PHARMACY PROVIDER MANUAL

Nebraska

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Introduction:

Thank you for your agreement to partner with BeneCard PBF as a Network Pharmacy. We value your participation and commitment to our Member's wellness.

BeneCard PBF, a division of Benecard Services, Inc., is a privately held company specializing in administering prescription benefit programs to thousands of Members.

Our business philosophy revolves around five goals:

1. Deliver maximum value for benefit dollars spent;
2. Eliminate conflicts of interest among the parties serving the Plan;
3. Help members stay healthy;
4. Provide exceptional service to Pharmacies…really;
5. Make sure you are prepared for the future.

As a Participating Network Pharmacy provider, you are in many cases the only contact our Members experience with BeneCard PBF, therefore the value of our partnership is of the utmost importance when it comes to taking care of our Members. We recognize how important the Pharmacy is and we work hard to take care of you with our claim processing system and 24x7x365 Pharmacy Help Desk.

With BeneCard PBF's Transparent business model our goal is to provide our clients with the lowest net cost; we do not profit from pricing spread since our clients are billed the exact same amount that you are paid.

The following Provider Manual was developed to assist you when processing claims for our Members. Please review this and keep it handy for future reference. As always, our Pharmacy Help Desk is available to provide assistance when needed 24 hours a day, 7 days a week, 365 days a year at 1-888-907-0050.

We look forward to our continued partnership.

Sincerely,

BeneCard PBF Provider Relations

1.1 About this Manual

This manual is intended to provide pharmacy claims submission guidelines using EDS online system and to alert BeneCard PBF Pharmacies to new and changed program information.

This manual can be mailed, faxed or e-mailed to a BeneCard PBF Participating Pharmacy Provider. It is also available on the Web at:

www.benecardpbf.com

2 Key Terms

Centers for Medicare and Medicaid Management Services (CMS)

- A federal agency in charge of providing quality healthcare coverage for beneficiaries.

Claim

- A request for payment of healthcare services.

Electronic Data Interchange

- A method of transmitting claims electronically.

Long Term Care (LTC)

- Refers to institutional settings that include skilled nursing facilities and intermediate care facilities.

National Council for Prescription Drug Programs (NCPDP)

- A not-for-profit ANSI-accredited Standards Development Organization.

Point of Sale (POS)

- On-line, real-time claim adjudication.

Prior Authorization (PA)

- Certain medication requires information from the prescribers and physicians regarding safety, efficacy, and appropriate utilization to determine coverage of a medication in compliance with P&T committee approved protocols. The authorization must be obtained prior to the services being rendered.

Concurrent Drug Utilization Review

- Clinical messages accompany an adjudicated claim to identify safety issues and concerns.

3 Contact Information

3.1 Provider Services 24 hr. Call Center Number: 1-888-907-0050

Provider Services Fax Number: 1-888-723-6008

Reimbursement Inquiries Number: 1-877-723-6004

Prior Authorization Number: 1-888-723-6001

Prior Authorization Fax Number: 1-609-219-1078

Provider Services Email: NetworkQuality@benecardpbf.com

MAC Appeals Email: NetworkQuality@benecardpbf.com

3.2 Mailing Address:

BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055
Attention: Vice President, Pharmacy Trade Relations

Claims Mailing Address:

BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055
Attention: Claims Processing Dept.

3.3 Provider Enrollment

Enrolling as a Participating Pharmacy is simple and easy. You need to complete our Pharmacy Application, become credentialed, and sign our contract. All of this can be done within 24 hours. Contact BeneCard PBF for an Enrollment Packet at 877-723-6004.

3.4 Batch Identification Number:

Also known as the BIN is:

014179 for BeneCard PBF

017688 for EmpiRx

3.5 *Processing Control Number*:

Also known as the PCN:

9743 for BeneCard PBF

9743 for EmpiRx

You will need both the BIN and PCN to submit claims electronically.

4 *POS SPECIFICATIONS:*

4.1 *Required Data Elements:*

See Payer Sheets (under mandatory segments)

4.2 *Claim Reversals:*

Pharmacies have ninety (90) days to reverse a claim otherwise you will need assistance from BeneCard PBF

4.3 *Adjudication Codes:*

Pharmacy Help Desk: Adjudication Notes

Error Code # 1 – Missing/Invalid BIN number
- ✓ BIN Number is 014179

Error Code # 4 – Missing/Invalid Processor Control Number
- ✓ PCN number is 9743

Error Code # 6 – Missing/Invalid Group Number
- ✓ Utilize RxGRP identified on Member Card

Error Code # 52 – Non-Matched Cardholder ID
- ✓ Always submit Full Card ID (ALL alpha-numeric characters on Card ID)

Error Code # 56 – Non-Matched Prescriber ID
- ✓ Prescriber's NPI number is required on all claims

Error Code # 17 – Missing/Invalid Fill Number
- ✓ The refill number must be equal to or less than the original refill amount authorized

5 Prior Authorizations

5.1 Drugs Requiring PA:

A prior authorization reject means that the medication requires a diagnosis and information from the treating physician. The process begins by submitting the request to BeneCard PBF. This is done by calling the number that appears on the screen for a rejection or 888-907-0050. A form is then submitted to the physician and a determination will be made once all the paperwork has been received following the ERISA timelines.

5.2 Emergency PA Protocol:

BeneCard PBF has an emergency policy for prior authorizations. Pharmacists or physicians need to call the above number (888-907-0050) and identify the issue and that it is an emergency. The representative then will follow the emergency protocol if the issue is considered an emergency or life-threatening issue.

5.3 Filing Client PA Appeals:

Appeals need to be filed by the member within the ERISA time frames or submit information in writing to BeneCard PBF.

6 Timely Filing Limits:

Filing limits are Client specific although the standard is fourteen (14) days.

7 Dispensing Limits:

Day supply limits are Client specific and will vary from one client to another. Review the Client's Sponsor Plan Specifications ("SPS").

8 Dispensing Fees

Dispensing fees vary from client to client. Review the Client SPS.

9 MAC Appeals

9.1 MAC Appeal Process

If a pharmacy disagrees with the MAC Price reimbursement, the pharmacy may request a MAC Appeal within fifteen (15) business days of the processed claim. Benecard will investigate and resolve any appeal within seven (7) business days after the appeal is received. The request can be submitted via fax at 888-732-6008, submitted using the web portal request link or by mailing the request to:

Benecard PBF
Provider Relations
5040 Ritter Road
Mechanicsburg, PA 17050

The MAC appeal request must contain all of the following information before the review process can begin.

Pharmacy Name
Pharmacy NPI
Pharmacy NABP
Pharmacy Contact
Pharmacy Phone Number
Pharmacy State
Member's ID (Card ID)
Member Group ID (Client ID)
Rx Number
Date of Service
Quantity
Days' Supply
Drug Name
NDC Number
Pharmacy Invoice Cost
Pharmacy Package Size
Pharmacy Unit Price
Copy of invoice or evidence of cost of drug

Benecard will provide a reason for any denial of an appeal and identify the national drug code (NDC) for the drug that may be purchased by the pharmacy at a price at or below the price on the maximum allowable cost (MAC) price as determined by the pharmacy benefit manager. Benecard makes an adjustment in the drug price no later than one (1) day after the appeal is approved and permits the appealing pharmacy to reverse and rebill the claim in question using the date of the original claim.

* If the pharmacy is trying to request a MAC Appeal for a claim over sixty (60) days in age the pharmacy will need to call 877-723-6004 for further assistance.

9.2 *Daily & Weekly MAC Notifications*

Benecard updates any maximum allowable cost (MAC) price list at least every seven (7) business days, noting any price change from the previous list, and provides a means by which a network pharmacy may promptly review a current price in an electronic, print, or telephonic format within one (1) business day of any such change at no cost to the pharmacy.

Benecard shall not place a prescription drug on a maximum allowable cost price list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete.

Daily communication will be sent out to in-network Nebraska pharmacies when there is an approved MAC appeal from the previous day. This notification will only be generated when a MAC Appeal has been approved.

Weekly communication will be sent out to in-network Nebraska pharmacies of any MAC pricing changes that occurred during the previous week with a link to the current MAC pricing.

www.benecardpbf.com

All notifications and changes will be accessible through the web portal for sixty (60) days.

9.4 Other Appeals:

All Other appeals should follow the same steps that are listed in 9.1.

