Covered Individual's exhaustion of the prescription drug benefit. Further, Pharmacy agrees to charge and collect the Co-payment from the Covered Individual, except as stated above. When the Co-payment is a fixed amount, Pharmacy agrees to only charge and collect from Covered Individuals the lower of the Co-payment or Pharmacy's Usual and Customary Charges.

Pharmacy agrees that none of PBM, BCBSRI or their affiliates or clients, shall have any liability or obligation to pay for prescriptions that are not Covered Prescriptions.

Notwithstanding anything in this Agreement to the contrary, Pharmacy shall not bill, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against or impose any charges on Covered Individuals or persons acting on their behalf for Covered Services and shall regard the payment from PBM as payment in full for all benefits covered by this Agreement, with the exception of Co-payments specifically authorized in the applicable subscriber agreement and consistent with the Covered Individual's BCBSRI benefits. Neither PBM nor Pharmacy shall under any circumstances, including nonpayment by BCBSRI, the insolvency of BCBSRI, or breach or expiration or termination of this Agreement, seek compensation from, have any recourse against or impose any additional charge on any Covered Individual or persons acting on his/her behalf, and Pharmacy shall look only to PBM for payment and PBM shall look only to BCBSRI for payment of Covered Services.

Neither PBM, its agents, trustees, nor Pharmacy, its agents, trustees or assignees shall commence or maintain any action at Law against a Covered Individual to collect sums owed by BCBSRI.

Notwithstanding anything in this Agreement to the contrary, Pharmacy agrees to hold harmless BCBSRI from any liability arising from the services provided under or related to this Agreement.

In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

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PHARMACY PROGRAM CONDITIONS/REQUIREMENTS
SCHEDULE 4

WELLPOINT WORKERS' COMPENSATION "PRECISION COMPRx" NETWORK

These Pharmacy Program Conditions/Requirements are hereby made a part of and effective in accordance with the terms of this Participating Pharmacy Provider Agreement.

Participation

Pursuant to the requirements set forth below and applicable requirements defined in the base pharmacy contract, Pharmacy agrees to participate in the WellPoint Pharmacy Workers' Compensation Network. Unless otherwise set forth by statute or regulation, Pharmacy agrees to provide Covered Services to Covered Individuals in accordance with (but not limited to) the following provisions:

A. Prescription Charge. Pharmacy will be compensated for dispensing Covered Prescriptions/Pharmaceuticals to Covered Members/Individuals as follows:

1. For those Brand Covered Pharmaceuticals not on our MAC List, the lesser of:

   (a) AWP minus 13% plus a dispensing fee of $2.00 or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   as calculated via the electronic claim submission system.

2. For those Generic Covered Pharmaceuticals not on our MAC List, the lesser of:

   (a) AWP minus 13% plus a dispensing fee of $2.50 or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   as calculated via the electronic claim submission system.

3. For those Covered Pharmaceuticals on our Workers' Compensation MAC List, the lesser of:

   (a) MAC plus a dispensing fee of $2.50, or
   (b) AWP minus 13% plus a dispensing fee of $2.50, or
   (b) The dispensing Pharmacy's Usual and Customary Charge

   as calculated via the electronic claim submission system.

B. MAC. The Workers' Compensation MAC is defined as a range of AWP – 55 to 60%.

C. Program Conditions. Pharmacy will submit claims via the on-line system with the following information on each new workers compensation claim.

- Member first and last name
- Date of birth
- Date of injury
- Group name, Group ID number and Carrier ID number (this will be presented by the member)

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D. Taxes. If a provider tax or similar fee is imposed on you for provision of Covered Services by any government authority (excepting all applicable sales taxes), you shall be responsible for the provider tax and shall not pass such tax on to Covered Individual or PBM unless specifically required to do so under applicable law or regulation.

E. Confidential and Proprietary Information. The provider agrees that all terms contained herein and within any other Agreement between PBM and the provider is confidential and/or proprietary. The provider agrees not to disclose the terms and conditions contained herein or contained in any other WellPoint Agreement without the expressed written consent of WellPoint.

F. In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

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PHARMACY PROGRAM CONDITIONS/REQUIREMENTS
SCHEDULE 5
MEDICARE PART D – RETAIL PHARMACY PROGRAM CONDITIONS

These Medicare Part D Retail Pharmacy Program Conditions/Requirements (herein "Program Conditions") are hereby made a part of and effective in accordance with the terms of this Participating Pharmacy Provider Agreement.

SERVICES AND OBLIGATIONS OF PHARMACY

1. Participation-Medicare Part D. PHARMACY agrees to participate in the applicable Medicare Part D programs managed by WellPoint in accordance with the terms of these Program Conditions and the Participating Pharmacy Provider Agreement. In the event that there is a conflict between these Program Conditions and the Participating Pharmacy Provider Agreement, these Program Conditions shall control, but only as they relate to services provided to Covered Individuals or Covered Members enrolled in a Medicare Part D plan.

