To: County of Chatham

From: Blue Cross and Blue Shield of North Carolina (Blue Cross NC)

Re: Administrative Services Agreement (ASA) Contract Changes – 2019

Date: June 11, 2019

Attached is the 2019 renewal amendment for your (ASA) Administrative Services Agreement and Business Associate Agreement (BAA) amendmentwith Blue Cross NC. Below is a brief overview of the changes Blue Cross NC is proposing to the ASA for this Agreement Period.

1. Amendment re: Value Based Programs. This agreement is being amended to include Blue Premier Value Based Program language. The changes reflect Value-Based Compensation arrangements under which a Provider's compensation is based, in whole or in part, on the achievement of goals related to cost, quality, utilization or other outcomes.

2. Amendment re: Compensation to Blue Cross NC. The Agreement is being amended to address pharmacy medical benefit rebates.

3. Amendment re: Notices. This provision will be updated at each renewal to ensure we have the most current contact information.

4. Amendment re: Force Majeure. This provision will be updated to address situations that occur during natural disasters which may threaten to disrupt health care and other services.

5. Administrative Fees Exhibit. The new exhibit reflects the current renewal rates as well as any other changes to this exhibit.

6. Pharmacy Program Exhibit. This exhibit is being updated to clarify the terms of the Pharmacy Program.

7. Business Associate Addendum (BAA). Part 2 rule - This provision is being added to clarify Blue Cross NC's responsibility with regards to the use and disclosure of information protected by the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2).

If you have any questions concerning the amendments listed above or to the content in the amendment, please contact your Blue Cross NC Client Manager or Blue Cross NC ASO Contract Management via Paige.McKinstry@bcbsnc.com for assistance.

Thank you.

AMENDMENT TO
ADMINISTRATIVE SERVICES AGREEMENT

This AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT ("Amendment") is made and entered July 1, 2019, by and between by and between County of Chatham ("Plan Sponsor"), County of Chatham Group Health Plan ("Group Health Plan") and County of Chatham ("Plan Administrator") and Blue Cross NC (each, a "Party" and collectively, the "Parties").

W I T N E S S E T H:

WHEREAS, the Parties previously entered into an Administrative Services Agreement (the "Agreement") pursuant to which Blue Cross NC provides certain services with respect to administration of the Group Health Plan;

WHEREAS, the Parties desire to amend the Agreement regarding certain matters as provided for herein;

NOW THEREFORE, in consideration of the mutual promises and covenants made herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties do hereby agree to amend and renew the Agreement effective July 1, 2019 as follows:

1. Article 1 – **Definitions -** shall be amended to include the following definitions. The definitions shall be inserted alphabetically and the section renumbered accordingly. The new definitions are:

   "Attributed Member" means a Member who has been attributed or assigned to a Provider based on the attribution standards established for that Provider.

   "PAMPM" means per Attributed Member per month.

   "Value-Based Payment or Value-Based Compensation" means compensation paid to a Provider based in-whole or in-part on the achievement of goals related to cost, quality, utilization or other outcomes.

   "Value-Based Program" means a healthcare payment model by which compensation to Providers is determined, in whole or in part, by the achievement of goals related to cost, quality, utilization or other outcomes.

   "Value-Based Program Measurement Period" means the time period by which Value-Based Payments are calculated. The Value-Based Program Measurement Period may be the Plan Year, the Calendar Year or such other period as determined by Blue Cross NC.

The Value-Based Program Measurement Period for determining Value Based Payments may differ from the term of this Agreement.

2. Section 5.17 (Value-Based Programs) shall be deleted in its entirety and replaced with the following:

5.17 Value Based Programs.

a. **Overview**. In addition to fee-for-service payments for Covered Services, Blue Cross NC has Value-Based Compensation arrangements under which a Provider's compensation is based, in whole or in part, on the achievement of goals related to cost, quality, utilization or other outcomes. Value-Based Compensation to Providers may be either positive or negative, and can take various forms, including, but not limited to prospective payments, retrospective settlements, incentive-based fee schedules, provider cost savings disbursements, provider care coordination fees, utilization/efficiency incentives, capitation arrangements, and/or other allowed amounts. Value-Based Compensation may also be incorporated into models related to new forms of health care delivery and provider-payer collaborations, such as Patient-Centered Medical Homes (PCMH), Accountable Care Organizations (ACO), episodic-based arrangements (bundles), Pay for Performance, narrow networks and provider-specific products and services.

b. **Attributed Members**. Value-Based Fees under this Section shall apply only to Members who are Attributed Members. Provider attribution requirements will vary by Provider and may be based on factors such as claims experience and primary care provider designation. A Member will be attributed to a Provider for a given month if he or she satisfies the attribution requirements for that Provider at any time during that month. There will be no retroactive changes or adjustments to PAMPM billings based on retroactive changes to Group Health Plan eligibility.

c. **Value-Based Programs Administration:** Blue Cross NC will pass Value-Based Program expenses directly on to Plan Sponsor, Plan Administrator, and/or Group Health Plan as medical expense amounts charged separately in addition to any associated claims. Such amounts are billed separately from the price of the claim and will be billed as follows:

- **Per Attributed Member Per Month (PAMPM) Charges**. Beginning in the first quarter of 2020, Blue Cross NC will begin collecting a prospective monthly Value-Based Payment for Attributed Members. These PAMPM charges for Attributed Members will be billed to Plan Sponsor/Plan Administrator within 90 days following the date the Member is attributed to a Provider. For example, the May 2020 Statement of Account will

contain a PAMPM charge for members who were Attributed Members as of February 2020.

The PAMPM charge is an actuarially projected amount based on expected risk sharing and incentive fee arrangements with each Provider. The amount of the PAMPM charge may be adjusted monthly based on actual Provider performance relative to the estimate. The total monthly charge for Attributed Members is derived from prospective estimated shared savings liability proportional to the Group Health Plan's Attributed Members for the applicable Provider.

Because these amounts are determined prospectively, there may be positive or negative differences based on actual Provider performance and such differences will be accounted for at the end of the applicable Value-Based Program Measurement Period. The PAMPM Value Based Payment may be decreased before the end of the Value-Based Program Measurement Period if the amount collected is projected to exceed the amount necessary to fund the program or may be increased before the end of the Value-Based Program Measurement Period if it is projected to be insufficient to fund the program.