When it is required to dispense a clinician-administered drug through a specialty pharmacy, the health care provider or pharmacy may appeal and have exceptions to the use of a specialty pharmacy when:

(a) A drug is not delivered as specified in Nebraska Revised Statute §44-4613(2); or

(b) An attending health care provider reasonably believes a covered person may experience harm without the immediate use of a clinician-administered drug that a health care provider or pharmacy has in stock.

10 *Pharmacy Payment Information*

BeneCard PBF works on a two (2) cycle billing month. The cycle closes on the 1st and 15th of each month. Pharmacy payments are mailed within ten (10) business days of the cycle closing. Any questions regarding payment you may contact the Provider Relations Team at 866-723-6004.

11 *BeneCard PBF Credentialing Policy*

It is the policy of BeneCard PBF, to certify and recertify the credentials, patient care quality and other factors of all Participating Pharmacies using the standards set out in this policy.

BeneCard PBF retains the right to terminate a Participating Pharmacy in any of our Pharmacy networks when a Participating Pharmacy breaches the covenants of the Retail Pharmacy Agreement; the health, safety and welfare of a Member is in jeopardy; or Participating Pharmacy engages in any fraudulent activity.

➢ Credentialing Standards

In order to qualify as a Participating Pharmacy for BeneCard PBF networks, the Pharmacy must meet the following current standards:

- *Valid State Pharmacy and/or Business License(s)*
- *Board Certification(s)*
- *DEA Certification*
- *CDS Certification*
- *Completed and signed Retail Pharmacy Agreement*
- *Professional Liability Insurance Certificate of Coverage*
- *W-9 Completed Form(s) required each different Tax ID number*
- *Compliance with the Retail Pharmacy Agreement and all requirements for plan administration*
- *Satisfactory History of Professional Conduct including any sanctions*
- *Satisfactory Education and Training*

➢ Verification

BeneCard PBF's Relations Network Support staff will verify the information on the Retail Pharmacy Agreement using all available public sources, direct contact verification, and the following resources:

- http://www.healthguideusa.org
- http://www.oig.hhs.gov/fraud/exclusions.asp

Once verified, the BeneCard PBF's Provider Relations Network Support staff will determine if the Participating Pharmacy is eligible to participate in BeneCard PBF Pharmacy Network. If the determination is to approve the submitted application, Provider Relations staff will:

- Recommend approval.
- Update BeneCard PBF Participating Pharmacy Network Systems with all applicable information.

If the Retail Pharmacy Agreement is incomplete, Provider Relations Network Support staff will contact the Pharmacy and offer the opportunity to correct any deficiencies or to provide supplemental information. If the Pharmacy fails to correct the incomplete Retail Pharmacy Agreement within thirty (30) calendar days of notice, the application is placed on hold and will be returned to the Pharmacy or destroyed.

If the application is not approved, the Provider Relations Network Support staff will:

- Recommend denial.
- Send the Pharmacy a denial letter specifying the reasons why the application was not approved. The denial letter will contain the Pharmacy's appeal rights.
- Reconsideration of the denial is possible if additional information and/or other evidence are submitted by the Pharmacy within fourteen (14) calendar days of the delivery of the letter.
- Provider Relations Network Support staff will recommend continued denial or approval to the Credentialing Committee based on any new information received from Pharmacy.
- The rejected Pharmacy has the right to appeal this decision to the Vice President, Pharmacy Trade Relations.

➢ Appeal process

If the Pharmacy disagrees with the credentialing determination, the Pharmacy may request an appeal by submitting a written request to the BeneCard PBF Vice President, Pharmacy Trade Relations at the following address:

BeneCard PBF

Attn: Vice President, Pharmacy Trade Relations

5040 Ritter Road

Mechanicsburg, PA 17055

The formal appeal request must be written and submitted within thirty (30) days of the notification of the rejected application.

The Vice President, Pharmacy Trade Relations will review the requested Appeal on the current record and make a determination to affirm or reverse the denial decision. The determination shall be submitted in writing to the Pharmacy within sixty (60) days.

➢ Re-Credentialing

- Re-credentialing will occur on a one (1) or two (2) year cycle, depending on the state the license was issued, or at any time adverse information is obtained about a Participating Pharmacy. Re-credentialing will follow the same standards and processes outlined above, as well as take into account any new on-site visit, patient satisfaction, contract and plan administration compliance, member access needs and other Participating Pharmacy agreement updates during the participation period.
- Re-credentialing review will include, but not be limited to, Quality, Cost, Administrative Compliance, Member Complaints (if applicable), etc.
- Should a negative re-credentialing decision be made by the Vice President, Pharmacy Trade Relations, the Participating Pharmacy may appeal the decision to the Senior Vice President, Pharmacy Trade Relations, or his/her equivalent for review.

➢ Corrective Action

- After participation has been granted, Provider Relations Network Support staff will monitor the performance of the Participating Pharmacy. Should adverse information be obtained regarding the items verified in the credentialing process, patient satisfaction, quality, cost, and/or administrative compliance, the Provider Relations Network Support staff will investigate these findings. The purpose of this investigation is to confirm the information obtained. This research is done through

various outlets, as stated in the verification process above, as well as other resources if available and applicable (*i.e., member surveys, complaints, etc.*).

- Upon completion of the investigation by the Network Support Staff, if the information obtained is found to be true, the Provider Relations Network Support staff will recommend to the Vice President, Pharmacy Trade Relations a disciplinary action depending upon the severity of the findings. BeneCard PBF will require a Corrective Action Plan ("CAP") with the Pharmacy, and could require further actions which may include, but limited to, the following:
    1. Audit of Participating Pharmacy member claims;
    2. Participating Pharmacy written warning of non-compliance;
    3. Termination of Participating Pharmacy.
- A documented record will be kept of all disciplinary proceedings and their outcome.
- Provider Relations Network Support staff will forward the Participating Pharmacy file to the Vice President, Pharmacy Trade Relations.
- Within thirty (30) days of the Professional Relations Network Support staff recommendation, the Vice President, Pharmacy Trade Relations will determine whether to affirm, reverse or modify the recommendation. The Vice President's determination will be submitted in writing to the Participating Pharmacy within this 30-day period.
- The Participating Pharmacy has the right to appeal the decision of the Manager of Quality Assurance to the Credentialing Committee or its Sub-committee, within thirty (30) days of receipt of the decision.

➢ Delegation

- Any delegate of credentialing authority must meet the same or comparable standards to be qualified for delegation of credentialing and be approved by the Vice President, Pharmacy Trade Relations.
- All entities responsible for credentialing are subject to the terms of the Retail Pharmacy Agreement and terms of the prescription benefit coverage.
- Whether credentialing is delegated or not, Participating Pharmacies are subject to regular reviews and will be audited as needed, typically in a one (1) or two (2) year cycle to ensure complete compliance with BeneCard PBF guidelines.
- All delegated entities will provide a copy of their credentialing standards of the organization.
- All delegated entities will report to BeneCard PBF any negative findings within 30 days of the finding.

12 *Pharmacy Audit Program*

SUSPECTED FRAUD AND ABUSE

For suspected fraud or abuse by a covered Member, prescribing physician or a Network Pharmacy, please contact;

BeneCard PBF
Attn: Pharmacy Audit Manager
5040 Ritter Rd
Mechanicsburg, PA 17055
Or call 973-574-2478

DISPENSING LIMITS:

QUANTITY – The quantity submitted should be the number of units dispensed according to NCPDP guidelines and the client's plan design limitations (SPS).

DAYS SUPPLY – The days supply submitted should be based on the directions indicated on the prescription. Overstating the days supply may affect future refills, while understating the days supply may exceed the Members plan parameters. The Pharmacy is responsible for submitting the correct quantity and day supply when adjudicating a prescription claim.

BeneCard PBF conducts both desk-top and on-site claim reviews. All claims submitted for payment by the Pharmacy are subject to desk-top and/or on-site audit by our Audit Department. Audits are conducted in compliance with federal and state guidelines along with the client's pharmacy benefits coverage (SPS).

The Pharmacy shall provide BeneCard PBF access to their records. The audit may include but is not limited to the following areas:

- Hard copy prescription files
- Usual and customary pricing
- Signature logs (electronic signature logs are acceptable)
- Purchase invoices
- Patient profiles

BeneCard PBF will use these records to compare the on-line claim submissions with the hard copies of prescription and other documentation.

On-site audits will be conducted during regular business hours with prior written notification to the Pharmacy.

Non-compliance with audit requests may be grounds for termination of our Retail Participating Pharmacy Agreement.

No fees or charges will be allowed by the Pharmacy to perform a claims audit review. The Pharmacy provider will bear the expense of providing records requested by BeneCard PBF.

