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SENATE BILL NO. 410

Offered January 14, 2026

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A BILL to amend and reenact §§ 32.1-325.5, 38.2-3407.7, 38.2-3465, 38.2-3467, 38.2-3468, 38.2-4209.1, and 38.2-4312.1 of the Code of Virginia, relating to pharmacy benefits managers; requirements; choice of pharmacy.

Patron—Peake

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325.5, 38.2-3407.7, 38.2-3465, 38.2-3467, 38.2-3468, 38.2-4209.1, and 38.2-4312.1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-325.5. State pharmacy benefits manager.

A. As used in this section:

"Pharmacy benefits manager" means the same as that term is defined in § 38.2-3465.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

"State pharmacy benefits manager" means the pharmacy benefits manager contracted by the Department pursuant to this section to administer pharmacy benefits for all Medicaid recipients in the Commonwealth.

B. By July 1, 2026, the Department shall select and contract with a single third-party administrator to serve as the state pharmacy benefits manager to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization by such date with whom the Department contracts for the delivery of Medicaid services. Each managed care contract entered into or renewed by the Department for the delivery of Medicaid services by a managed care organization shall require the managed care organization to contract with and utilize the state pharmacy benefits manager for the purpose of administering all pharmacy benefits for Medicaid recipients enrolled with the managed care organization. Notwithstanding the provisions of § 38.2-3470, the state pharmacy benefits manager shall adhere to subdivision A ~~5~~ *11* of § 38.2-3467 unless otherwise prohibited by federal law.

C. The Department's contract with the state pharmacy benefits manager shall:

1. Establish the state pharmacy benefits manager's fiduciary duty owed to the Department;

2. Require the use of pass-through pricing;

3. Require the state pharmacy benefits manager to use the common formulary, reimbursement methodologies, and dispensing fees negotiated by the Department;

4. Require transparency in drug costs, rebates collected and paid, dispensing fees paid, administrative fees, and all other charges, fees, costs, and holdbacks; and

5. Prohibit the use of spread pricing.

§ 38.2-3407.7. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer or its pharmacy benefits manager, as defined in § 38.2-3465, proposing to issue either preferred provider policies or contracts or exclusive provider policies or contracts shall prohibit any person receiving pharmacy benefits, including specialty pharmacy benefits, furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes any pharmacy that is a nonpreferred or nonparticipating provider and that has previously notified the insurer on its own behalf or through an intermediary, by facsimile or otherwise, of its agreement to accept reimbursement for its services at rates applicable to pharmacies that are preferred or participating providers, including any copayment consistently imposed by the insurer, as payment in full. Each insurer or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred or nonparticipating provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred or nonparticipating provider in excess of the copayment and the insurer's reimbursement applicable to all of its preferred or participating pharmacy providers. If a pharmacy has provided notice pursuant to this subsection through an intermediary, the insurer or its intermediary may elect to respond directly to the pharmacy instead of the intermediary. Nothing in this subsection shall (i) require an insurer or its intermediary to contract with or to disclose confidential information to a pharmacy's intermediary or (ii) prohibit an insurer or its

intermediary from contracting with or disclosing confidential information to a pharmacy's intermediary.

B. No such insurer or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such policy or contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred or nonparticipating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; ~~or~~

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred or nonparticipating providers*; or*

4. Any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to the purchase of pharmaceutical benefits from any pharmacy that is more costly or more restrictive than that which would be imposed upon such person if the same pharmaceutical services were purchased from a mail order pharmacy provider.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred or nonparticipating provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred or participating providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by an insurer or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the insurer or its pharmacy benefits manager the direct service agreement or preferred or participating provider agreement that the insurer requires all of its preferred or participating providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that insurer or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a direct service agreement or a participating provider agreement shall be acted upon by an insurer or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the insurer or its pharmacy benefits manager.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

F. Nothing in this section shall limit the authority of an insurer proposing to issue preferred provider policies or contracts or exclusive provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this ~~subsection~~ *section*, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

§ 38.2-3465. Definitions.