2. Participation-Medicare Part D Program. By virtue of the fact that PHARMACY is a Medicare Part D Participating Pharmacy, PHARMACY hereby acknowledges and agrees that PHARMACY shall provide services to any person enrolled in a Medicare Part D product managed by WellPoint that utilizes the Medicare Part D Pharmacy Network.

3. Covered Individual or Covered Member/Covered Service-Defined. The parties agree that all references in the Agreement to Covered Individual(s) or Covered Member(s) include Covered Individuals or Covered Members of WellPoint's Medicare Part D Program and all references to Covered Services include services offered pursuant to Medicare Part D Programs managed by WellPoint.

4. Accountability/Oversight. WellPoint delegates to PHARMACY its responsibility under its Medicare Part D contract with CMS to provide the services set forth in this Attachment to Medicare Part D Covered Individuals or Covered Members. WellPoint may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate the Agreement if CMS or WellPoint determines that PHARMACY has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of this Attachment. Performance of the PHARMACY shall be monitored by WellPoint on an ongoing basis as provided for in this Attachment. PHARMACY further acknowledges that WellPoint is accountable to CMS for the functions and responsibilities described in the Medicare Part D regulatory standards and ultimately responsible to CMS for the performance of all services. PHARMACY acknowledges that WellPoint shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Part D regulatory standards. Further, PHARMACY acknowledges that WellPoint may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §423.505(i)(4).

5. Non-Discrimination. In accordance with, but not limited to, 42 C.F.R. 423.505(b)(3) & 423.34(a), PHARMACY shall not deny, limit, or condition the furnishing of Covered Services to Medicare Part D Covered Individuals or Covered Members of WellPoint on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

6. Timely Access to Care. PHARMACY agrees to provide Covered Services consistent with WellPoint's standards for timely access to care and member services.

7. Covered Individual or Covered Member Confirmation. PHARMACY shall verify that the individual who presents a Medicare Part D card is the Medicare Part D Covered Individual or Covered Member, and shall confirm such individual's Medicare Part D membership through the on-line computer system.

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8. Data Submission. PHARMACY shall submit data through the on-line computer system in the format required by WellPoint for Covered Services.

9. Multi-Source Brand Disclosure Obligation. When a multi-source brand is dispensed, PHARMACY shall advise Medicare Part D Covered Individuals or Covered Members of the price difference between the multi-source brand and corresponding generic. Such disclosure shall be provided to Medicare Part D Covered Individual or Covered Member at the point of sale.

10. Cultural Competency. PHARMACY shall take reasonable measures to ensure that Covered Services rendered to Medicare Part D enrollees, both clinical and non-clinical, are accessible to all Medicare Part D enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. PHARMACY shall take reasonable measures to provide information regarding treatment options in a culturally-competent manner.

11. Standards of Care. PHARMACY agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care.

12. Hold Harmless. In accordance with, but not limited to, 42 C.F.R. 423.505(i) and 423.505(g), PHARMACY agrees that in no event, including but not limited to non-payment by WellPoint, insolvency of WellPoint or breach of the Agreement, shall the PHARMACY bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Part D Covered Individual, Covered Member or persons other than WellPoint acting on their behalf for Covered Services provided pursuant to the Agreement. This provision does not prohibit the collection of supplemental charges or Copayments on WellPoint's behalf made in accordance with the terms of the Medicare Part D enrollee's Part D benefits.

13. Survival of Agreement. PHARMACY further agrees that: (1) the hold harmless provision shall survive the termination of the Medicare Part D Covered Individual or Covered Member; (2) the hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PHARMACY and a Medicare Part D Covered Individual, Covered Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions of these clauses; and (3) any modifications, addition or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the Administrator of CMS has received written notice of such proposed changes.

14. Compliance with WellPoint's Clinical and Quality Management Programs. PHARMACY agrees to comply and cooperate with WellPoint's clinical and quality management programs. Nothing in these Program Conditions or Agreement is intended or should be construed to limit a pharmacist's professional judgment or violate applicable law.

15. Data Submissions and Accuracy. PHARMACY agrees to provide to WellPoint all information necessary for WellPoint to meet its data reporting and submission obligations to the CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Medicare Part D Covered Individual or Covered Member and the PHARMACY. PHARMACY further agrees to certify the accuracy, completeness, and truthfulness of PHARMACY generated data that WellPoint is obligated to submit to CMS, while these Program Conditions are in effect. Such certification shall be in writing, in a format that WellPoint specifies, and it shall certify the accuracy, completeness, and truthfulness of PHARMACY's data submitted to WellPoint during the specified period.