During a claims review if a discrepancy is found, BeneCard PBF will contact the Pharmacy to inquire about the claim(s) in question. Most of the claim inquiries can be resolved through fax, telephone or through claim reversal and resubmission. If a request for a hard copy is needed on the claim(s) in question, the Pharmacy will be asked to provide a copy for review.

There are several situations that could prompt an audit -

- Referral by a client or member;
- Pharmacy exceeds its peers in one or more of our standard audit profile categories;
- Routine area audit of Pharmacies for a specific location.

On-Site Audit:
BeneCard PBF performs routine on-site audits. BeneCard PBF will notify the Pharmacy approximately three weeks prior to a scheduled audit date. During an on-site audit, the auditor will review specific records related to claims paid to the Pharmacy during the time period specified in the notification letter.

Claims Review and Desk Audits:
BeneCard PBF regularly monitors paid claim data for potential billing errors. If a question arises, BeneCard PBF will contact the Pharmacy regarding the claim(s) in question. The Pharmacy will be asked to provide copies of the prescription in question. A review and determination will be made based on the documents provided.

Prescription Requirements:
All prescription documentation must contain the following information:

- Full name, address, and date of birth of the member
- Full name and telephone number of the prescribing physician along with the NPI and/or DEA number of physician
- Name and strength of medication and quantity
- Specific dosage directions - If there is a change in directions, a new prescription must be created
- If a patient requests a brand medication, DAW 2 needs to be indicated on the written prescription
- The physician must write 'Dispense as Written' on the prescription – if the prescription is phoned in, the pharmacist must manually write 'Dispense as Written'. Failure to do so may result in a chargeback

Compound Prescriptions:
Compounded prescriptions must be submitted with the most expensive drug and are reimbursed according to the Participating Pharmacy Agreement. The compound drug must contain at least one federal legend ingredient. All compound drugs must have a

valid NDC number. The Pharmacy may not include costs for labor, equipment, professional fees, or flavoring. A prescription will not be considered a compound if only water is added to the active ingredient.

Time Frame:
BeneCard PBF reserves the right to review claims history for up to five years. However, our standard audits generally include one year prior to the date of audit.

Unacceptable Practices:
Based on the claim submission requirements, the following are examples of unacceptable and in some cases fraudulent billing practices:

- Billing for a quantity that is greater than the quantity prescribed
- Dispensing a lesser quantity than what was prescribed
- Billing for a prescription drug without a valid physician prescription
- Refilling a prescription greater than what the physician had stated on the original claim
- Submitting a claim with a National Drug Code (NDC) other than the NDC on the product dispensed
- If a patient requests a smaller amount, a notation should be made on the hard copy of the prescription
- Submitting a claim with incorrect information including but not limited to the NPI

BeneCard PBF may terminate a Pharmacy for violations of these or other restrictions that constitute fraud or billing abuses.

Any payment made to a Pharmacy that exceeds the amount that should have been made to a Pharmacy whether intentional or in error may be recovered by BeneCard PBF. BeneCard PBF shall notify the Pharmacy of over-payments and shall have the right to offset such excess payment amounts against any future Pharmacy payments that may be due to Pharmacy or to require reimbursement from Pharmacy for any excess payment amounts. If a claim is eligible to be submitted to Medicare Part B carrier, the claim will be submitted to the carrier first.

Non-Compliance:
A Pharmacy must provide services to all covered members. A Pharmacy cannot refuse to accept a valid member ID card or eligibility verification. All Pharmacies must collect from the member the co-pay and other amounts displayed in the claims system.

Disciplinary Actions:
Any disciplinary actions will be handled according to the process set out in the credentialing section of this Manual.

Confidentiality:
Except as required by law, BeneCard PBF will maintain the confidentiality of all information received by the Pharmacy in regard to prescription claim audits and reviews.

13 *Drug Utilization Review (DUR)*

The most common DUR rejections are caused by therapeutic duplications, high doses, drug interactions, drug to age, or drug to gender issues. Please pay close attention to them as member safety and appropriate use of medication is the primary responsibility of pharmacists.

DUR rejections are handled by reviewing the issue at hand along with any extra information provided by BeneCard PBF, the Pharmacy, Member or Physician. For example, if a drug is over the FDA maximum amount, the message will say "x pills exceed the maximum of x-x pills per day". The pharmacist should then review the claim and correct as needed. All DUR messages have a safety concern and need to be addressed. Please note the conflicting medication may not have been filled at your Pharmacy. When the rejection is received you may contact the physician and resolve the issue. Once this occurs you may use the appropriate POS edits and the claim will be processed. If you cannot confirm the information, please call BeneCard PBF and we will contact the physician and call you back with a response. It is imperative that you read the messages and confirm the information provided to avoid a safety issue.

Pharmacy Override Codes – DUR Rejection

I. High Dose: Pharmacist verification
   (i) Patient has been on this treatment or
   (ii) New treatment verified by prescriber

Override Code – High Dose or No Dose Provided
- HD DE 1B - (High Dose + Dosing evaluation/determination + Fill Prescription as Is)
- HD M0 1B - (High Dose + Prescriber consulted + Fill Prescription as Is)

II. Patient Allergy
   (i) Prescriber consulted or
   (ii) Patient consulted / Pharmacist Dispensed as is

Override Code – Patient Allergy
- DA M0 1B - (Drug Allergy + Prescriber consulted + Fill Prescription as Is)
- DA P0 1B - (Drug Allergy + Patient consulted + Fill Prescription as Is)

Contact Information:
- ➢ *Pharmacy Prior Authorization Assistance* *1-888-907-0050*
- ✓ Select the number "1" for Pharmacy Prior Authorization Assistance

14 *Step Therapy*

If a medication is rejected for step therapy that means the Member must try a medication in Level 1 prior to obtaining the medication being submitted. The Level 1

alternatives are provided in the message back to you for that claim. If the Member has tried that medication or has a medical reason as to why they cannot take a Level 1 prescription, please call BeneCard PBF and we will contact the physician for the necessary information we need to determine if an exception is warranted.

15 *Fraud, Waste and Abuse*

Reporting and Investigation of Violations

Reporting of Violations

Reporting mechanisms and our internal processes are designed to raise standards across the industry and contribute to the goals of good governance and social responsibility. If you become aware of a possible violation of any federal or state rule, law, regulation, or policy, or of any violation of BeneCard PBF's *Principles of Business Ethics: Compliance and Fraud Prevention Guide*, immediately report it by calling our Compliance Hot-Line at 1-609-434-5121.

No Retaliation

BeneCard PBF strictly prohibits retaliation against any health care professional, member, employee, or vendor who, in good faith, reports an actual or possible violation of any federal or state law or regulation, any policy or ethical standard. Your call to the Hot-Line may be made anonymously.

Investigation of Violations

BeneCard PBF promptly investigates any reported potential violations of its *Principles of Business Ethics: Compliance and Fraud Prevention Guide,* federal or state rules, laws, regulations and other policies and procedures. All reported issues are treated as confidentially as possible. You are expected to cooperate fully in any investigation of an alleged violation. If you wish to remain anonymous, please provide enough information to enable BeneCard PBF to investigate the issue.

Corrective Action for Violations

Health care professionals, members, employees, and vendors should do what is permissible, acceptable, and expected. That means using common sense, good judgment, and proper behavior. Violation of any federal or state law or regulation, or of BeneCard PBF's *Principles of Business Ethics: Compliance and Fraud Prevention Guide* and other policies and procedures could compromise BeneCard PBF's integrity and

reputation, and will result in penalties and/or corrective action, up to and including termination of a provider's contract, member, or employee, and based on the violation, it will be reported to the appropriate authorities as appropriate.

Compliance with Federal and State Laws

BeneCard PBF is committed to complying with applicable state and federal rules, laws, regulations, Medicare Parts A, B, C, D, Medicaid requirements and other requirements as they pertain to providing services to its members. BeneCard PBF requires such compliance not only for the company and its employees, but also for all contracted providers, prescribers, suppliers, and vendors providing services to its members. While there are a multitude of laws and regulations governing the activities of BeneCard PBF, there are several key laws that govern the actions of health care professionals, entities, and vendors.

Federal False Claims Act

This law was enacted to give leverage to the federal government against persons/entities involved in fraudulent activities while dealing with the government and to impose civil penalties. Under the False Claims Act, those who knowingly submit, or cause another person to submit, false claims for payment by the government are liable for three times the government's damages plus civil penalties for each false claim. Health care fraud was established as a federal criminal offense, with the basic crime carrying a federal prison term in addition to significant financial penalties (USC, Title 18, Section 1347).

