terms specified in this Agreement. Accompanying each payment will be a complete explanation of the claims for which payment is being made. Payment date as used in this Agreement will mean the date payment is to be delivered to the designated location, as set forth below.

4.2 Pharmacy will submit claims in the prescribed format to Argus Health System, Inc. or other designated claims processor via on-line electronic submission, at Pharmacy's communication access fee expense. Pharmacy Claims may also be submitted to designated prescription claims processor on magnetic tape by an approved datalink. All on-line electronic submissions, tapes and diskettes used for billing must be formatted in an approved format and layout. Pharmacy will bill Providence using the National Drug Code (NDC) as it appears on the package labeling of the dispensed product. Pharmacy must provide accurate and complete data on all billing documents. All complete and accurate electronic pharmacy claims will include all information or data elements described by the NCPDP Telecommunications Standard Format (NCPDP Version 3.2 or most recent applicable version) and billing information submitted in that format. Providence may change electronic claim submission requirement upon thirty (30) day written notification to the Pharmacy. Pharmacy will bill usual and customary charges on all claims taking into account any discount offered or given.

Pharmacy will submit all original claims for payment on-line to Providence and/or its processor within forty-five (45) days of the date of pharmacy service is rendered to Member. In the event that any such claim is rejected, suspended or additional information is required for further processing by Providence and/or its processor, Pharmacy will resubmit the claim for payment to Providence and/or its processor within thirty (30) days of Pharmacy's receipt of such rejected claim. For continuing service, date of service shall be understood to be the last day of any month of service. Appeals of payment or denial decisions must be made according to guidelines, if any, set forth in the Rules and Regulation of Providence's.

4.3 Pharmacy agrees to accept payment of claims from Providence as full and final payment for covered prescription drug benefits rendered to eligible Members, except for collection of Copayments, Co-insurances, or Deductibles. Pharmacy's compensation for Services shall be at the rates set forth in the Attachments. Payment will be within thirty-five (35) days from submission of complete and accurate claim. Furthermore, it is understood that Pharmacy will seek payment only from Providence and under no circumstances will bill Providence Members for covered prescription drug benefits, unless so instructed by Providence in writing. In the event the revenues of Providence are insufficient to pay Pharmacy the compensation due under this Agreement, Pharmacy agrees to furnish to Providence Members services in accordance with applicable Oregon and Washington State law, including ORS 750.095.

4.4 Providence requires Members to pay a fee or Copayment, Coinsurance or Deductible for certain Covered Services as set forth in the Member's Individual or Group Service Agreement with Providence. Pharmacy shall collect the lesser of: the Copayment, Coinsurance or Deductible amount shown on the electronic on-line billing system at the time the prescription is filled, or the usual and customary charge minus any discounts or coupons offered. In no instance, Pharmacy shall collect more than the usual and customary charge, including any discounts or coupons offered to the general public, from Member. Compensation to Pharmacy shall consist of Member fee or Copayment, Coinsurance or Deductible and Providence payment, the sum total of all shall be the amounts set forth in the Attachments. Pharmacy shall be responsible for the collection and Members shall be responsible for payment of such fees or Copayments, Coinsurance or

3.03.05 Documentation

Provider must maintain documents to demonstrate its compliance with terms of section **3.03 Patient Pay** of the Provider Manual, and Provider agrees that such documentation is subject to Caremark audit.

3.03.06 Excess Collections

If Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims adjudication system, Provider must promptly reimburse Eligible Person for the excess amount upon Caremark request; otherwise, Caremark reserves the right to recover the excess amount from Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the Eligible Person.

3.03.07 Limitation on Collection

Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including non-payment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

3.03.08 Violations

Any act, omission, or scheme that encourages or allows conduct resulting in a violation of section **3.03 Patient Pay** of the Provider Manual, such as but not limited to, pharmacy-sponsored coupons, advertisements, pamphlets, flyers, and website postings promoting waiver of Patient Pay Amounts, is strictly prohibited and may result in the immediate termination of the Provider Agreement and other remedies available to Caremark. Claims submitted in violation of this section are subject to chargeback. Provider agrees that absent the waiver or reduction of Patient Pay Amount, the prescription would not have been dispensed.

3.03.09 Patient Inducements

Provider may not offer or provide any item of value, including but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider's records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed separately in the Provider Manual.

3.03.10 Waivers

Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system unless otherwise authorized in writing by Caremark or except for a non-routine, unadvertised waiver of a Patient Pay Amount that does not violate applicable Law and is either:

- A waiver based on an individualized determination of financial need made under a Financial Hardship Program that meets the Financial Hardship Program requirements set forth below; or
- A waiver made following exhaustion of reasonable collection efforts, such as invoices, billing letters, and collection calls.

Provider must document its reasonable collection efforts, and such documentation must include, at minimum, the date the collection effort was sent or contact made, the Patient Pay Amount owed by Eligible Person, results of each collection effort, and final disposition.

If a payment plan is agreed to by Provider with an Eligible Person for the payment of a Patient Pay Amount, all terms of the payment plan, including the total amounts subject to the payment plan and repayment terms, must be documented and written confirmation of such terms must be sent to the Eligible Person. The payment plan must be reasonable and expected to result in full collection of outstanding Patient Pay Amounts owed and must be readily retrievable upon request from Caremark.

3.03.11 Financial Hardship Program

Waivers based on an individualized determination of financial need under a Financial Hardship Program must meet the following requirements.