A. As used in this article, unless the context requires a different meaning:

"Aggregate retained rebate percentage" means the sum total dollar amount of a pharmacy benefits manager's retained rebates relating to all carrier clients of such pharmacy benefits manager divided by the sum total dollar amount of all rebates received by such pharmacy benefits manager relating to all such clients.

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15. However, "carrier" does not include a nonprofit health maintenance organization that operates as a group model whose internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization.

"Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering, filling, or refilling a prescription for a drug or for providing a medical supply or device.

"Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include (i) receiving payments for pharmacist services, (ii) making payments to pharmacists or pharmacies for pharmacist services, or (iii) both receiving and making payments.

"Contract pharmacy" means a pharmacy operating under contract with a 340B-covered entity to provide dispensing services to the 340B-covered entity, as described in 75 Fed. Reg. 10272 (March 5, 2010) or any superseding guidance published thereafter.

"Covered entity" means an entity described in § 340B(a)(4) of the federal Public Health Service Act, 42 U.S.C. § 256B(a)(4).

"Covered individual" means an individual receiving prescription medication coverage or reimbursement provided by a pharmacy benefits manager or a carrier under a health benefit plan.

"Health benefit plan" has the same meaning ascribed thereto in § 38.2-3438.

"Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail or through electronic submissions and to dispense medication to covered individuals through the use of the United States mail or other common or contract carrier services and that provides any consultation with covered individuals electronically rather than face-to-face.

"National average drug acquisition cost" means the publicly available, most current pharmacy acquisition cost benchmark published by the Centers for Medicare and Medicaid Services, which reflects the average price that retail community pharmacies pay to acquire prescription drugs from wholesalers, excluding rebates and discounts.

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a carrier for the benefit of covered individuals. "Pharmacy benefits management" does not include any service provided by a nonprofit health maintenance organization that operates as a group model provided that the service is furnished through the internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization.

"Pharmacy benefits manager" or "PBM" means an entity that performs pharmacy benefits management. "Pharmacy benefits manager" includes an entity acting for a PBM in a contractual relationship in the performance of pharmacy benefits management for a carrier, nonprofit hospital, or third-party payor under a health program administered by the Commonwealth.

"Pharmacy benefits manager affiliate" means a business, pharmacy, or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership interest or control with a pharmacy benefits manager.

"Rebate" means a discount or other price concession, including without limitation incentives, disbursements, and reasonable estimates of a volume-based discount, or a payment that is (i) based on utilization of a prescription drug and (ii) paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

"Retail community pharmacy" means a pharmacy that is open to the public, serves walk-in customers, and makes available face-to-face consultations between licensed pharmacists and persons to whom medications are dispensed.

"Retained rebate" means a rebate that is not passed on to a health benefit plan.

"Retained rebate percentage" means the sum total dollar amount of a pharmacy benefits manager's retained rebates relating to a health benefit plan divided by the sum total dollar amount of all rebates received by such pharmacy benefits manager relating to such health benefit plan.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

§ 38.2-3467. Prohibited conduct by carriers and pharmacy benefits managers.

A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall:

1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue;

2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission;

3. Reimburse a pharmacy or pharmacist an amount less than the *(i)* amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration *or (ii) national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee*;

4. Base pharmacy reimbursement for prescription drugs on patient outcomes, scores, or metrics;

5. Impose a point-of-sale or retroactive fee on a pharmacy, pharmacist, or covered individual;

6. Receive deductibles or copayments;

7. Directly or indirectly divert, transfer, or otherwise redirect any prescription drug claims submitted by a pharmacist or pharmacy to any third-party discount card program, cash discount program, or any other non-insurance adjudication platform;

8. Use pharmacy benefits manager policy documents that are incorporated into a pharmacy agreement, including provider manuals, administrative guidelines, operational policies, ancillary documents, claims processing rules, or audit and compliance procedures, to materially change, alter, or modify the pharmacy agreement, to modify, limit, or negate reimbursement rates, payment terms, or other financial obligations, or introduce material changes to the definitions of brand and generic drugs, claims adjudication, audit process, or contractual rights of the pharmacy or pharmacist;