The False Claims Act is the primary federal law used to fight fraud in Medicaid and Medicare. It has become one of the most widely enforced statutes to fight health care fraud.

The False Claims Act is enforced against any individual entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal government. In addition, parties have a continuing obligation to advise the government of any new information indicating the falsity of the original statement. Consequently, if you determine after processing a claim that the information contained therein is or may be false, you must notify BeneCard PBF immediately.

The False Claims Act prohibits any person or entity from:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim to an employee of the United States government for payment or approval.

- Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.

- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

- Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government.

A violation of the False Claim Act occurs if the person or entity:

- Has actual knowledge of the fraudulent activity and does not report the occurrence.

- Acts in deliberate ignorance of the truth or falsity of the information.

- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

The federal government does not consider an innocent mistake as a legitimate defense for submitting a false claim, and the violation could result in a multitude of penalties. Potential cases may be reported to the Office of Inspector General (OIG). The OIG would make the determination whether or not the case warranted additional investigation.

Anti-Kickback Laws

The federal anti-kickback laws that apply to Medicare and Medicaid prohibit health care professionals and vendors from knowingly offering, paying, soliciting or receiving remuneration of any kind to *induce the referral* of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates. Remuneration under the federal anti-kickback statute includes the transfer of anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.

Violators are subject to criminal sanctions such as imprisonment, as well as high fines, exclusion from Medicare and Medicaid, very costly civil penalties, and possible prosecution under many similar state laws.

- A pharmaceutical vendor giving a physician an expensive gift in exchange for a prescription for its drug would be considered a kickback.
- A provider waiving copayments in certain instances may be considered an anti-kickback violation.

The anti-kickback law is extremely broad and covers a wider range of activities than just traditional kickbacks. Federal regulations include safe harbors that protect certain activities from prosecution. If you are unsure whether an activity violates the anti-kickback law, you should seek the advice of the Compliance Officer.

Antitrust Laws

State and federal antitrust laws prohibit monopolistic conduct and agreements that restrain trade. BeneCard PBF is committed to competition and consumer choice in the marketplace. All health care professionals and vendors must adhere to the antitrust laws and must avoid any agreements or understandings with competitors on price, customers, markets, or other terms of dealing and avoid trade practices that unfairly or unreasonably restrain competition in dealings with providers or customers.

Examples of illegal practices are price-fixing conspiracies, corporate mergers likely to reduce the competitive vigor of particular markets and predatory acts designed to achieve or maintain monopolistic power.

Fraud, Waste and Abuse

BeneCard PBF has zero tolerance for any activity that constitutes fraud, waste or abuse. The detection, correction and prevention of fraud, waste and abuse is essential to maintaining a health care system that is affordable for everyone. Every health care professional, entity and vendor are responsible for developing their own comprehensive plan for detecting, correcting and preventing fraud, waste and abuse. Both state and federal law enforcement agencies are increasingly focused on investigating health care fraud, waste, and abuse. In 2006, CMS issued the Medicare Fraud, Waste and Abuse Guidance that may be found at:

https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance

False claims are the #1 types of Medicaid and Medicare fraud and abuse. The following are definitions of fraud, waste, and abuse:

- Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Some examples of indicators that fraud may be happening:
    - Provider double billing
    - Billing for more expensive services, procedures or goods than were actually provided or performed
    - Doctor shopping for prescription drugs
    - Pharmacy shopping for prescription drugs
    - Using multiple health plans to obtain drugs
    - Falsifying Eligibility
    - Pharmacies short-filling prescriptions
    - Prescription forging or altering

- Use of untrained personnel to provide services
- Distribution of FDA-unapproved devices or drugs

Getting Answers to Compliance and Business Ethics

- Our fundamental objective is to promote appropriate and efficient use of drug prescription benefit services. We provide the following resources to increase understanding of compliance and fraud prevention.

- Compliance Hotline: 1-609-434-5121

- If you have compliance questions or become aware of any compliance, HIPAA, or ethical violations, call our confidential Hot-Line at 1-609-434-5121.

- We will take your calls very seriously. BeneCard PBF's Compliance Officer will review the question and determine if any action is required. Calls may be made anonymously, and they cannot be traced or otherwise identified. If you choose to remain anonymous, BeneCard PBF encourages you to provide enough information regarding the potential violation to allow the company to review the situation and respond appropriately. You will be assigned a confidential identification number to follow up on the status of your call.

- You may also report a concern, anonymously if you choose, by emailing BeneCard PBF at complianceofficer@benecard.com. You will be provided with a confidential report number, personal identification number for confidential follow up and a recommended follow-up date.

Special Investigations Unit

- BeneCard PBF's Special Investigations Unit (SIU) is responsible for detection, correction and prevention of health insurance fraud, waste, and abuse. In an effort to facilitate proper business practices and preserve reasonable premium rates, the SIU staff investigates and works with appropriate law enforcement, as well as state and federal agencies, when dealing with insurance fraud, waste and abuse by providers, insured, agents, employer groups, company employees, first-tier entities, downstream entities, related entities, and other individuals.

- BeneCard PBF's SIU may be contacted to report suspected fraud, waste, or abuse via:

  Phone: 1-609-434-5125
  Fax: 1-609-219-0161

  Email: ethics@benecard.com

Mail: BeneCard PBF
Special Investigation Unit
3131 Princeton Pike, Building 2B, Suite 103
Lawrenceville, New Jersey 08648

16 *NPI Requirements:*

All claims require valid NPI numbers. NPI'S are validated as part of BeneCard PBF's overall quality measurements.

17 *Payer Sheet:*

General Information

Payer Name: BeneCard PBF

Plan Name/Group Name: All

Effective as of: January 2012

Version/Release: NCPDP D.Ø

Pharmacy Help Desk Information
Pharmacy Help Desk: 888-907-0050
Contact Information Source: Not required
Certification Testing Window: 888-907-0050

The following pages identify the segments available in a transaction and list values as defined under NCPDP Version D.Ø. The segment summaries included below list the data fields used by BeneCard PBF.

DATA KEY

M = Mandatory as defined by NCPDP

D = Depends upon the Plan definition

R = Required as defined by the Processor

O = Optional

RequestHeaderSegment							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
101-A1	Bin Number	Ø14179	M		Y	int	6
102-A2	Version/Release Number		M	NCPDP version D.Ø	Y	enum	2
103-A3	Transaction Code	B1	M	Billing Transaction	Y	enum	2
104-A4	Processor Control Number	9743	M		Y	string	1Ø
109-A9	Transaction Count	1, 2, 3 or 4	M	Up to 4 per transmission	Y	int	1
202-B2	Service Provider Id Qualifier		M	Code qualifying the Service	Y	enum	2
201-B1	Service Provider Id	'Ø1' = National Provider ID (NPI) 'Ø7' = NCPDP Provider ID '12' = DEA #	M	Provider ID	Y	string	15
401-D1	Date of Service	CCYYMMDD	M		Y	date	8
11Ø-AK	Software Vendor/Certification Id		M	ID assigned by the switch or processor to identify the software source	Y	string	1Ø

Patient (BillingRequest 5.1-D.Ø) & (ReversalRequest 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
331-CX	Patient Id Qualifier	'Ø1' = SSN 'Ø4' = non SSN based # assigned by health plan 'Ø5' = SSN based # assigned by health plan	0	Code qualifying the 'Patient ID'	Y	enum	2
332-CY	Patient Id		0		Y	string	2Ø
3Ø4-C4	Date Of Birth	CCYYMMDD	R		Y	date	8
3Ø5-C5	Patient Gender Code		0		N	enum	1
31Ø-CA	Patient First Name		R		Y	string	35
311-CB	Patient Last Name		0		Y	string	35
322-CM	Patient Street Address		0		Y	string	3Ø
323-CN	Patient City Address		0		Y	string	2Ø
324-CO	Patient State/Province Address		0		Y	enum	2
325-CP	Patient ZIP/Postal Zone		0		Y	string	15
326-CQ	Patient Phone Number		0		N	long	1Ø
3Ø7-C7	Place Of Service		0		N	enum	2
333-CZ	Employer Id		0		Y	string	15
334-1C	Smoker/Non-Smoker Code		0		Y	enum	1
335-2C	Pregnancy Indicator		0		Y	enum	1
35Ø-HN	Patient Email Address		0		Y	string	8Ø
384-4X	Patient Residence		0		N	enum	2