16. Approval of Materials. PHARMACY agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and policies relevant to PHARMACY's marketing activities under this Agreement, including but not limited to, CMS marketing guidelines for Medicare Part D Prescription Drug Plans, and any requirements for CMS prior approval of

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materials. Any printed materials, including but not limited to letters to Medicare Part D Covered Individuals or Covered Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by PHARMACY or any of his/her/its subcontractors pursuant to this Agreement must be submitted to WellPoint for review and approval at each planning stage (i.e., creative, copy, mechanicals, blue lines, etc.) to assure compliance with Federal, State, and other applicable guidelines. WellPoint agrees its approval will not be unreasonably withheld or delayed.

17. Subcontractors. PHARMACY agrees that if PHARMACY enters into subcontracts to perform services under the terms of this Attachment, PHARMACY's subcontracts shall include: (1) an agreement by the subcontractor to comply with all of the PHARMACY's obligations in the Agreement and this Attachment; (2) a provision setting forth the term of the subcontract (preferably one year or longer); and (3) dated signatures of all the parties to the subcontract.

ACCESS: RECORDS/FACILITIES

1. Inspection of Books/Records. Consistent with, but not limited to, 42 C.F.R. 423.505(i), PHARMACY acknowledges that Health and Human Services department (HHS), the Comptroller General, or their designees have the right to inspect, evaluate, and audit any books, contracts, records, patient care documentation, and other records of PHARMACY, or his/her/its subcontractors or transferees involving transactions related to Medicare Part D through ten (10) years from the final date of the Prescription Drug Plan contract period or from the date of the completion of any audit, or for such longer period provided for in other applicable law, whichever is later. For the purposes specified in this provision, PHARMACY agrees to make available PHARMACY's premises, physical facilities and equipment, records relating to Medicare Part D Covered Individuals or Covered Members, and any additional relevant information that CMS may require.

2. Confidentiality. PHARMACY agrees to abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information. In addition, PHARMACY agrees to abide by the confidentiality requirements established by WellPoint and the Medicare Part D Program. PHARMACY agrees to maintain records and other information with respect to Medicare Part D enrollees in an accurate and timely manner; to ensure timely access by enrollees to the records and information that pertain to them; and to safeguard the privacy of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals. PHARMACY must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders or subpoenas.

COMPLIANCE

1. Compliance: Medicare Laws/Regulations. In accordance with, but not limited to, 42 C.F.R. 423.505(i)(4), PHARMACY agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare laws, regulations, and CMS instructions. Further, PHARMACY agrees that any Covered Services provided by the PHARMACY or his/her/its subcontractors to Medicare Part D Covered Individuals or Covered Members will be consistent with and will comply with the Prescription Drug Plan's Medicare Part D contractual obligations.

2. Compliance: Exclusion from Federal Health Care Program. PHARMACY may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any Federal health care program under § 1128 or § 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following:

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- healthcare;
- utilization review;
- medical social work; or
- administrative services.

3. Compliance: Appeals/Grievances. PHARMACY agrees to comply with WellPoint's policies and procedures in performing his/her/its responsibilities under the Agreement. PHARMACY specifically agrees to comply with Medicare requirements regarding Medicare Part D Covered Individual or Covered Member appeals and grievances and to cooperate with WellPoint in meeting its obligations regarding Medicare Part D enrollee appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

4. Illegal Remunerations. PHARMACY specifically represents and warrants that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

GENERAL PROVISIONS

1. Termination for Medicare Exclusion. PHARMACY acknowledges that this Attachment shall be terminated if PHARMACY, or a person or entity with ownership or control interest in PHARMACY, is excluded from participation in Medicare under § 1128A of the Social Security Act or from participation in any other Federal health care program.

2. Term and Termination. This Attachment shall be effective on the effective date set forth above, and shall continue in effect for a term of one year, automatically renewing for consecutive one year terms unless otherwise terminated as provided for in this Attachment or in the Agreement.

3. Inconsistencies. In the event of an inconsistency between the terms of these Program Conditions and the terms and conditions set forth in the Agreement, the terms and conditions of these Program Conditions shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

4. Interpret According to Medicare Law and/or Federal Laws. PHARMACY and WellPoint intend that the terms of the Agreement and this Attachment as they relate to the provision of Covered Services under the Medicare Part D Program shall be interpreted in a manner consistent with applicable requirements under Medicare law and/or Federal Laws.

COMPENSATION

1. PHARMACY agrees to accept the compensation noted in these Program Conditions as payment in full for each Covered Pharmaceutical provided to a Medicare Part D Covered Individual or Covered Member. PHARMACY shall not bill a Medicare Part D Covered Individual or Covered Member any amount that results in compensation to PHARMACY exceeding the amounts as set forth in these Program Conditions.