At the end of the Value-Based Program Measurement Period, if the amount collected exceeds the amount owed to the Provider, surplus funds will be carried over to reduce the Group Health Plan's PAMPM charge in the subsequent Value-Based Program Measurement Period. Any deficit in funds at the end of the Value-Based Program Measurement Period will be recouped through a higher PAMPM charge in the subsequent Value-Based Program Measurement Period. No overpayment refunds will be issued, nor will deficit collections be required in the event of termination of this Agreement.

PAMPM Value-Based Payments will not continue to accrue during a Run-Out period, however PAMPM Value-Based Payments incurred for attribution that occurred during the Plan Year will be collected during the Run-Out Period. If Blue Cross NC is not providing Run-Out Services, Plan Sponsor will be obligated to pay any remaining PAMPM fees due for Attributed Members during the Plan Year, but not yet collected as of the last day of the Plan Year.

d. **One-Time 2019 Value Based Program Charge**. For the 2019 calendar year, in lieu of a monthly prospective PAMPM Billing as described in Subsection (c) above, the 2019 Value Based Program Charge will be billed as a one-time lump sum fee in July 2020. This will be calculated based on the Group Health Plan's total Attributed Members for the 2019 calendar year. This one-time charge is a retroactive settlement derived from Provider shared savings on Attributed Members in 2019. Groups that terminate this Agreement prior to the July 2020

collection date will owe a proportionate share of this lump sum payment based on the Group Health Plan's Attributed Members for 2019.

3. This Agreement shall be amended by adding the following new section to Article 10 – Compensation to Blue Cross NC:

10. 6 Medical Plan Prescription Rebates. Medical benefit rebate allocations to Group Health Plan will be made based on actual prescription drug rebates generated for each Group Health Plan medical claim. Blue Cross NC will pass through to the Plan Sponsor rebates received on prescription drugs paid under the Group Health Plan's medical benefit, minus an administrative charge. The administrative charge shall not exceed the lesser of 25% of rebate earned on the drug or 4.5% of the wholesale acquisition cost.

4. Section 18. 5 (Force Majeure) shall be deleted in its entirety and replaced with the following:

18.5 Force Majeure. None of the Parties to this Agreement shall be responsible for the failure to fulfill its obligations under this Agreement to the extent that a natural disaster, war, act of terrorism, riot, civil insurrection, epidemic, complete or partial destruction of facilities atomic explosion or other release of nuclear energy, disability of any Provider that has entered into a contract to provide Covered Services to Members pursuant to this Agreement, or similar events not within the control of the Parties results in the facilities, personnel, or financial resources of Blue Cross NC not being available to provide or arrange for services or benefits under this Agreement, each Party's obligation to provide such services or benefits shall be limited to the requirements that the Party make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities, personnel, or resources.

In addition, Plan Sponsor recognizes that certain natural disasters and other similar emergencies may disrupt or seriously threaten to disrupt health care and other services provided for under this Agreement. If such a disaster or emergency occurs or is imminent, Plan Sponsor authorizes Blue Cross NC to make appropriate business decisions to implement and act in accordance with the threat or risk, including but not limited to any action necessitated by declarations, rules, regulations or similar official statements by state or federal authorities. Plan Sponsor agrees to reimburse Blue Cross NC for Claims Expenses and Covered Services provided to Members of the Plan during this period, even if not compliant with the Benefit Booklet or this Agreement. In the event that such threat or risk extends beyond 30 days, Blue Cross NC will contact Plan Sponsor to determine next steps.

5. Section 18.11 (Notices) shall be deleted in its entirety and replaced with the following:

18.11 Notices. Any notices required to be given pursuant to the terms and provisions of this Agreement, or any Business Associate Agreement herein incorporated by reference, shall be in writing, postage prepaid, and shall be sent by first class mail or electronic mail to the Parties at the addresses below. The notices shall be effective on the date indicated on the return receipt or, if emailed, on the date the email is sent.

To: Blue Cross and Blue Shield of North Carolina

Post Office Box 2291
Durham, North Carolina 27702
Attention: Chief Sales and Marketing Officer

To: Plan Sponsor
County of Chatham
12 E. Street
PO Box 1809
Pittsboro, NC 27312
Attention: Director, Human Resources
Contact email: carolyn.miller@chathamnc.org

To: Group Health Plan or Plan Administrator
County of Chatham
12 E. Street
PO Box 1809
Pittsboro, NC 27312
Attention: Director, Human Resources
Contact email: carolyn.miller@chathamnc.org

6. This Agreement shall be amended by deleting **Exhibit A** (Administrative Fees), in its entirety, and replaced with the attached revised **Exhibit A** (Administrative Fees).

7. This Agreement shall be amended by deleting **Exhibit G** (Pharmacy Program), in its entirety, and replaced with the attached revised **Exhibit G** (Pharmacy Program).

8. This Agreement shall be amended by adding the following new section to **Exhibit J** (Business Associate Addendum - BAA). This new section will be inserted after section G – Inspection of Books and Records. The remaining sections will be re-lettered accordingly.

H. Patient Identifying Information. As applicable, the Parties acknowledge that information subject to the Part 2 Rule (as defined below) may be exchanged under the terms of this Agreement. This section addresses the obligations with respect to such information.

1. **Definitions.** For purposes of this section:

"Part 2 Rule" means the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2).

"Patient Identifying Information" means information that (a) would identify, directly or indirectly, an individual as having been diagnosed, treated or referred for treatment for a substance use disorder, such as indicated through standard medical codes, descriptive language, or both and (b) is subject to the Part 2 Rule, limited to Patient Identifying Information that Business Associate receives from or on behalf of Covered Entity.

2. **Business Associate's Obligations**. As applicable, Business Associate will:

a) Comply with the requirements of the Part 2 Rule with respect to all Patient Identifying Information it receives from or on behalf of Covered Entity;

b) Implement appropriate safeguards, compliant with 42 C.F.R. § 2.16, to prevent unauthorized uses and disclosures of Patient Identifying Information;

c) Report to Covered Entity any unauthorized Use, Disclosure, or Breach of Patient Identifying Information in accordance with Section I.1 of this Agreement; and

d) Use and Disclose Patient Identifying Information for the payment or health care operations activities Business Associate performs on behalf of Covered Entity as permitted in Section B.1 of this Agreement, or by an applicable provision of the Part 2 Rule.