Insurance (BillingRequest 5.1-D.Ø) & (ReversalRequest 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
3Ø2-C2	Cardholder Id		M		Y	string	2Ø
312-CC	Cardholder First Name		0		Y	string	35
313-CD	Cardholder Last Name		0		Y	string	3Ø
314-CE	Home Plan		0		Y	string	3
524-FO	Plan ID		0	RXGROUP as printed on the card	Y	string	8
3Ø9-C9	Eligibility Clarification Code		0		N	enum	1
3Ø1-C1	Group ID		0	RXGROUP as printed on the card	Y	string	15
3Ø3-C3	Person Code		0		Y	string	3
3Ø6-C6	Patient Relationship Code		0		N	enum	1
336-8C	Facility ID		0		Y	string	1Ø
99Ø-MG	Other Payer BIN Number		0		Y	int	6
991-MH	Other Payer Processor Control Number		0		Y	string	1Ø
356-NU	Other Payer Cardholder ID		0		Y	string	2Ø
992-MJ	Other Payer Group ID		0		Y	string	15
359-2A	Medigap ID		0		Y	string	2Ø
36Ø-2B	Medicaid Indicator		0		Y	enum	2
361-2D	Provider Accept Assignment Indicator		0		Y	enum	1
997-G2	CMS Part D Defined Qualified Facility		0		Y	enum	1
115-N5	Medicaid ID Number		0		Y	string	2Ø
116-N6	Medicaid Agency Number		0		Y	string	15

Claim (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing 2 = Service Billing	M		Y	enum	1
4Ø2-D2	Prescription/Service Reference Number		M	Reference number (RX Number for RX Billing) assigned by the provider for the dispensed drug/product and/or service provided	Y	long	12
436-E1	Product/Service ID Qualifier	Ø3 = National Drug Code (NDC)	M		Y	enum	2
4Ø7-D7	Product/Service ID		M	ID of the product dispensed (NDC) or service provided	Y	string	19
456-EN	Associated Prescription/Service Reference #		0		N	long	12
457-EP	Associated Prescription/Service Date		0		N	date	8
458-SE	Procedure Modifier Code Count		0		N	int	2
459-ER	Procedure Modifier Code		0		N	enum	2
442-E7	Quantity Dispensed		0	Quantity dispensed expressed in metric decimal units	Y	decimal	1Ø

4Ø3-D3	Fill Number	Ø = Original dispensing 1-99 = Refill number	0	The code indicating whether the prescription is an original or a refill	Y	int	2
4Ø5-D5	Days Supply		0		Y	int	3
4Ø6-D6	Compound Code	1 = not a compound 2 = compound	0	Required for Compound Drugs	N	enum	1
4Ø8-D8	Dispense As Written (DAW)/Product Selection Code		0	Usually required	N	enum	1
414-DE	Date Prescription Written		0	CCYYMMDD	Y	date	8
415-DF	Number Of Refills Authorized		0		N	int	2
419-DJ	Prescription Origin Code		0		N	enum	1
354-NX	Submission Clarification Code Count		0		N	int	1
42Ø-DK	Submission Clarification Code		0		N	enum	2
46Ø-ET	Quantity Prescribed		0	Amount expressed in metric decimal units	N	decimal	1Ø
3Ø8-C8	Other Coverage Code		0		N	enum	1
429-DT	Special Packaging Indicator		0		N	enum	1
453-EJ	Originally Prescribed Product/Service ID Qualifier		0		Y	enum	2
445-EA	Originally Prescribed Product/Service Code		0		Y	string	19
446-EB	Originally Prescribed Quantity		0		N	decimal	1Ø
33Ø-CW	Alternate ID		0		Y	string	2Ø
454-EK	Scheduled Prescription ID Number		0		Y	string	12
6ØØ-28	Unit Of Measure		0		Y	enum	2

418-DI	Level Of Service		0		N	enum	1
461-EU	Prior Authorization Type Code		0		N	enum	1
462-EV	Prior Authorization Number Submitted		0		N	long	11
463-EW	Intermediary Authorization Type ID		0		N	enum	2
464-EX	Intermediary Authorization ID		0		Y	string	11
343-HD	Dispensing Status		0		Y	enum	1
344-HF	Quantity Intended To Be Dispensed		0		N	decimal	1Ø
345-HG	Days Supply Intended To Be Dispensed		0		N	int	3
357-NV	Delay Reason Code		0		Y	enum	2
88Ø-K5	Transaction Reference Number		0		Y	string	1Ø
391-MT	Patient Assignment Indicator		0		Y	enum	1
995-E2	Route Of Administration		0		Y	enum	11
996-G1	Compound Type		0		Y	enum	2
114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number		0		Y	string	2Ø
147-U7	Pharmacy Service Type		0		Y	enum	2

Pharmacy Provider (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
465 -EY	Provider ID Qualifier	'Ø1' = Drug Enforcement Agency ID (DEA) 'Ø5' = National Provider Identity (NPI) '99' = other	0	Code qualifying the 'Provider ID' (Use 99 for NCPDP Provider ID)	Y	enum	2
444 -E9	Provider ID		0	Unique ID assigned to the person responsible for the dispensing of the prescription or provision of the service	Y	string	15

Prescriber (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
466 -EZ	Prescriber ID Qualifier	Ø1' = National Provider ID (NPI) 'Ø7' = NCPDP Provider ID '12' = DEA #	0	Code qualifying the 'Prescriber ID'	Y	enum	2
411 -DB	Prescriber ID		0	ID assigned to the prescriber	Y	string	15
427 -DR	Prescriber Last Name		0		Y	string	15
498 -PM	Prescriber Phone Number		0		N	long	1Ø
467 -1E	Prescriber Location Code		0	Location address code assigned to the prescriber as identified in the National Provider System (NPS)	Y	SOtring	3
468 -2E	Primary Care Provider ID Qualifier		0		Y	enum	2
421 -DL	Primary Care Provider ID		0		Y	string	15
47Ø -4E	Primary Care Provider Last Name		0		Y	string	15
469 -H5	Primary Care Location Code		0		Y	string	3
364 -2J	Prescriber First Name		0		Y	string	12
365 -2K	Prescriber Street Address		0		Y	string	3Ø
366 -2M	Prescriber City Address		0		Y	string	2Ø
367 -2N	Prescriber State/Province Address		0		N	enum	2
368 -2P	Prescriber ZIP/Postal Zone		0		Y	string	15

Coordination of Benefits/Other Payments (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
337-4C	Coordination Of Benefits/Other Payments Count		M	Count of other payment occurrences	Y	int	1
338-5C	Other Payer Coverage Type	Blank = Not Specified Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary, etc.	R		Y	enum	2
339-6C	Other Payer ID Qualifier	'Ø1' = National Payer ID 'Ø2' = Health Industry Number (HIN) 'Ø3' = BIN 'Ø4' = NAIC 'Ø5' = Medicare '99' = Other	0	Code qualifying the 'Other Payer ID' Repeating field	Y	enum	2
34Ø-7C	Other Payer ID		0	ID assigned to the payer. Repeating field	Y	string	1Ø
443-E8	Other Payer Date		0	CCYYMMDD Repeating field	Y	date	8
993-A7	Internal Control Number		0		Y	string	3Ø
341-HB	Other Payer Amount Paid Count		0		Y	int	1
342-HC	Other Payer Amount Paid Qualifier		0		Y	enum	2
431-DV	Other Payer Amount Paid		0		Y	dollar	8
471-5E	Other Payer Reject Code Count		0		Y	int	2
472-6E	Other Payer Reject Code		0	The error encountered by the previous "Other Payer" in Reject Code' Repeating field	Y	enum	3

353-NR	Other Payer-Patient Responsibility Count		0		Y	int	2
351-NP	Other Payer-Patient Responsibility Amount Qualifier		0		Y	enum	2
352-NQ	Other Payer-Patient Responsibility Amount		0		Y	dollar	10
392-MU	Benefit Stage Count		0		Y	int	1
393-MV	Benefit Stage Qualifier		0		Y	enum	2
394-MW	Benefit Stage Amount		0		Y	dollar	8