2. Federal Funds. PHARMACY acknowledges that payments PHARMACY receives from WellPoint to provide Covered Services to Medicare Part D Covered Individuals or Covered Members are, in whole or part, from Federal funds. Therefore, PHARMACY and any of his/her/its subcontractors may be subject to certain laws that are applicable to individuals and entities receiving Federal funds.

3. Compensation-Medicare Part D. For Covered Services provided to Medicare Part D Covered Individuals or Covered Members, PHARMACY shall be compensated as follows according to the network options selected as part of its participation in the WellPoint Medicare Part D program. PHARMACY has the option of participating in one or both networks by completing each network option.

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1. For those Brand Covered Pharmaceuticals up to and including a 34 day supply, which are not on WellPoint's Medicare MAC List, the lesser of:

(a) AWP minus 17% plus a dispensing fee of $1.50, or
(b) The dispensing PHARMACY's Usual and Customary Charge.
less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

2. For those Generic Covered Pharmaceuticals up to and including a 34 day supply, which are not on WellPoint's Medicare MAC List, the lesser of:

(a) AWP minus 17% plus a dispensing fee of $1.75, or
(b) The dispensing PHARMACY's Usual and Customary Charge.
less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

3. For those Covered Pharmaceuticals up to and including a 34 day supply, which are on WellPoint's Medicare MAC list, the lesser of:

(a) MAC plus a dispensing fee of $1.75, or
(b) AWP minus 17% plus a dispensing fee of $1.75, or
(c) The dispensing PHARMACY's Usual and Customary Charge
less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

IN WITNESS WHEREOF, an authorized representative for PHARMACY and WellPoint have executed these Program Conditions intending to be bound by the terms set forth herein.

PHARMACY

By: _____
Signature

_____
Print Name

_____
Title

_____
Pharmacy Name

_____
Pharmacy Address

_____
City, State, Zip Code

_____
Pharmacy Phone Number

_____
Pharmacy NCPDP Number

_____
Pharmacy NPI Number

_____
Date

ANTHEM PRESCRIPTION MANAGEMENT, LLC AND PROFESSIONAL CLAIM SERVICES, INC., d/b/a WellPoint Pharmacy Management

By:

Keith Dostal

P.O. Box 4488
Woodland Hills, CA 91365

_____
Date

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The WellPoint 90 Day Medicare Network

1. For those Covered Brand Pharmaceuticals on or between a 35 day and a 90 day supply, which are not on *WellPoint's* Medicare MAC List, the lesser of:
   (a) AWP minus 20% plus a dispensing fee of $1.00 or
   (b) The dispensing Pharmacy's Usual and Customary Charge
   less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

2. For those Covered Generic Pharmaceuticals on or between a 35 day and a 90 day supply, which are not on *WellPoint's* Medicare MAC List, the lesser of:
   (a) AWP minus 20% plus a dispensing fee of $1.00 or
   (b) The dispensing Pharmacy's Usual and Customary Charge
   less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

3. For those Covered Pharmaceuticals on or between a 35 day and a 90 day supply, which are on *WellPoint's* Medicare MAC List, the lesser of:
   (a) MAC plus a dispensing fee of $1.00, or
   (b) AWP minus 20% plus a dispensing fee of $1.00, or
   (c) The dispensing Pharmacy's Usual and Customary Charge
   less the applicable discount, rebates, and Copayments (all as calculated via the electronic claim submission system).

In accordance with the terms of this Agreement, for each on-line transmission, including but not limited to, each submission and/or reversal of a Claim through the PBM's claims system, Pharmacy will be assessed a fee of $0.03 per on-line transmission (herein referred to as "Transaction Fees"). Pharmacy agrees that the applicable Transaction Fees may be deducted from the Claims payments owed to Pharmacy by the PBM. In the event that Claims payments owed by Pharmacy are insufficient to cover applicable Transaction Fees owed to the PBM, Pharmacy agrees to reimburse the PBM within thirty (30) days of being notified of such due and owing Transaction Fees.

IN WITNESS WHEREOF, an authorized representative for *PHARMACY* and *WellPoint* have executed these Program Conditions intending to be bound by the terms set forth herein.

PHARMACY

By: _____
Signature

_____
Print Name

_____
Title

_____
Pharmacy Name

_____
Pharmacy Address

_____
City, State, Zip Code

_____
Pharmacy Phone Number

_____
Pharmacy NCPDP Number

_____
Pharmacy NPI Number
Date: _____

ANTHEM PRESCRIPTION MANAGEMENT, LLC AND PROFESSIONAL CLAIM SERVICES, INC.,
d/b/a WellPoint Pharmacy Management

By:

Keith Dostal

P.O. Box 4488
Woodland Hills, CA 91365

_____
Date

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