PHARMACY BENEFITS MANAGER (“PBM”) LICENSING PACKET

ALL APPLICATIONS SHOULD BE MAILED TO THE FOLLOWING ADDRESS:

Tennessee Department of Commerce and Insurance
PBM Licensing/Admission Analyst
500 James Robertson Parkway, 7th Floor
Nashville, Tennessee 37243

Questions? Call 615-741-1670
PHARMACY BENEFITS MANAGER (“PBM”) LICENSING PACKET REQUIREMENTS
FOR FILING A NEW PBM LICENSE APPLICATION:

1. PBM License Application Form – Last page of this packet
   a. Must bear original signatures and notarization. The Application must contain a street address, not
   a post office box. If mail is received at a P.O. Box, please state this in your cover letter.

2. Non-refundable Application Review Fee of $100.00
   a. Payable to: Tennessee Department of Commerce and Insurance.

3. Articles of Incorporation (or Partnership Agreement)
   a. Must be certified by the Secretary of State in the state of domicile.
   b. Must bear the original certification (not a photocopy).
   c. Must be in the name of the applicant company.
   d. If not a Tennessee business entity, must include a copy of proof of registration with the Tennessee
      Secretary of State.

4. Financial Statements
   a. Must be audited by a Certified Public Accountant.
   b. Must be in the name of the PBM applicant seeking the license. We accept consolidated statements if
      they state separately the amounts of the applicant.
   c. Must show a positive Net Worth.
NO RENEWAL NOTICES WILL BE SENT. All required items below must be submitted to the satisfaction of this Department before the expiration date. A renewal license will not be granted until the Department approves all required items.

A renewal package consists of the following items as listed below:

1. **Letter of intent to renew containing company contact person information accompanied by a Non-refundable Application Review Fee of $50.00**
   a. Payable to: Tennessee Department of Commerce and Insurance.

2. **Financial Statements**
   a. Must be audited by a Certified Public Accountant.
   b. Must be in the name of the PBM applicant seeking the license. We accept consolidated statements if they state separately the amounts of the applicant.
   c. Must show a positive Net Worth.

3. **Any Amendments to the Previous License Filings.**
• APPLICABLE TENNESSEE INSURANCE LAWS FOR PBMS

• TITLE 56 – INSURANCE

• CHAPTER 7 – POLICIES AND POLICYHOLDERS

• PART 31 – PHARMACY BENEFITS MANAGERS

• § 56–7–3101 Pharmacy Benefits Managers; Compliance
• § 56–7–3102 Definitions
• § 56–7–3103 Audits; Recoupment of Funds; Appeals
• § 56–7–3104 Reimbursement; Reference Price Updates
• § 56–7–3105 Contracts
• § 56–7–3106 Maximum Allowable Cost List; Drug Addition or Removal
• § 56–7–3107 Maximum Allowable Cost List; Information; Updates
• § 56–7–3108 Maximum Allowable Cost for Drug or Medical Product or Device; Appeal
• § 56–7–3109 Medical Products and Devices Subject to Requirements of Part
• § 56–7–3110 Violation; Sanctions
• § 56–7–3111 Maximum Allowable Cost Lists; Disclosure
• § 56–7–3112 Fair Disclosure of State Funded Payments for Pharmacists' Services Act

For additional information, refer to the Department’s website at: http://tn.gov/commerce/insurance
LICENSE APPLICATION FOR PHARMACY
BENEFITS MANAGER (“PBM”)

On behalf of _______________________________, a ________________________________ with its principal office located at:

______________________________ (Individual, Corporation, Partnership or Association)

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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<tbody>
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<td>______________________________</td>
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and Tennessee office of:

______________________________ (Street Address) (City) (State) (ZIP)

I hereby apply for a PBM License authorizing and empowering the above entity to act as a PBM pursuant to:

1. The PBM agrees to abide by all requirements of Tenn. Code Ann. §56-7-3101 through Tenn. Code Ann. §56-7-3112;
2. The applicant has not had a prior license to be a PBM denied for cause or revoked by the Department within the past five (5) years;
3. The applicant has not been declared insolvent or discharged from bankruptcy within the past five (5) years;

FURTHERMORE, I hereby certify that:

<table>
<thead>
<tr>
<th>Name:</th>
<th>PBM Application Contact Person or Application Preparer Information (required)</th>
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<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip Code:</td>
<td></td>
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<tr>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td>E-Mail Address:</td>
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</tbody>
</table>
Subscribed and sworn before me, this _____ day of________________________, 20__

________________________
(Notary Public)

My commission expires on the ___of______, 20__

(Seal Required)