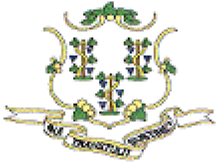


Pharmacy Benefits Manager (PBM) Certificate of Registration (Renewal)

Instructions and Application

Public Act 07-200, (codified as Section 38a-479aaa, Connecticut General Statutes) requires all Pharmacy Benefits Managers (PBMs) operating in the State of Connecticut on January 1, 2008, to obtain a certificate of registration not later than April 1, 2008. Any new PBM seeking to do business in Connecticut must first obtain a Certificate of Registration.

The State of Connecticut Insurance Department (the Department) is charged with registering PBM entities. If you have any questions about your responsibility to register please refer to CT Public Act 07-200 for more information.

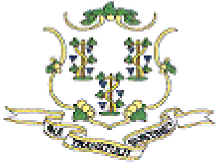
Instructions:

- **To assure that a PBM certificate of registration is issued timely, the Department recommends that applications be submitted with the $100 nonrefundable application fee.**
- **Connecticut law requires that applications for registration renewal be submitted prior to December 31st of each year.**
- **Any changes to the initial application should be submitted to this Department.**
- **The application must be completed, including all attachments and signed by the CEO of the PBM entity certifying that all information provided is true and accurate.**
- **Submit your application, attachments and fee to:**

State of Connecticut
Insurance Department
Pharmacy Benefits Manager Registration
P O Box 816
Hartford, CT 06142-0816

Hand delivery or Overnight delivery address ONLY:

State of Connecticut
Insurance Department
Pharmacy Benefits Manager Registration
153 Market Street, 7th floor
Hartford, CT 06103



Pharmacy Benefits Manager (PBM)
Certificate of Registration (Renewal)
Instruction and Application

Name of PBM: ____

PBM CT Registration Number (renewals only) ______________________________________

PBM Tax Identification Number (TIN/FEIN) _______________________________________

PBM Business Address: ____

____

____

PBM Mailing Address (if different): ____

____

____

PBM Phone Number: ____

Has any suspension, sanction or disciplinary action been taken against the PBM in Connecticut or any other state?

[ ] **No**

[ ] **Yes If answered yes, explain:**

____

____

____

____

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

[ ] **No**

[ ] **Yes If answered yes, explain:**

____

____

____

____

Describe the PBM's service area: ____

____

____

How many total enrollees are served by the PBM: Nationwide: ___________________________

Connecticut: __________________________

List all entities on whose behalf the PBM has contracts or agreements to provide pharmacy benefit services to Connecticut enrollees (e.g. Managed Care Organizations):

____

____

____

PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

[ ] **A Certificate from the Secretary of State affirming that the PBM and its controlling company or organization (if applicable) is in good standing in Connecticut. In addition, for out of state PBMs, controlling companies or organizations, a certificate that such PBM, controlling company or organization is in good standing in its state of organization.**

[ ] **A contingency plan describing how contracted pharmacy benefit services will be provided in the event of insolvency.**

[ ] **Copies of PBM certificates of registration or PBM licenses held in other states**

[ ] **Proof that the PBM meets the surety bond requirements as described in P.A. 07-200. The surety bond must be held exclusively for use in paying any outstanding amounts owed participating members/providers in the event of insolvency or nonpayment. [Sample bond language is attached.] Please note that the beneficiaries of the surety bond are the members/providers.**

Note: ***Under no circumstance should the State of Connecticut or the State of Connecticut Insurance Department be named as the beneficiary.***

[ ] **The most recently concluded fiscal year-end financial statements for the PBM** ***AND***

[ ] **The most recently concluded fiscal year-end financial statements for the controlling company or organization.**

- **Financial statements must include an audit opinion rendered by an independent certified public accountant (CPA) on the statements stating that they were prepared in accord with generally accepted accounting principles (GAAP).**

Financial Security Requirement:

Per Connecticut Public Act 07-200 the financial security amount shall be "evidence of a surety bond in an amount equivalent to ten (10%) of one month of claims in this state over a twelve-month average, except such bond shall not be less than twenty-five thousand or more than one million dollars."

Enter below the amount of the average monthly Connecticut claims over the last twelve months. If ten percent (10%) of the monthly average is less than twenty-five thousand dollars ($25,000), the surety bond shall be in the amount of twenty-five thousand dollars ($25,000). If ten percent (10%) of the monthly average is greater than one million dollars ($1,000,000), the surety bond shall be in the amount of one million dollars ($1,000,000).

Calculation of Surety Bond:

Period beginning: Month _____________ Day _________ Year ___________

Period ending: Month _____________ Day _________ Year ___________

Total Connecticut claims over the prior twelve months:

$__________________________

Average Monthly Claims:
(Connecticut business only – one 12th of the total claims in the prior twelve months)

$______________________ Multiplied by 10% = Surety Bond Amount $_____________________

CEO CERTIFICATION OF ACCURACY

I, ____________________________________, ____of
(Printed Name) (Title)

____, hereby certify that
(Pharmacy Benefits Manager)

I have reviewed the information submitted in accordance with Connecticut Public Act 07-200, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this application must be filed with the Insurance Commissioner within thirty (30) days of such modification, including supporting documents to explain the modification.

____ ______________________________
(Signature of CEO) (Date)

SAMPLE BOND FORM

STATE OF CONNECTICUT
Pharmacy Benefits Manager (PBM) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, ____ of the
(Name of PBM)

County of _______________________________________ State of ____________________

as Principal, and ____, a surety

company having its principal place of business in ____________________________________

County of ____________________State of ____________________________duly authorized

to do business in the State of Connecticut, as Surety, are held and firmly bound unto the

member/providers of the Pharmacy Benefits Manager named, as Obligees, in the sum of

____ dollars ($_______________) for the payment of which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT WHEREAS, the Principal has made application to the Insurance Commissioner of the State of Connecticut for registration to engage in the business of a Pharmacy Benefits Manager (PBM) in accordance with the provisions of Public Act 07-200 and any regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as described in Public Act 07-200 Sec 2.(c) for the exclusive use of paying any outstanding amounts owed in the event of insolvency or nonpayment.

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or involuntary termination of such registration except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this ______________ day of ______________________ 20_________.

WITNESS

________________________ By ____________________________ L.S.

(As to Principal) ____________________________ L.S.

________________________ By ____________________________ L.S. Corporate Seal

(As to Surety) ____________________________ L.S.

____________________________ L.S.