9. Prohibit a pharmacist or pharmacy that dispenses a pharmaceutical product from informing an

individual about the cost of the pharmaceutical product, the amount in reimbursement that the pharmacy or pharmacist receives for dispensing the pharmaceutical product, the cost and clinical efficacy of a less expensive alternative to the pharmaceutical product, or any difference between the cost to the individual under the covered individual's health benefit plan and the cost to the individual if the individual purchases the pharmaceutical product without making a claim for benefits under the individual's health benefit plan;

10. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article;

~~5.~~ *11.* Impose requirements, exclusions, reimbursement terms, or other conditions on a covered entity or contract pharmacy that differ from those applied to entities or pharmacies that are not covered entities or contract pharmacies on the basis that the entity or pharmacy is a covered entity or contract pharmacy or that the entity or pharmacy dispenses 340B-covered drugs. Nothing in this subdivision shall (i) apply to drugs with an annual estimated per-patient cost exceeding $250,000 or (ii) prohibit the identification of a 340B reimbursement request; or

~~6.~~ *12.* Interfere with a covered individual's right to choose a pharmacy or provider, based on the pharmacy or provider's status as a covered entity or contract pharmacy.

B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall *(i) charge a pharmacy a fee related to participation in a pharmacy network, (ii)* restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards*, or (iii) require multiple specialty pharmacy accreditations as a prerequisite for participation in a pharmacy network that dispenses specialty drugs or exclude a specialty pharmacy from the right to participate in the pharmacy network.*.

C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy under any law or contract in the Commonwealth.

D. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall conduct spread pricing *or derive any revenue from a pharmacist, pharmacy, or covered individual in connection with performing pharmacy benefits management services* in the Commonwealth.

E. Each carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall comply with the provisions of this section in addition to complying with the provisions of § 38.2-3407.15:1.

F. Each carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall calculate a covered individual's out-of-pocket cost for a covered prescription drug based on the net price of the prescription drug after taking into account all retained rebates associated with the prescription drug.

§ 38.2-3468. Examination of books and records; reports; access to records.

A. Each carrier, on its own or through its contract for pharmacy benefits, shall ensure that the Commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a carrier that are relevant to determining if the pharmacy benefits manager is in compliance with this article. The carrier shall be responsible for the charges incurred in the examination, including the expenses of the Commissioner or his designee and the expenses and compensation of his examiners and assistants.

B. Each carrier, on its own or through its contract for pharmacy benefits, shall report the following information to the Commissioner for each health benefit plan:

1. *The aggregate wholesale acquisition costs to the pharmacy benefits manager from manufacturers or wholesale distributors for each therapeutic category of drugs covered, net of all rebates, direct or indirect, from all sources.*

2. The aggregate amount of rebates received by the pharmacy benefits manager;

~~2.~~ *3.* The aggregate amount of rebates distributed to the appropriate health benefit plan;

~~3.~~ *4.* The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;

~~4.~~ *5.* The aggregate amount of the pharmacy benefits manager's retained rebates;

~~5.~~ *6.* The pharmacy benefits manager's aggregate retained rebate percentage;

~~6.~~ *7.* The aggregate amount of administrative fees received by the pharmacy benefits manager;

~~7. Upon the request of the Commission, the~~ *8. The* individual and aggregate amount paid by the health benefit plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and services; and

~~8. Upon the request of the Commission, the~~ *9. The* individual and aggregate amount a pharmacy benefits manager paid for services itemized by pharmacy, by product, and by goods and services.

The report required by this subsection shall be filed on a quarterly basis ~~through March 31, 2023. The final quarterly report shall include information for the period ending December 31, 2022. Thereafter, by~~

~~March 31 of each year, the report shall be filed on a calendar year basis. The 2023 calendar year report shall be filed by March 31, 2024~~.