Workers' Compensation (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
434 -DY	Date Of Injury		M	CCYYMMDD	Y	date	8
315 -CF	Employer Name		0		Y	string	3Ø
316 -CG	Employer Street Address		0		Y	string	3Ø
317 -CH	Employer City Address		0		Y	string	2Ø
318 -CI	Employer State/Province Address		0		Y	enum	2
319 -CJ	Employer ZIP/Postal Zone		0		Y	string	15
32Ø -CK	Employer Phone Number		0		N	long	1Ø
321 -CL	Employer Contact Name		0		Y	string	3Ø
327 -CR	Carrier ID		0		Y	string	1Ø
435 -DZ	Claim/Reference ID		0	Identifies the claim number assigned by Workers' Compensation Program	Y	string	3Ø
117 -TR	Billing Entity Type Indicator		0		Y	enum	2
118 -TS	Pay To Qualifier		0		Y	enum	2
119 -TT	Pay To ID		0		Y	string	15
12Ø -TU	Pay To Name		0		Y	string	2Ø
121 -TV	Pay To Street Address		0		Y	string	3Ø
122 -TW	Pay To City Address		0		Y	string	2Ø
123 -TX	Pay To State/Province Address		0		Y	enum	2
124 -TY	Pay To ZIP/Postal Zone		0		Y	string	15
125 -TZ	Generic Equivalent Product ID Qualifier		0		Y	enum	2
126 -UA	Generic Equivalent Product ID		0		Y	string	19

DUR/PPS (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
473-7E	DUR/PPS Code Counter		0	Repeating field	Y	int	1
439-E4	Reason For Service Code		0	Repeating field	Y	enum	2
44Ø-E5	Professional Service Code		0	Repeating field	Y	enum	2
441-E6	Result Of Service Code		0	Repeating field	Y	enum	2
474-8E	DUR/PPS Level Of Effort		0	Repeating field	N	enum	2
475-J9	DUR Co-Agent ID Qualifier		0	Repeating field	Y	enum	2
476-H6	DUR Co-Agent ID		0	Repeating field	Y	string	19

Pricing (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
4Ø9-D9	Ingredient Cost Submitted		0		N	dollar	8
412 -DC	Dispensing Fee Submitted		0		N	dollar	8
477 -BE	Professional Service Fee Submitted		0		N	dollar	8
433 -DX	Patient Paid Amount Submitted		0		N	dollar	8
438 -E3	Incentive Amount Submitted		0		N	dollar	8
478 -H7	Other Amount Claimed Submitted Count		0		N	int	1
479 -H8	Other Amount Claimed Submitted Qualifier		0		Y	enum	2
48Ø -H9	Other Amount Claimed Submitted		0		N	dollar	8
481 -HA	Flat Sales Tax Amount Submitted		0		N	dollar	8
482 -GE	Percentage Sales Tax Amount Submitted		0		N	dollar	8
483 -HE	Percentage Sales Tax Rate Submitted		0		Y	decimal	7
484 -JE	Percentage Sales Tax Basis Submitted		0		Y	enum	2
426 -DQ	Usual And Customary Charge		0		Y	dollar	8
43Ø -DU	Gross Amount Due		0		N	dollar	8
423 -DN	Basis Of Cost Determination		0		N	enum	2
113 -N3	Medicaid Paid Amount		0		Y	dollar	8

Coupon (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
485-KE	Coupon Type		M		Y	enum	2
486-ME	Coupon Number		M		Y	string	15
487-NE	Coupon Value Amount		0		N	dollar	8

Compound (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
45Ø-EF	Compound Dosage Form Description Code		M		Y	enum	2
451-EG	Compound Dispensing Unit Form Indicator		M		Y	enum	1
452-EH	Compound Route Of Administration		M		Y	enum	2
447-EC	Compound Ingredient Component Count		M		Y	int	2
488-RE	Compound Product ID Qualifier		M	Repeating field	Y	enum	2
489-TE	Compound Product ID		M	Repeating field	Y	string	19
448-ED	Compound Ingredient Quantity		R	Repeating field	Y	decimal	1Ø
449-EE	Compound Ingredient Drug Cost		0	Repeating field	N	dollar	8
49Ø-UE	Compound Ingredient Basis Of Cost Determination		0	Repeating field	Y	enum	2
362-2G	Compound Ingredient Modifier Code Count		0		Y	int	2
363-2H	Compound Ingredient Modifier Code		0		Y	enum	2

Prior Authorization (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
498-PA	Request Type		M		Y	enum	1
498-PB	Request Period Date-Begin		M		Y	date	8
498-PC	Request Period Date-End		M		Y	date	8
498-PD	Basis Of Request		M		Y	enum	2
498-PE	Authorized Representative First Name		0		Y	string	12
498-PF	Authorized Representative Last Name		0		Y	string	15
498-PG	Authorized Representative Street Address		0		Y	string	3Ø
498-PH	Authorized Representative City Address		0		Y	string	2Ø
498-PJ	Authorized Representative State/Province Address		0		Y	enum	2Ø
498-PK	Authorized Representative ZIP/Postal Zone		0		Y	string	15
498-PY	Prior Authorization Number-Assigned		0		N	long	11
5Ø3-F3	Authorization Number		0		Y	string	2Ø
498-PP	Prior Authorization Supporting Documentation		0		Y	string	5ØØ

Clinical (RequestBillingTransaction 5.1-D.Ø) & (RequestReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
491-VE	Diagnosis Code Count		0		N	int	1
492-WE	Diagnosis Code Qualifier		0	Repeating field	Y	enum	2
424-DO	Diagnosis Code		0	Repeating field	Y	string	15
493-XE	Clinical Information Counter		0	Repeating field	Y	int	1
494-ZE	Measurement Date		0	Repeating field	N	date	8
495-H1	Measurement Time		0	Repeating field	Y	time	4
496-H2	Measurement Dimension		0	Repeating field	Y	enum	2
497-H3	Measurement Unit		0	Repeating field	Y	enum	2
499-H4	Measurement Value		0	Repeating field	Y	string	15

Additional Documentation (RequestBillingTransaction D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
369-2Q	Additional Documentation Type ID		M		Y	enum	3
374-2V	Request Period Begin Date		0		Y	date	8
375-2W	Request Period Recert/Revised Date		0		Y	date	8
373-2U	Request Status		0		Y	enum	1
371-2S	Length Of Need Qualifier		0		Y	enum	1
37Ø-2R	Length Of Need		0		Y	int	3
372-2T	Prescriber/Supplier Date Signed		0		Y	date	8
376-2X	Supporting Documentation		0		Y	string	65
377-2Z	Question Number/Letter Count		0		Y	int	2
378-4B	Question Number/Letter		0		Y	string	3
379-4D	Question Percent Response		0		Y	decimal	5
38Ø-4G	Question Date Response		0		Y	date	8
381-4H	Question Dollar Amount Response		0		Y	dollar	11
382-4J	Question Numeric Response		0		Y	long	11
383-4K	Question Alphanumeric Response		0		Y	string	3Ø

Facility (RequestBillingTransaction D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
336-8C	Facility ID		0		Y	string	1Ø
385-3Q	Facility Name		0		Y	string	3Ø
386-3U	Facility Street Address		0		Y	string	3Ø
388-5J	Facility City Address		0		Y	string	2Ø
387-3V	Facility State/Province Address		0		Y	enum	2
389-6D	Facility ZIP/Postal Zone		0		Y	string	15

Narrative (RequestBillingTransaction D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
39Ø-BM	Narrative Message		M		Y	string	2ØØ

Repricing (RequestBillingTransaction D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
99Ø-!1	Brand Or Generic		M		Y	enum	1
994-!8	Override Mail Order To BCF		M		Y	bool	1
995-!9	Ignore Category Coverage Template		M		Y	bool	1
991-!5	Price Replacement ID		0		Y	long	19
992-!6	Price Replacement Drug Identifier Type		0		Y	string	3Ø
993-!7	Price Replacement Pricing Source ID		0		Y	long	19

Response HeaderSegment							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
1Ø2-A2	Version/Release Number		M		Y	enum	2
1Ø3-A3	Transaction Code		M		Y	enum	2
1Ø9-A9	Transaction Count		M		Y	int	1
5Ø1-F1	Header Response Status		M		Y	enum	1
2Ø2-B2	Service Provider Id Qualifier		M		Y	enum	2
2Ø1-B1	Service Provider Id		M		Y	string	15
4Ø1-D1	Date of Service		M		Y	date	8

Response Message (BillingResponse 5.1-D.Ø) & (ReversalResponse 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
5Ø4-F4	Message		0		Y	string	2ØØ

Response Insurance (BillingResponse 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
3Ø1-C1	Group ID		0		Y	string	15
524 -FO	Plan ID		0		Y	string	8
545 -2F	Network Reimbursement Id		0		Y	string	1Ø
568 -J7	Payer Id Qualifier		0		Y	enum	2
568 -J8	Payer Id		0		Y	string	1Ø
115 -N5	Medicaid ID Number		0		Y	string	2Ø
116 -N6	Medicaid Agency Number		0		Y	string	15
3Ø2-C2	Cardholder Id		0		Y	string	2Ø