[EXECUTION PAGE FOLLOWS]

IN WITNESS WHEREOF, the Group Health Plan, Blue Cross NC, the Plan Sponsor and the Plan Administrator have caused their duly authorized representatives to execute this Amendment to be effective as of the date first above written.

Signed For: Plan Sponsor

By: _____
Signature of Authorized Official

Name _____

Title _____

Date _____

Signed For: Plan Administrator and the Group Health Plan

By: _____
Signature of Authorized Official

Name _____

Title _____

Date _____

Signed For: BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

By: _____
Signature of Authorized Official

Name Patrick Conway, MD

Title President & Chief Executive Officer

Date June 11, 2019

EXHIBIT A

ADMINISTRATIVE FEES

In accordance with the specific rate information contained in the medical rate page(s) and, if applicable the dental rate page(s), herein incorporated by reference, and Article 10 of the Agreement, the Plan Sponsor shall pay or cause to be paid to Blue Cross NC fees for administrative services provided to the Group Health Plan during the term of this Agreement as follows:

A. MONTHLY ADMINISTRATIVE CHARGE

1. Medical Benefits

For the Agreement Period, the monthly Administrative Fee will be:

$20.00 per health contract per month

The above monthly Administrative Fee includes:

- Charges for services related to claims and appeals processing services as described in the Agreement.
- The administrative expense allowances associated with Inter-Plan Programs as described in Exhibit E.
- The cost of the following additional programs or services provided by BCBSNC to the Group Health Plan:
  - Claims Fiduciary Services

B. INTER-PLAN ACCESS FEES

Access fees related to the BlueCard Program, as described in **Exhibit E** (Inter-Plan Programs Arrangement), are processed in the following manner:

- Access fees are billed to the Plan Sponsor, Plan Administrator, and/or Group Health Plan separately. The calculation to determine these fees is described in Exhibit E, and shall not exceed $2,000 per claim.

C. RUN-OUT SERVICES ADMINISTRATIVE FEES

In accordance with the Run-Out Services provision in Article 17 of the Agreement, Plan Sponsor shall pay or cause to be paid to BCBSNC Administrative Fees for run-out services following the termination of this Agreement as follows:

BCBSNC shall continue for a period of 12 months to administer all claims that were incurred prior to the effective date of the termination in accordance with the Run-Out Services provision in Article 17. BCBSNC shall charge a claim processing fee for this twelve month run-out period equal to the sum of the last three (3) months of the Monthly Administrative Charge prior to the termination of this Agreement. Fifty percent (50%) of the claim processing fee shall be due upon the termination of the Agreement, and the remaining fifty percent (50%) shall be due half-way through the period during which the run-out services are being provided.

In addition, the Security Amount that Plan Sponsor is required to maintain shall be refunded after three months of the run-out period provided there have been no delinquency in the funding of the Claims Expense.

Except as specifically stated herein, Plan Sponsor shall pay BCBSNC for run-out services according to the method of payment described in Exhibit C.

D. ADDITIONAL ADMINISTRATIVE SERVICES

For the Agreement Period, the Administrative Fees for Additional Administrative Services will be as follows:

(1) Health Management Programs:

a. Healthy Outcomes Health Assessment. The health assessment tool, referenced in the Healthy Outcomes Program provision in Article 5, will be available as paper surveys upon request. There will be additional fees for processing of paper health assessments. Plan Sponsor will be responsible for the printing and distributing of paper copies. The fees are listed on the Program Selection Chart herein incorporated by reference.

b. Custom Reporting. Plan Administrator may request custom reporting for an additional fee as mutually agreed upon by Blue Cross NC and Plan Administrator or Plan Sponsor.

(2) External Review. The External Review Process provision, referenced in Article [7], provides a selection of services related to adverse benefit determinations. Current fees and expenses for those services are listed on the External Review Process Price List which is incorporated by reference and available upon request.

(3) Pharmacy Program: Utilization Management- Blue Cross NC agrees to perform Drug Utilization Review services as described in **G** (Pharmacy Program). This includes review for benefit denials. The Fee for these services will be forty dollars ($40.00) per review.

(4) Routine Vision Care: If the Plan elects to utilize Blue Cross NC routine vision care services, a network access fee will be billed in addition to the allowed amount. This network access fee related to routine eye care services shall be no more than 27% of the vision claim's allowed amount. This network access fee will be billed to the Plan

Sponsor, Plan Administrator and/or Group Health Plan separately from the routine vision care medical expense, but will be included in the monthly Statement of Account.

EXHIBIT G

PHARMACY PROGRAM

1. DEFINITIONS

Whenever used in this exhibit, the following definitions apply:

1.1 "A Rated Generics" means drugs designated by the FDA to have a therapeutically equivalent (A rated) generic equivalent.

1.2 "Average Wholesale Price" (AWP) means the average wholesale price of a covered prescription drug as set forth in the Blue Cross NC price file at the time a Claim is processed. The AWP that will be applied for prescriptions filled by a Participating Pharmacy will be based on the date dispensed and the 11-digit NDC for the product. The AWP that will be applied for prescriptions filled by the Mail Service Pharmacy or Specialty Pharmacy will be based on the date dispensed and the appropriate NDC for the product dispensed. The price file will be updated no less frequently than once every three (3) business days through Medi-Span or such other Pricing Source as designated by Blue Cross NC.

1.3 "Brand Drugs" means those pharmaceuticals designated by the Pricing Source as having a multi-source indicator of M, N or O, or as otherwise defined by Pricing Source

1.4 "Claim" means a request for payment submitted by Network Participants or Members for prescription drugs or services. A claim does not include reversals or rejects. A claim does not include an initial claim that was eventually reversed or rejected.

1.5 "Claim Adjudication" or "Adjudication" means the process which Blue Cross NC uses to apply the criteria and parameters of the Group Health Plan to determine eligibility for coverage of pharmacy benefit management services, perform concurrent (on-line at point of service) Drug Utilization Reviews and determine drug pricing reimbursement amounts.