C. All working papers, documents, reports, and copies thereof, produced by, obtained by or disclosed to the Commission or any other person in the course of an examination made under this article and any analysis of such information or documents shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person. Access may also be granted to (i) a regulatory official of any state or country; (ii) the National Association of Insurance Commissioners (NAIC), its affiliate, or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such papers, documents, reports or copies thereof. Any parties receiving such papers must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section.

D. The Commissioner shall annually prepare a report based on the information submitted pursuant to subsection B. Such report shall only contain aggregated data and shall not contain information that would cause financial, competitive, or proprietary harm to any individual carrier or pharmacy benefits manager. The Commissioner shall submit such report to the Governor and the General Assembly by September 30 of each year. The Commissioner shall not be considered in violation of subsection C for preparing or submitting such report and the provisions of subsection C requiring confidentiality shall not apply to such report.

§ 38.2-4209.1. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts or its pharmacy benefits manager, as defined in § 38.2-3465, shall prohibit any person receiving pharmaceutical benefits, including specialty pharmacy benefits, thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that have previously notified the corporation or its pharmacy benefits manager, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers, including any copayment consistently imposed by the corporation, as payment in full. Each corporation or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure payment verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred provider in excess of the copayment and the corporation's reimbursement applicable to all of its preferred pharmacy providers.

B. No such corporation or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; ~~or~~

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers*; or*

4. Any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to the purchase of pharmaceutical benefits from any pharmacy that is more costly or more restrictive than that which would be imposed upon such person if the same pharmaceutical services were purchased from a mail order pharmacy provider.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a corporation or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the corporation or its pharmacy benefits manager the direct service agreement or preferred provider agreement that the corporation requires all of its preferred providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that corporation or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for any retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a direct service agreement or a participating provider agreement shall be acted upon by a corporation or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the corporation or its pharmacy benefits manager.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

F. Nothing in this section shall limit the authority of a corporation issuing preferred provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this ~~subsection~~ *section*, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

§ 38.2-4312.1. Pharmacies; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans, or its pharmacy benefits manager, as defined in § 38.2-3465, shall prohibit any person receiving pharmaceutical benefits, including specialty pharmacy benefits, thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes any pharmacy that is not a participating provider under any such health care plan and that has previously notified the health maintenance organization or its pharmacy benefits manager on its own behalf or through an intermediary, by facsimile or otherwise, of its agreement to accept reimbursement for its services at rates applicable to pharmacies that are participating providers, including any copayment consistently imposed by the plan, as payment in full. Each health maintenance organization or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonparticipating provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonparticipating provider in excess of the copayment and the health maintenance organization's reimbursement applicable to all of its participating pharmacy providers. If a pharmacy has provided notice pursuant to this subsection through an intermediary, the health maintenance organization or its intermediary may elect to respond directly to the pharmacy instead of the intermediary. Nothing in this subsection shall (i) require a health maintenance organization or its intermediary to contract with or to disclose confidential information to a pharmacy's intermediary or (ii) prohibit a health maintenance organization or its intermediary from contracting with or disclosing confidential information to a pharmacy's intermediary.

B. No such health maintenance organization or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; ~~or~~

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers*; or*

4. Any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to the purchase of pharmaceutical benefits from any pharmacy that is more costly or more restrictive than that which would be imposed upon such person if the same pharmaceutical services were purchased from a mail order pharmacy provider.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonparticipating provider and that has complied with subsection E or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on participating providers.

D. The provisions of this section are not applicable to any pharmaceutical benefit covered by a health care plan when those benefits are obtained from a pharmacy wholly owned and operated by, or exclusively operated for, the health maintenance organization providing the health care plan.

E. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a health maintenance organization or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the health maintenance organization or its pharmacy benefits manager, the direct service agreement or participating provider agreement that the health maintenance organization or its pharmacy benefits manager requires all of its participating providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that health maintenance organization or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a direct service agreement or a participating provider agreement shall be acted upon by a health maintenance organization or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the health maintenance organization or its pharmacy benefits manager.

F. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

G. Nothing in this section shall limit the authority of a health maintenance organization providing health care plans to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this ~~subsection~~ *section*, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.