Response Insurance Additional Information							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
139 -UR	Medicare Part D Coverage Code		M		Y	enum	2
138 -UQ	CMS Low Income Cost Sharing (LICS) Level		0		Y	string	2Ø
24Ø -U1	Contract Number		0		Y	string	8
926 -FF	Formulary ID		0		Y	string	1Ø
757 -U6	Benefit ID		0		Y	string	15
14Ø -US	Next Medicare Part D Effective Date		0		Y	date	8
141 -UT	Next Medicare Part D Termination Date		0		Y	date	8

Response Patient (BillingResponse D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
31Ø-CA	Patient First Name		0		Y	string	12
311-CB	Patient Last Name		0		Y	string	15
3Ø4-C4	Date Of Birth		0		Y	date	8

Response Status (Response BillingTransaction 5.1-D.Ø) & (Response ReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
112-AN	Transaction Response Status		M		Y	enum	1
5Ø3-F3	Authorization Number		0	For approved records only	Y	string	2Ø
51Ø-FA	Reject Count		0		Y	int	2
511-FB	Reject Code		0		Y	enum	3
546-4F	Reject Field Occurrence Indicator		0		Y	int	2
547-5F	Approved Message Code Count		0		Y	int	1
548-6F	Approved Message Code		0		Y	enum	3
13Ø-UF	Additional Message Information Count		0		Y	int	2
132-UH	Additional Message Information Qualifier		0		N	int	2
526-FQ	Additional Message Information		0		Y	string	4Ø
131-UG	Additional Message Information Continuity		0		N	enum	1
549-7F	Help Desk Phone Number Qualifier		0		Y	enum	2
55Ø-8F	Help Desk Phone Number		0		Y	string	15
88Ø-K5	Transaction Reference Number		0		Y	string	1Ø
993-A7	Internal Control Number		0		Y	string	3Ø
987-MA	URL		0		Y	string	255

Response Claim (ResponseBillingTransaction 5.1-D.Ø) & (ResponseReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
455-EM	Prescription/Service Reference Number Qualifier		M		Y	enum	1
4Ø2-D2	Prescription/Service Reference Number		M		Y	long	12
551-9F	Preferred Product Count		0		Y	int	1
552-AP	Preferred Product ID Qualifier		0		Y	enum	2
553-AR	Preferred Product ID		0		Y	string	19
554-AS	Preferred Product Incentive		0		Y	dollar	8
555-AT	Preferred Product Cost Share Incentive		0		Y	dollar	8
556-AU	Preferred Product Description		0		Y	string	4Ø
114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number		0		Y	string	2Ø

Response Pricing (ResponseBillingTransaction 5.1-D.Ø) & (ResponseReversalTransaction 5.1-D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
5Ø5-F5	Patient Pay Amount	R	0	Total of copay and ancillary. For approved records only	Y	dollar	8
5Ø6-F6	Ingredient Cost Paid		0		Y	dollar	8
5Ø7-F7	Dispensing Fee Paid		0		Y	dollar	8
557-AV	Tax Exempt Indicator		0		Y	enum	1
558-AW	Flat Sales Tax Amount Paid		0		Y	dollar	8
559-AX	Percentage Sales Tax Amount Paid		0		Y	dollar	8
56Ø-AY	Percentage Sales Tax Rate Paid		0		Y	decimal	7
561-AZ	Percentage Sales Tax Basis Paid		0		Y	enum	2
521-FL	Incentive Amount Paid		0		Y	dollar	8
562-J1	Professional Service Fee Paid		0		Y	dollar	8
563-J2	Other Amount Paid Count		0		Y	int	1
564-J3	Other Amount Paid Qualifier		0		Y	enum	2
565-J4	Other Amount Paid		0		Y	dollar	8
566-J5	Other Payer Amount Recognized		0		Y	dollar	8
5Ø9-F9	Total Amount Paid		0	This is what the pharmacy will get paid from the Processor. For approved records only	Y	dollar	8
522-FM	Basis Of Reimbursement Determination		0		Y	enum	2
523-FN	Amount Attributed To Sales Tax		0		Y	dollar	8

512 -FC	Accumulated Deductible Amount		0		Y	dollar	8
513 -FD	Remaining Deductible Amount		0		Y	dollar	8
514 -FE	Remaining Benefit Amount		0		Y	dollar	8
517 -FH	Amount Applied To Periodic Deductible		0		Y	dollar	8
518 -FI	Amount Of Copay		0		Y	dollar	8
52Ø -FK	Amount Exceeding Periodic Benefit Maximum		0		Y	dollar	8
346 -HH	Basis Of Calculation-Dispensing Fee		0		Y	enum	2
347 -HJ	Basis Of Calculation-Copay		0		Y	enum	2
348 -HK	Basis Of Calculation-Flat Sales Tax		0		Y	enum	2
349 -HM	Basis Of Calculation-Percentage Sales Tax		0		Y	enum	2
571 -NZ	Amount Attributed To Processor Fee		0		Y	dollar	8
575 -EQ	Patient Sales Tax Amount		0		Y	dollar	8
574 -2Y	Plan Sales Tax Amount		0		Y	dollar	8
572 -4U	Amount Of Coinsurance		0		Y	dollar	8
573 -4V	Basis Of Calculation Coinsurance		0		Y	enum	2
392 -MU	Benefit Stage Count		0		Y	int	1
393 -MV	Benefit Stage Qualifier		0		Y	enum	2
394 -MW	Benefit Stage Amount		0		Y	dollar	8
577 -G3	Estimated Generic Savings		0		Y	dollar	8
128 -UC	Spending Account Amount Remaining		0		Y	dollar	8
129 -UD	Health Plan-Funded Assistance Amount		0		Y	dollar	8
133 -UJ	Amount Attributed To Provider Network Selection		0		Y	dollar	8

134 -UK	Amount Attributed To Product Selection/Brand Drug		0		Y	dollar	8
135 -UM	Amount Attributed To Product Selection/Non Preferred Formulary Selection		0		Y	dollar	8
136 -UN	Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection		0		Y	dollar	8
137 -UP	Amount Attributed To Coverage Gap		0		Y	dollar	8
148 -U8	Ingredient Cost Contracted/Reimbursable Amount		0		Y	dollar	8
149 -U9	Dispensing Fee Contracted/Reimbursable Amount		0		Y	dollar	8

Response DUR/PPS (ResponseBillingTransaction 5.1-D.Ø) & (ResponseReversalTransaction 5.1)

Field	Field Name	Value	Data	Comment	Critical	Type	Length
567 -J6	DUR/PPS Response Code Counter		0		Y	int	1
439 -E4	Reason For Service Code		0		Y	enum	2
528 -FS	Clinical Significance Code		0		Y	enum	1
529 -FT	Other Pharmacy Indicator		0		Y	enum	1
53Ø -FU	Previous Date Of Fill		0		Y	date	8
531 -FV	Quantity of Previous Fill		0		Y	decimal	1Ø
532 -FW	Database Indicator		0		Y	enum	1
533 -FX	Other Prescriber Indicator		0		Y	enum	1
544 -FY	DUR Free Text Message		0		Y	string	3Ø
57Ø -NS	DUR Additional Text		0		Y	string	1ØØ

Response Prior Authorization (Response BillingTransaction 5.1) & (Response ReversalTransaction 5.1)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
498 -PR	Prior Authorization Processed Date		0		Y	date	8
498 -PS	Prior Authorization Effective Date		0		Y	date	8
498 -PT	Prior Authorization Expiration Date		0		Y	date	8
498 -RA	Prior Authorization Quantity		0		Y	decimal	10
498 -RB	Prior Authorization Dollars Authorized		0		Y	dollar	8
498 -PW	Prior Authorization Number of Refills Authorized		0		Y	int	2
498 -PX	Prior Authorization Quantity Accumulated		0		Y	decimal	10
498 -PY	Prior Authorization Number-Assigned		0		Y	long	11

Response Coordination of Benefits/Other Payers (Response BillingTransaction D.Ø)							
Field	Field Name	Value	Data	Comment	Critical	Type	Length
355 -NT	Other Payer ID Count		M		Y	int	1
338 -5C	Other Payer Coverage Type		M		Y	enum	2
339 -6C	Other Payer ID Qualifier		0		Y	enum	2
34Ø -7C	Other Payer ID		0		Y	string	1Ø
991 -MH	Other Payer Processor Control Number		0		Y	string	1Ø
356 -NU	Other Payer Cardholder ID		0		Y	string	2Ø
992 -MJ	Other Payer Group ID		0		Y	string	15
142 -UV	Other Payer Person Code		0		Y	string	3
127 -UB	Help Desk Phone Number		0		Y	string	18
143 -UW	Other Payer Patient Relationship Code		0		Y	enum	1
144 -UX	Other Payer Benefit Effective Date		0		Y	date	8
145 -UY	Other Payer Benefit Termination Date		0		Y	date	8

18 Appendix:

18.1 BeneCard PBF Broadcast:

BeneCard PBF
Prescription Benefit Facilitator

BroadCast

New Groups and Adjudication Notes: February 2011

Prescriptions for the groups identified below will process utilizing Benecard PBF's RxBin (014179) and PCN (9743) numbers.