1.6 "Claims Adjudication System" means an electronic Claims processing system providing for the Adjudication of Claims.

1.7 "Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Services, calculated as a percentage of the charge for such services, which is to be paid by Members pursuant to the Group Health Plan. Members will pay the lowest of: (i) eligible charge (discounted AWP + dispensing fee + applicable tax or MAC + dispensing fee + applicable tax); (ii) U&C; and (iii) applicable co-payment.

1.8 "Compound Drug" means a prescription where two or more medications are mixed together, and which, at a minimum, one medication must be a Federal Legend Drug. The

end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.

1.9 "Copayment/Deductible" means a fixed dollar portion of the amount claimed for Covered Prescription Drug Services that is to be paid by Members pursuant to the Group Health Plan. Members will pay the lowest of: (i) eligible charge (discounted AWP + dispensing fee + applicable tax or MAC + dispensing fee + applicable tax); (ii) U&C; and (iii) applicable co-payment.

1.10 "Covered Prescription Drug Services" means the pharmacy services and/or pharmaceuticals available to Members and eligible for reimbursement pursuant to the Group Health Plan.

1.11 "Dispensing Fee" means the fee paid to Network Participants for the professional service of filling a prescription and is typically added to the AWP or MAC calculated cost.

1.12 "Drug Utilization Review" or "DUR" means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Group Health Plan.

1.13 "Electronic Prescribing" or "E-prescribing" means the process of creating, storing and transmitting prescription information electronically, either by computer or hand-held device.

1.14 “Eligible Prescription Drug Claim” is any electronically or manually adjudicated Claim payable under the prescription drug benefit for a prescription drug that is covered within established benefit limits for a Member.

Eligible Prescription Drug Claims may exclude certain specialty medications, medications that have A Rated Generics, OTC medications, vaccines, or any paid claims where coverage is subsequently denied or claims filed on behalf of persons who do not have coverage at the time the prescription drug is filled.

1.15 "Extended Supply Network" or "ESN" means the retail Network Participants who have agreed to provide Members more than a one-month's (or as mutually agreed) quantity supply of Covered Prescription Drug Services provided that the Group Health Plan has a mail service benefit and a retail quantity days supply limit of three months.

1.16 "Federal Legend Drug" means a drug, which is required by law to bear on its packaging, "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only".

1.17 "Foreign Drug Claims" means Claims submitted through the Paper Claim process for reimbursement of drugs purchased outside of the United States.

1.18 "Formulary" means a list of various pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of Covered Prescription Drug Services.

1.19 "Generic Drugs" means all drugs that are not defined as “Brand Drugs”.

1.20 "Mail Service Pharmacy" means the services through which Members may receive prescription drugs through the mail from PrimeMail®, the home delivery pharmacy service of Prime Therapeutics LLC.

1.21 "Manufacturer" means a company that manufactures and/or distributes pharmaceutical drug products.

1.22 "Maximum Allowable Cost" or "MAC" means the highest drug cost at which Plan Sponsor will reimburse the Network Participant or Member for a specific drug.

1.23 "Maximum Allowable Cost List(s)", "MAC List(s)", or "Blue Cross NC's MAC List(s)" means the proprietary database listing(s), owned and maintained by Blue Cross NC or its designee, of multi-source pharmaceutical drug products and supplies and the corresponding MAC. A separate MAC List may be maintained for the Mail Service Pharmacy.

1.24 "Network" or "Pharmacy Network" means the group of pharmacies that have been accepted as Network Participants and have entered into agreements with Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members.

1.25 "Network Contract" means a contract between a Network Participant and Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members, as may be amended from time to time.

1.26 "Network Participant" or "Participating Pharmacy" means each individual pharmacy, chain or other dispensing provider that has entered into a Network Contract with Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members.

1.27 "Open Refill Transfer File" means a data file created by the Group Health Plan’s previous pharmacy benefit manager containing its Members’ mail prescriptions, thus enabling a subsequent pharmacy benefit manager, such as Blue Cross NC or its designee, to continue to fill those open mail prescriptions.

1.28 “Over-the-Counter Drugs” or “OTC Drugs” are products classified as OTC by Medi-Span as of the fill date based on the NDC-11 dispensed. OTCs are subject to cost share based on Brand or Generic drug designation.

1.29 "Paper Claims" means prescription drug services that are submitted to Blue Cross NC for adjudication through the use of a paper claim form, generally by a Member subsequent to the point of sale.

1.30 "Pharmacy Operations Manual" means the document to be distributed to Network Participants which describes the administrative policies and procedures of the Claims Adjudication System. The Pharmacy Operations Manual details the method for submitting Claims from the Network Participant to the Claims Adjudication System and procedures for the resolution of Claims rejected by the Claims Adjudication System.

1.31 "Pricing Source" means Medi-Span, or such other national drug database as Blue Cross NC may solely designate, which establishes and provides updates to Blue Cross NC no less frequently than once every three (3) days, or as otherwise required by law, regarding the AWP or other alternative pricing benchmark as determined by Blue Cross NC for Covered Prescription Drug Services.

1.32 "Provider Tax" means any tax on a Covered Prescription Drug Service and other services taxable in the jurisdiction required to be collected or paid by a retail or mail seller for a Covered Prescription Drug Service or the provider of the services.

1.33 “Specialty Pharmacy” means a designated pharmacy provider that provides Specialty Pharmacy Products.

1.34 "Specialty Pharmacy Product(s)" means a pharmaceutical that may be administered orally, by injection or by infusion; may be subject to limited availability or special handling, utilization management, AWP greater than six-hundred dollars, distribution or purchase arrangements from the Manufacturer; may require more support or patient educational services than commonly required for drugs obtained from retail pharmacies; or may be covered under either a medical or pharmacy Group Health Plan.

1.35 "Usual and Customary" or "U&C" means the lowest price, including any Dispensing Fee a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

1.36 "Utilization Management" or "UM" means a broad collection of standard clinical products and services that are designed to encourage proper drug utilization in order to enhance Member outcomes while managing drug benefit costs for Plan Sponsor. Such services include, but are not limited to the following, Formulary exception, prior authorization, step therapy, quantity limits, restricted access, and retrospective DUR.

2. GENERAL SERVICES

2.1 **Plan Administrator Management Services.** Blue Cross NC will provide certain account management services as set forth herein.

2.1.1 Account Management Team. Blue Cross NC will designate a team of employees or other personnel that will provide account management and clinical services to

the Group Health Plan. Such Blue Cross NC employees or other personnel may be allowed to work on other projects as time permits. The account management team will include at least these members:

- Blue Cross NC Client Manager
- Prime Account Executive
- Implementation project manager

2.1.2 Account Management. Blue Cross NC agrees to provide account services to support the overall effectiveness of the services provided under this Exhibit, and promote the integration of such services with operations. The account team will facilitate and plan routine meetings with Plan Administrator to provide updates on program performance, present benefit consultations, and consult on operational improvements. Benefit design consultation and analysis may consist of analysis of different benefit designs, the financial impact of Copayment differentials, Pharmacy Network options, shifts in utilization patterns, generic savings opportunities, and Formulary options. The account team will also present new Blue Cross NC products and services to Plan Administrator, to support meeting their pharmacy program objectives. Other activities may include some or all of the following:

(a) Research and propose solutions to Claims, eligibility, provider, and Member service issues;

(b) Collaboration with Plan Administrator on an annual strategic plan and supporting work plans to coordinate the activity;

(c) Attend quarterly face-to-face meetings with Plan Administrator;

(d) Provide and interpret pharmacy reports, quarterly performance reports and semi-annual program updates. Conduct financial analysis of Blue Cross NC sponsored programs and products at the Group Health Plan level; and

(e) Plan and coordinate implementation meetings for Blue Cross NC programs and services.

2.2 Claims Processing Information Management

2.2.1 Group Health Plan Information Management. Blue Cross NC or its designee will enter Group Health Plan and Pharmacy Network information as soon as practicable after receiving such information from Plan Administrator but agrees that it will enter such standard data no later than ninety (90) days after receiving the data from Plan Administrator. If Plan Administrator requests Blue Cross NC to enter such data sooner than ninety (90) days, the Parties will mutually agree on the time frame and any potential increased costs associated with such activities.

2.2.2 Adjudication of Claims. Blue Cross NC or its designee will adjudicate Claims for Covered Prescription Drug Services electronically submitted by Network Participants through the Claims Adjudication System or manually submitted by a Member as a Paper Claim, according to the Group Health Plan, Member eligibility, and other information submitted by the Plan Administrator. In adjudicating claims, Blue Cross NC will rely on the information provided to it by the Plan Administrator and will not be responsible for inaccuracies in the information. Adjudication will include eligibility and coverage determination under the Group Health Plan, including the calculation of allowable costs and applicable Copayment/Deductible, or Coinsurance, payment of eligible claims, and notification of declined or ineligible Claims.

2.2.3 NDC File. Blue Cross NC or its designee will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC. Blue Cross NC or its designee will update the NDC File no less frequently than monthly with information provided by Pricing Source. The NDC file is provided for internal data purposes only and may not be used for pricing purposes.

2.3 **Web-based Tools, Products and Services.** Blue Cross NC or its designee shall offer several web-based products and services to Plan Administrator. Products range from communicating drug news and pipeline information, to an interactive, user-friendly Web site designed for Members.

2.4 **Contact Center Services**

2.4.1 Member Contact Center. Blue Cross NC or its designee will make available a toll-free customer service line for use by Members.

2.4.2 The Mail Service Pharmacy Contact Center. Blue Cross NC or its designee will make available a toll-free customer service line for use by Members utilizing the Mail Service Pharmacy.

2.4.3 Pharmacy Locator. Blue Cross NC or its designee will provide a means, either toll-free telephone line and/or electronic, for Members to contact to identify Network Participants in a particular area. The toll-free telephone line will be available during Pharmacy Help Desk hours.

2.4.4 Pharmacy Help Desk Service. Blue Cross NC or its designee will provide help desk service for pharmacist Claim inquiries twenty-four (24) hours a day, seven (7) days a week. This help desk service will also handle calls from Network Participants in the event they have questions concerning reconciliation reports provided to them for purposes of pharmacy payments.

2.5 **Clinical Services**

2.5.1 Formulary Management.

2.5.1.1 Blue Cross NC will provide Formulary clinical services in accordance with NCQA standards and all applicable state and federal laws.

2.5.1.2 Blue Cross NC will provide Formulary management services and will update the Formulary in a timely manner.

2.5.1.3 Blue Cross NC will coordinate Pharmacy & Therapeutics (P&T) Committee meetings at least quarterly and include developing agenda, therapeutic class reviews, drug monographs and quarterly updates of Formulary publications available on Blue Cross NC's website.

2.5.2 Utilization Management. Blue Cross NC will provide cost containment programs in the form of Utilization Management programs on behalf Plan Sponsor and such services will be subject to additional fees as described in Exhibit A.

2.6 **E-Prescribing.** Blue Cross NC or its designee will support e-Prescribing transaction standards for eligibility, formulary, and medication history to allow prescribers to electronically send Members' prescriptions directly to a Network Participant from the point-of-care.

2.7 **Special Projects.** Special Projects may be mutually agreed to by the parties and described in an amendment to this Agreement as applicable, including any additional fees.

2.8 **Cooperation upon Termination.** Should Plan Sponsor terminate this Agreement, Blue Cross NC will provide and not withhold for any reason all standard industry PBM transition/data files that will be used by the new PBM to minimize member disruption, including full historical NCPDP claims files, prior authorization files, accumulator files, mail open refill files, both pre and post termination date.

2.9 **Access to Information.** Subject to the limitations in Article 15, if Plan Administrator needs pharmacy claims information from Blue Cross NC for audit or to conduct health care operations, Blue Cross NC shall give Plan Administrator access to that information if allowed by law, upon the completion of a data use agreement. Blue Cross NC reserves the right to restrict the provision of certain information it deems confidential, proprietary or a trade secret.

3. PHARMACY NETWORK SERVICES

3.1 **Network Utilization and Pricing.** Blue Cross NC or its designee will provide and maintain Pharmacy Network(s) to provide Covered Prescription Drug Services to Members. For the Pharmacy Network selected, the rates are described in Section 3.5 of this

exhibit. In the event Plan Administrator elects to have Blue Cross NC maintain or administer additional Networks, the rates will be subject to change.

3.2 **Network Establishment and Maintenance.** Through the chosen Pharmacy Network(s), Members will have access to certain Network Participants that have (a) executed a Network Contract as required by Blue Cross NC or its designee (as amended from time to time), and (b) have agreed to provide Covered Prescription Drug Services to Members in accordance with a pharmacy reimbursement schedule and the terms of the Network Contract. Blue Cross NC or its designee will maintain Network Contracts with an adequate number of Network Participants in the various geographical areas where Members reside and will comply with all applicable regulatory access requirements. Blue Cross NC or its designee will furnish each Network Participant with Group Health Plan information in such a format and media as Blue Cross NC deems appropriate for the purpose of assisting such Network Participants in providing Covered Prescription Drug Services to Members. Blue Cross NC reserves the right to periodically change Network Participants in order to maintain satisfactory compliance with Blue Cross NC's policies on pricing, quality, and operations.

3.3 **Network Contracts.** Blue Cross NC will comply, or will require its designee to comply, with all laws applicable to pharmacy network contracts, including applicable state regulatory or other governmental agencies' filings if necessary (including, but not limited to, filings regarding all Network Participant terminations).

3.4 **Blue Cross NC Maximum Allowable Cost List.** Network Pharmacies will be required to accept Blue Cross NC's MAC List(s) for Members.

3.5 **Drug Pricing.**

Plan Sponsor will be invoiced for pharmacy claims using Schedule A that provides an average annual effective rate for each level of discount (specialty, brand, generic, mail, retail, and each type of network) of Average Wholesale Price (AWP) minus the percentage indicated in Schedule A for each level of discount ("Contract Price"). Blue Cross NC uses the Pricing Source for AWP. This Contract Price is the rate that includes all medications included in each level of discount, mail service brand and mail service generic prescriptions, as well as retail brand and retail generic prescriptions (excluding specialty pharmacy and compound prescriptions). Specialty Pharmacy Pricing is described under Section 5.2.3.

See Schedule A for pricing terms and conditions. Schedule A will be the underwriting terms and conditions and will be included as an exhibit to the pharmacy exhibit.

Mail service drugs dispensed under the Pharmacy Program will be provided by Prime Therapeutics, LLC., a company in which Blue Cross NC has an ownership interest. [Although the Contract Price may be more or less than the amounts Blue Cross NC is required to pay to Participating Pharmacies for the Plan's drugs, Plan Sponsor shall pay only the Contract Price.

3.6 **Pharmacy Network Audit Services.** Blue Cross NC or its designee will perform pharmacy Claims audits to promote Network Participants' compliance with contractual obligations and applicable laws. Blue Cross NC or its designee will perform its pharmacy Claims audits pursuant to the authority granted to Blue Cross NC or its designee in the applicable Network Contracts. Such audits may include:

3.6.1 Daily Claims Review. Blue Cross NC or its designee will conduct manual review of selected questionable Claims by Network Participant from a population of Claims that meet or exceed a defined dollar threshold. Blue Cross NC or its designee will contact Network Participant and instruct pharmacist to reverse and reprocess the applicable Claim using accurate Claim information, when appropriate.

3.6.2 Desktop Audits. Blue Cross NC or its designee will perform desktop audits of Network Participants identified through the pharmacy audit profile, upon request, through Blue Cross NC's compliance hotline, or as otherwise identified by Blue Cross NC. Blue Cross NC or its designee will review and verify up to twelve (12) months of Claims by Network Participant and will contact Network Participant through correspondence to address questionable Claims issues. Blue Cross NC or its designee will request a copy of prescription to verify accuracy, when appropriate.

In certain cases, inaccurate Claims will result in a chargeback to the Network Participant. During each calendar year, Blue Cross NC or its designee will perform the number of desktop audits that equals nine percent (9%) of Network Pharmacies. If additional audits are needed, the volume and associated fees will be mutually agreed upon in advance.

3.6.3 On-Site Audits. Blue Cross NC or its designee will perform on-site audits of Network Participants identified through the pharmacy audit profile, upon request, through Blue Cross NC's compliance hotline, or as otherwise identified by Blue Cross NC. Blue Cross NC or its designee will review and verify up to twenty-four (24) months of Claims at the Network Participant's location. Blue Cross NC or its designee will also verify Network Participant is in compliance with the Network Contract and the Pharmacy Operations Manual. In certain cases, inaccurate Claims will result in a chargeback to the Network Participant. During each calendar year, Blue Cross NC or its designee will perform the number of on-site audits that equals five percent (5%) of Network Pharmacies. If additional audits are needed the volume and associated fees will be mutually agreed upon in advance.

3.7 **Network Participant Interface and Payments**

3.7.1 Claims Submission. Network Participants will be required to submit Claims for Covered Prescription Drug Services to Blue Cross NC or its designee in accordance with the procedures detailed in the National Council of Prescription

Drug Programs (NCPDP) Online Claims Submission Telecommunication Standard.

3.7.2 Claims Quality. Blue Cross NC or its designee will perform online edits of the information contained in the Claims based upon the provisions and guidelines of the applicable Group Health Plan. Missing, illegible or erroneous information will cause such Claims to be rejected and the Network Participant will be notified online according to the NCPDP standards for communicating such rejections. All rejected Claims must be resubmitted in their entirety.

3.7.3 Payment Methodology/Network Participant Reimbursement Calculation. Blue Cross NC or its designee will pay Claims consistent with the applicable Benefit Booklet. Reimbursement to the Network Participant will be based upon the agreed-upon pricing contained in the Network Contract with the Network Participant on the date the prescription transaction is processed, referred to as the Allowed Amount. The negotiated amount, or Allowed amount for Participating Pharmacies, will be: any provider or sales taxes, where applicable; plus the lesser of: (i) U&C; or (ii) the Pharmacy Network submitted cost plus the contracted Dispensing Fee; or (iii) the sum of the MAC or AWP less the contracted discount percentage plus the contracted Dispensing Fee.

3.7.4 Material Change to AWP. If after the Effective Date: (i) material changes to the formula, methodology or manner in which AWP is calculated or reported by the Pricing Source take effect or (ii) the Pricing Source ceases to publish AWP for the Covered Prescription Drug Services under this Agreement, then the financial terms of this Agreement shall be automatically adjusted at the time of such change to return the Parties to their commercially reasonably respective economic positions as they existed under the Agreement prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Agreement shall immediately and automatically be converted to an alternative comparable pricing benchmark.

3.7.5 Provider Taxes. Blue Cross NC will bill Plan Sponsor and Plan Sponsor will pay Blue Cross NC for any federal, state or local Provider Taxes payable with respect to any sales of Covered Prescription Drug Services to a Member, and will remit to Network Participant any such taxes collected from Plan Sponsor. Network Participant is required to submit a request for tax payment at the time of an on-line claim submission. Network Participant will remit any such Provider Taxes to the appropriate taxing authority. Network Participant will be solely responsible for any other taxes or surcharges associated with its performance under the Network Contract.

4. REBATE MANAGEMENT SERVICES

4.1 **Negotiating Rebates.**

On its own behalf, Blue Cross NC or its designee have entered into, and may in the future, enter into arrangements with companies under which a portion of prescription drug charges are rebated. Pharmaceutical Rebates may be associated with drug claims processed under the Group Health Plan's pharmacy or, if applicable, medical benefit. These rebate amounts vary, and may change during the year, based upon the status of a drug in Blue Cross NC's prescription drug formulary, drug utilization, benefit coverage, unexpected Generic launches, and other factors. Plan Sponsor retains sole and complete control to (i) select and change the Formularies for its Plan, and (ii) determine and amend all benefit structures and terms under its Group Health Plan.

In addition, pharmacy management vendors may receive administrative reimbursement or fees directly from Blue Cross NC or drug or other companies for services they provide to Blue Cross NC and those companies. As compensation for costs and services provided in connection with pharmacy benefit management and other services provided under this Agreement, Blue Cross NC will retain 100% of the rebates it receives from its pharmacy management vendor(s) related to Group Health Plan's prescription drug utilization.

On an annual basis, after Blue Cross NC has received rebate payment and a reconciliation report from the pharmacy management vendor(s), Blue Cross NC will calculate upon request the "Average Rebate" amount, and make this information available to the Group Health Plan. The Average Rebate will be calculated taking the average of the rebate amount received per Eligible Prescription Drug Claim based on the aggregate of such amounts received by Blue Cross NC from pharmacy management vendor(s) for Blue Cross NC administered ASO health plans participating in such arrangements and for Blue Cross NC insured business.

For the purpose of ERISA reporting, Blue Cross NC's compensation received under this section shall be calculated as the average rebate per Eligible Prescription Drug Claim (determined as described in the above paragraph) multiplied by the number of Eligible Prescription Drug Claims.

5 PHARMACY SERVICES

5.1 Mail Service Pharmacy Services.

5.1.1 Mail Service Pharmacy Pricing Terms. Plan Sponsor will pay Blue Cross NC for Covered Prescription Drug Services dispensed by the Mail Service Pharmacy in an amount equal to the contracted rate for each Covered Prescription Drug Service dispensed as specified in Schedule A, less the applicable Copayment/Deductible or Coinsurance amount. The applicable AWP will be based on the package size dispensed and the appropriate NDC.

5.1.2 Mail Service Pharmacy Covered Prescription Drug Services. The Mail Service Pharmacy will provide medications under the following guidelines:

(a) The Covered Prescription Drug Services and days' supply limitation will be as set forth in the applicable Benefit Booklet.

(b) Based upon the prescription and Applicable Law, the Mail Service Pharmacy will provide a quantity of Covered Prescription Drug Services consistent with the Member's Benefit Booklet, subject to the quantity limitations written by the prescriber on the prescription, professional judgment of the dispensing pharmacist, limitations imposed on controlled substances and Manufacturer's recommendations. Prescriptions may be refilled providing the prescription so states. Prescriptions will not be filled (1) more than twelve (12) months after issuance, (2) more than six (6) months after issuance for controlled drug substances, or (3) if prohibited by Applicable Law.

5.1.3 Mail Service Pharmacy Dispensing Procedures.

(a) The Mail Service Pharmacy shall dispense Covered Prescription Drug Services to Members, and dispense Generic Drugs when authorized, in accordance with (1) Applicable Law, and (2) the terms of this Agreement.

(b) All matters pertaining to the dispensing of Covered Prescription Drug Services or the practice of pharmacy in general are subject to the professional judgment of the dispensing pharmacist.

(c) Any drug which cannot be dispensed in accordance with the Mail Service Pharmacy's reasonable dispensing protocols, which requires special record-keeping procedures, or which requires special handling, may not be dispensed by the Mail Service Pharmacy, provided that the Mail Service Pharmacy provides Members with reasonably prompt notice of any such drug.

(d) If it becomes impracticable, for reasons of force majeure or otherwise, for the Mail Service Pharmacy to dispense prescriptions to Members under the Mail Service Pharmacy Service, the Mail Service Pharmacy shall use reasonable efforts to have prescriptions dispensed from an alternative Network Participant, subject to Applicable Law.

5.1.4 Mail Service Pharmacy Postage, Mailing, and Shipping. The Mail Service Pharmacy will be solely responsible for all standard postage, mailing and shipping expenses of Covered Prescription Drug Services provided to Members pursuant to this Agreement, except in the instance when a Member requests expedited shipping, in which case the expedited shipping expenses shall be the sole responsibility of the Member. The Mail Service Pharmacy shall have discretion to waive the expedited shipping fee, but it shall remain responsible for the postage.

5.1.5 Mail Service Pharmacy Complaint Procedures. The Mail Service Pharmacy shall make commercially reasonable efforts to resolve oral or written complaints in an

informal process and to keep written records of events and actions surrounding each complaint that is not resolved to the Member's satisfaction, as much as is practicable.

5.2 **Specialty Pharmacy Services.** The following provisions apply only to services provided through the Specialty Pharmacy.

5.2.1 Specialty Pharmacy Services.

(a) Blue Cross NC or its designee will use Member enrollment and benefit coverage information provided by Plan Administrator to determine Member eligibility and benefit coverage at the time of dispensing.

(b) The Specialty Pharmacy will collect from each Member their applicable Copayment/Deductible and/or Coinsurance fee for each prescription or refill in accordance with the Benefit Booklet.

(c) The Specialty Pharmacy may withhold prescription services to a Member for good cause if allowed by law including, but not necessarily limited to, Plan Sponsor's nonpayment of prescription services provided to Members; the Member's failure to pay for services rendered (e.g., Copayments/Deductibles and/or Coinsurance or other out-of-pocket costs); requests by Members for quantities of Specialty Pharmacy Products in excess of prescribed quantities or refill limitations or where, in the professional judgment of the dispensing pharmacist, the prescription should not be filled.

(d) The Specialty Pharmacy will attempt to dispense Generic Drugs in lieu of prescribed brand name Specialty Pharmacy Products if commercially available, consistent with the prescription, and consistent with the dispensing pharmacist's professional judgment and Applicable Law. In addition, the Specialty Pharmacy will comply with the Group Health Plan Formulary to the extent the Formulary applies to such Specialty Drug Products, unless the Specialty Pharmacy is otherwise directed by a prescribing provider via a prescription which contains the handwritten words "Dispense as Written" or "Brand Necessary", or such other equivalent indication as may be required by applicable laws or regulations to indicate the same intention.

(e) Upon the Specialty Pharmacy's receipt of an appropriate Specialty Pharmacy Product prescription and any required Copayment/Deductible or Coinsurance from the Member, the Specialty Pharmacy will ship the Specialty Pharmacy Product to the Member or provider, as directed by the Member, via a third party carrier or any other comparable traceable method the Specialty Pharmacy may select.

(f) The Specialty Pharmacy will make every reasonable effort to resolve oral or written complaints in an informal process and keep written records of events

and actions surrounding each complaint that is not resolved to the eligible Member's or provider's satisfaction.

5.2.2 Specialty Pharmacy Dispensing Procedures.

(a) The Specialty Pharmacy will dispense Specialty Pharmacy Products to Members when authorized, in accordance with (1) Applicable Law, and (2) the terms of this Amendment and Benefit Booklet.

(b) All matters pertaining to the dispensing of Specialty Pharmacy Products or pharmacy in general are subject to the professional judgment of the dispensing pharmacist.

(c) If it becomes impracticable, for reasons of force majeure or otherwise, for the Specialty Pharmacy to dispense prescriptions to Members, Specialty Pharmacy will use commercially reasonable efforts to have Specialty Pharmacy Products dispensed from an alternative specialty pharmacy, subject to Applicable Law.

5.2.3 Specialty Pharmacy Pricing Terms.

(a) The Copayment/Deductible or Coinsurance amount for each prescription or refill dispensed through the Specialty Pharmacy will be as designated in the applicable Group Health Plan.

(b) Claims for Specialty Pharmacy Products will be processed as soon as reasonably practicable following receipt. The applicable AWP will be determined as of the date on which the Claim is processed using the most recently loaded Pricing Source data.

5.2.4 Specialty Copay Solutions – Copay Maximization.

Plan Sponsor has elected to participate in the Specialty Copay Solutions – Copay Maximization Program. This program maximizes the value of eligible manufacturer-sponsored patient assistance coupon programs (coupon program) by adjusting Member out-of-pocket liability to reach the full value of the benefit under the manufacturer's coupon program. In addition, the value of the manufacturer coupon will not be credited to Member deductible or out-of-pocket maximum amounts. The administrative fee for this program is $100 per eligible specialty drug claim.

EXHIBIT G- PHARMACY PROGRAM
SCHEDULE A

Chatham County		Members:	877
Effective Date:	7/1/18	Employees:	463
TRADITIONAL PRICING			
RETAIL			
Brand		Generic	
AWP minus		AWP minus	
Y1:	16.75%	Y1:	78.25%
Y2:	16.75%	Y2:	78.35%
Y3:	16.75%	Y3:	78.45%
DISPENSING FEE			
Brand		Generic	
Y1:	$1.00	Y1:	$1.00
Y2:	$1.00	Y2:	$1.00
Y3:	$1.00	Y3:	$1.00
MAIL			
Brand		Generic	
AWP minus		AWP minus	
Y1:	21.00%	Y1:	81.75%
Y2:	21.00%	Y2:	82.00%
Y3:	21.00%	Y3:	82.30%
DISPENSING FEE:		$0.00	

** see page 2 for notes*

Notes:

- Members will pay the lower of the contracted rate, U&C, or their applicable copayment. Zero balance logic is not employed.
- Discounts are based on the actual NDC-11 dispensed.
- Guarantees will be reconciled annually and applied in aggregate.
- Discounts provided do not include savings from DUR or other clinical programs.
- Guaranteed offer is based on adoption of the BCBSNC Net Results formulary and may be amended in the event there is a change in the formulary, implementation of new clinical programs, changes to the pharmacy benefit plan design, lock-out of drug classes, or unexpected generic launches.
- Assumes client does not have 340B pricing.
- Pricing is based upon the BCBSNC Broad Plus Network of 65,000+ pharmacies.
- Discount rates exclude compounds, foreign claims and specialty (as defined by the BCBSNC Specialty Fee Schedule).
- Pricing assumes 3% Mail penetration, if that differs by 5%, Prime reserves the right to revise pricing terms and financials accordingly.
- Retail discounts include 90-day at retail claims and are contingent on at least 18% of retail claims being filled through this channel.
- Pricing assumes membership of 10% or less in high deductible (CDHP) benefit designs and no material change in participation over the course of the contract.
- In the event the number of covered members or pharmacy claims volume varies by greater than 10%, Prime reserves the right to revise the pricing terms and financials accordingly.
- If changes occur within the PBM marketplace which lead to a significant deviation from the current economic environment, both parties agree to proactively amend the contract to make all parties commercially reasonably economically neutral.
- Guarantees are subject to change in the event that any law, regulation, interpretation of a law or regulation, or any change within the PBM marketplace would lead to a deviation from the current economic environment upon which these guarantees are based.
- Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to “M”, “N”, or “O”.
- Generic drugs are defined as all drugs available in sufficient supply that have a Medi-Span multisource code field equal to “Y”.