

STATE OF MAINE
Bureau of Insurance
PHARMACY BENEFITS MANAGER
License Application
Revised 10/08/2024

A \$100 LICENSE FEE IS DUE WITH YOUR ON-LINE APPLICATION
\$100 RENEWAL IS REQUIRED EVERY THREE YEARS
A \$25 Late Fee will be automatically charged after Due Date

Section I. General Information

1. Name of PBM:
2. Physical Address: (including City, State, Zip)
3. Mailing Address (if different): (including City, State, Zip)
4. Contact person/Title, telephone number, fax, email address:
5. Name of PBM's Parent Company (if applicable):
6. Federal ID#:
7. NAIC Company Code: (if applicable)
8. Does the company/organization hold any other licenses or registrations in Maine (If yes, specify what type. Please list all used. Use separate sheet if necessary.)
9. DBA/Trade Name (if applicable): (Please list all used. Use separate sheet if necessary.)
10. State Incorporated in:
11. Corporate Offices Direct Telephone:
12. Type of organization: Individual Limited Liability Company Corporation
a. Partnership Other (explain) _____

Foreign Corporations (Title 13-C M.R.S. § 1503), Foreign Limited Partnerships (Title 31 M.R.S. § 492), Limited Liability Companies (Title 31 M.R.S. § 712), or Limited Liability Partnerships (Title 31 M.R.S. § 852) must apply to the Maine Secretary of State for authority to do business in the State of Maine. ***Please attach proof of approval.***

a. Officers and Directors:

Provide Information on each officer and director (attach additional pages as necessary):

Name:
Title:
Direct Telephone:
Contact Email:
Mailing Address:

For each officer and director, please provide:

- A. Their principal occupation and all offices and positions held during the past five years;
- B. Whether any such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal governmental agency, and if so, the current status of each such license or registration and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith; and
- C. Whether the person has been convicted of a crime other than minor traffic violations.

b. Beneficially Interested Parties:

Provide Information on each person beneficially interested in the applicant (e.g. ownership of 10% or more of voting securities) (attach additional pages if necessary):

Name:
Title:
Direct Telephone:
Contact Email:
Mailing Address:

c. Service of Process:

Applicant's agent for service of process in Maine (must be an agent located in Maine):

Name:
Title:
Direct Telephone:
Contact Email:
Mailing Address:

Section II. Applicant Qualifications:

Attach to the application a full explanation and/or the requested information for questions below. Failure to provide the required information or any omissions may result in the denial of this application.

a. Organization & Background

1. Copies of the basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, including all amendments, bylaws, rules, regulations, and/or procedures regulating the internal conduct of the applicant.
2. Has the applicant ever been refused a registration, license or certification to act as a provider of pharmacy benefit management services in another state or has such license, registration or certification ever been revoked?
3. Has the applicant ever had a business relationship with an insurance company terminated due to alleged fraud, illegal, or dishonest activities in connection with the administration of pharmacy benefit management services? (If so, attach specific details explaining the termination, its nature, and date.)
4. Has the applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal, or dishonest activities in connection with the administration of pharmacy benefit management services?
5. Has the applicant, or any company or organization controlling the operation of the applicant, experienced any data security breaches or HIPAA security breaches? (If yes, please attach all pertinent information regarding the breach.)
6. Does the applicant own, operate, or affiliate with any pharmacy located outside Maine which ships, mails, or delivers in any manner, controlled substances, prescription or legend drugs or devices into Maine?

b. Expertise: Please provide the following:

1. A copy of the applicant's standard contract template which the applicant uses in this State for contracts with pharmacies or pharmacy services organizations in the administration of pharmacy services for insurers. If any client contract provision deviates materially from the standard contract, provide a description of the material deviations. The contract must have the disclosures required by 24-A M.R.S. § 4350(4)Rule 210 s. 4(1)(D)(2).
2. A signed copy of an Agreement Concerning Fiduciary Obligations (<https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/210-fiduciary-agreement.pdf>) for each contracted carrier.
3. A current client list.
4. The number of projected enrollees or beneficiaries in this State to be serviced by the applicant during the upcoming year for all contracted insurers. If applicable, provide the actual number of enrollees or beneficiaries administered by the applicant for each insurer during the previous calendar year.
5. A copy of the applicant's network service areas by Maine county for each contracted insurer and the applicant's pharmacy directory list. (A mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network. All mail order pharmacies must be listed separately.) The written

standards must provide a network sufficient numbers and types of pharmacies to assure that prescriptions to covered persons, including specialty prescriptions, will be reasonably accessible without unreasonable delay. Standards must be reasonable for the community, the delivery system, and clinical safety. Please also provide a description of the applicant's plan for providing prescription drugs for rural and underserved populations.

6. A description of how the applicant intends to comply with 24-A M.R.S. § 4349(4) and any relevant written procedures. (A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of: A) The applicable cost-sharing amount for the prescription drug; B) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and C) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost - sharing amount paid by a covered person.)
7. A description of how the applicant intends to comply with each portion of 24-A M.R.S. § 4350, including applicable procedures required by § 4350(3) (changes to the maximum allowable cost list), and §§ 4350(5) and (6) (the appeals process and resolution of appeals), § 4350(7) (prescription drugs not on maximum allowable cost list); and § 4350(8) (pharmacy payment). Also, provide a list of all prescription drugs for which a maximum allowable cost is set and their rating in accordance with § 4350(2).
8. A description of how the applicant intends to comply with each portion of §4350-A and any applicable procedures. (Responsibility to use compensation for benefit of covered persons, including any rebates.)
9. Documentation showing that the applicant has established a pharmacy and therapeutics committee and implemented conflict of interest/compensation procedures as required by § 4350(B)/Rule 210 §4(1)(D)(4).

Section III. Financial Integrity: Please provide the following:

1. A copy of the applicant's most recent fiscal year-end audited financial statement.
2. Does the applicant handle claims and/or collect premium? If so, a Third-Party Administrator License (TPA) Application must be completed. If the applicant already has a TPA license, provide information demonstrating that the license is in good standing or that one is pending.
3. An explanation of how the applicant has the necessary financial integrity to supply its proposed services. Please include a description of the applicant's business plan and attach any relevant documents in addition to the applicant's most recent fiscal year-end audited financial statement.

Section IV. Certify Compliance and Signature:

By submitting this application, the applicant hereby certifies that the applicant has read and complies with the Pharmacy Benefits Manager standards set forth in Chapter 56-A Title 24-A M.R.S.A. §§ 4347-4350-E, and Bureau of Insurance Rule Chapter 210.

As the authorized representative of the Applicant, I hereby certify that all of the information submitted in this application and attachments is true and complete.

Signature of Authorized Person

Date

Type or Print Name

Title