RxGroup	Client Name	Effective Date	RxBIN	RxPCN
1234	Example Client	**February 1, 2011**	014179	9743

STOP

Please Read Pharmacy Adjudication Notes below

Pharmacy Overides Codes – DUR Rejection

I. High Dose: Pharmacist verification

(i) Patient has been on this treatment or (ii) new treatment verified by prescriber

Overide Code – High Dose or No Dose Provided

- HD DE 1B - (High Dose + Dosing evaluation/determination + Fill Prescription As Is)
- HD M0 1B - (High Dose + Prescriber consulted + Fill Prescription As Is)

II. Patient Allergy

(i) Prescriber consulted or (ii) Patient consulted. Pharmacist Dispensed as is

Overide Code – Patient Allergy

- DA M0 1B - (Drug Allergy + Prescriber consulted + Fill Prescription As Is)
- DA P0 1B - (Drug Allergy + Patient consulted + Fill Prescription As Is)

Pharmacy Help Desk: Adjudication Notes

Error Code # 1 – Missing/Invalid BIN number
- ✓ BIN Number is 014179

Error Code # 4 – Missing/Invalid Processor Control Number
- ✓ PCN number is 9743

Error Code # 6 – Missing/Invalid Group Number
- ✓ Utilize RxGRP identified on Member Card

Error Code # 52 – Non-Matched Cardholder ID
- o Always submit Full Card ID (**ALL alpha-numeric characters on Card ID**)

Error Code # 56 – Non-Matched Prescriber ID
- ✓ Prescriber's NPI number is required on all claims

Error Code # 17 – Missing/Invalid Fill Number
- ✓ The refill number must be equal to or less than the original refill amount authorized

Contact Information:

- *Pharmacy Network Help Desk at 1-888-907-0050*
- *Pharmacy Prior Authorization Assistance 1-888-907-0050*
  - ✓ Select the number "1" for Pharmacy Prior Authorization Assistance

1.888.907.0050 Benecard PBF Network Development Help Desk
1.888.PBF.6008 Benecard PBF Network Development Facsimile #
www.benecardpbf.com

7.1.10

18.2 BeneCard PBF Contract:

Exhibit A

The following capitalized terms, including their single and plural forms, shall have the meanings set forth below:

Definitions

"Agreement" means this Agreement for Retail Pharmacy Participation; all amendments, appendices, modifications and exhibits hereto; and all policies and procedures of PBF, Sponsors and their plans made available by PBF to Participating Pharmacy.

"Average Wholesale Price" or "AWP" means the average wholesale price for a Prescription Drug or other pharmaceutical product, as published by Medi-Span® or another nationally recognized pricing source at the discretion of PBF. Unless there is a system complication which disallows so, the average wholesale price will be updated by or on behalf of PBF at least once each business week.

"BeneRx® System" means the NCPDP compatible point-of-sale communication system used to adjudicate claims information submitted by Participating Pharmacy.

"Cost Sharing Amount" means a copayment, coinsurance, deductible or other amount of money a Member is required to pay Participating Pharmacy for a Covered Drug or Covered Service in accordance with that Member's Sponsor's Plan Specifications and this Agreement.

"Covered Drugs" means those Prescription Drugs, insulin syringes and supplies, over the counter drugs and other medical devices and supplies that are covered by a Sponsor's Plan Specifications and are legally prescribed by a Practitioner.

"Covered Services" include Covered Drugs and the dispensing of Covered Drugs, the providing of counseling and utilization review, and seeking prior authorization and other related services performed by Participating Pharmacy to a Member, all of which are included in the fees set forth in the applicable Sponsor's Plan Specifications.

"Dispensing Fee" means the amount to be funded by the appropriate Sponsor and remitted by PBF to Participating Pharmacy for providing Covered Services to Eligible Members

"Effective Date" means the earlier of: (i) the date this Agreement is signed by an authorized individual on behalf of the Participating Pharmacy and accepted by PBF at its principal place of business; or (ii) the date the Participating Pharmacy submits a claim to PBF.

"Formulary" means a list of preferred Prescription Drugs developed, published and periodically revised by PBF and/or a Sponsor, which pharmacists are required to dispense, subject to their professional judgment and applicable Law and applicable Sponsor Plan Specifications.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

"HIPAA Rules" means the medical records privacy, security and standard transaction rules and regulations under 45 CFR Parts 160, 162 and 164.

"Law" means any federal, state, local, foreign, or sovereign Indian nation law, ordinance, rule, regulation or judicial or administrative interpretation thereof.

"Location" means each retail pharmacy that is owned, operated, or managed by Participating Pharmacy or authorizes Participating Pharmacy to contract on its behalf, is duly licensed as a pharmacy and provides Covered Drugs and Services pursuant to this Agreement.

"Maximum Allowable Cost" or "MAC" means the PBF's proprietary compensation level established and modified by PBF in its discretion for generic Covered Drugs.

"Member" means an employee, retiree, spouse, domestic partner, dependent or other individual who is enrolled in a Sponsor's prescription drug program and is eligible to receive Covered Services under the terms of that plan and such individual's representative authorized to receive such Covered Drugs.

"NCPDP" means the National Council for Prescription Drug Programs or its successor.

"Participating Pharmacy" includes: (a) the undersigned company (b) the company that owns or operates each retail, community pharmacy that is subject to this Agreement; and (c) each Location that submits claims to PBF for payment of Covered Drugs or Covered Services.

"Payment Sheet" means Exhibit C or such other agreed upon document that reflects the per transaction adjudication fees paid by Participating Pharmacy to PBF for processing claims which may be amended from time to time.

"Practitioner" means a dentist, nurse, physician, physician assistant or other health care provider who is licensed in the jurisdiction where the prescription is issued and is authorized by Law to prescribe Prescription Drugs, devices and/or supplies to individuals including Members.

"Plan Specifications" means the information made available by PBF to Participating Pharmacy describing, among other things, the applicable processes and Covered Services under a particular Sponsor's health benefit plan and all related amendments, provided by PBF to Participating Pharmacy in accordance with this Agreement. This information may include the amounts to be reimbursed to Participating Pharmacy for Covered Services; excluded items; Cost Sharing Amounts; benefit maximums; coverage or payment limitations; and other items, all subject to the actual requirements of that Sponsor's health benefit plan.

"Prescription Drugs" means all federal legend and state restricted drugs and drug products requiring a prescription and all mixtures and compounds containing a minimum of one prescription ingredient pursuant to applicable Law.

"Protected Health Information" or "PHI" means individually identifiable health information related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, as more fully defined in the HIPAA Rules or otherwise deemed confidential under other Law.

"Sponsor" means a health benefits plan, employer, health care service contractor, health care service plan, health maintenance organization, insurance company, managed care organization, preferred provider organization, third party administrator, trust, union or other entity that has entered into an agreement with PBF to provide access to a prescription drug program and is solely responsible for funding payments for Covered Drugs and Covered Services under its Plan Specifications or in connection with the coordination of benefits.

"Transaction Charge" means the per transaction adjudication fees paid by Participating Pharmacy to PBF for processing claims.

"Usual and Customary Price" means the price, that may or may not be advertised or posted, and that would have been charged to a Member for a Covered Drug, inclusive of all promotions and discounts, at the dispensing Location on the date of service for the drug (s) dispensed if the Member was a cash or uninsured paying customer.

"Wholesale Acquisition Cost" or "WAC" means the manufacturers' published catalog or list price for a drug product to wholesalers, as established and updated by Medi-Span. Reimbursement under the Agreement shall be based on the accurate pricing from Medi-Span as of the date dispensed.

18.3 Universal Claim Form: