



Request for Quote

Items marked with an asterisk (*) are required.

I. Plan Sponsor Information*

Contact Name _____

Email Address _____

Company Name _____

Type of Entity ___ Commercial ___ Government ___ Non-Profit ___ Union ___ Other

Address _____

City, State, Zip _____

Phone _____

II. General Plan Information

1. Plan Name (The "**Plan**") _____

2. Plan Year _____

3. Total # of Active Employees with Drug Coverage under the Plan _____

4. Total # of Retirees with Drug Coverage under the Plan ("**Covered Retirees**")* _____

5. Is your retiree plan self-funded or fully insured?* _____

6. Has an Actuary attested that the Retiree Drug Coverage is "Creditable"? _____

7. If yes, did the Actuary also find that the Retiree Drug Coverage qualified for Medicare Subsidy Payments? _____ **If Yes, stop here and submit form to the address shown. If No, go to Section III or V below.**

III. Plan Design and Expense Information - for SELF-FUNDED Plans *

8. What is the total amount of drug benefits paid by the Plan during the most recent plan year for Covered Retirees? (Note - the plan year used here should be the same plan year as described in question 2 above.) _____

9. What is the total amount of all retiree health benefits (i.e., medical, drug, dental and vision) paid by the Plan during the most recent plan year for Covered Retirees? (Note - the plan year used here should be the same plan year as described in question 2 above.)

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10. Are Covered Retirees required to make periodic contributions to get drug coverage under the Plan? _____
11. If the answer to Question 10 is no, go to Question #14.
If Question 10 is yes, is the required contribution by Covered Retirees for drug coverage separately stated from the required contribution amounts for medical coverage? _____
12. If the answer to Question 11 is no, does the required contribution by Covered Retirees include both medical and drug coverage (i.e. must a Covered Retiree elect medical coverage in order to elect drug coverage)? _____
13. What is the total amount of contributions to the Plan paid by all Covered Retirees during the most recent plan year for all health coverages (e.g., medical, drugs, dental, vision, etc.) under the Plan? _____
14. Is the retiree drug benefit subject to an annual maximum benefit limit? _____
If Yes, what is the limit? _____

IV. Plan Administration Information*

15. If retiree drug claims are administered separately by pharmacy benefit managers (PBMs) or other administrators, please check their names from the list below or provide their name(s) if not listed (check all that apply):

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Medco | <input type="checkbox"/> PharmaCare |
| <input type="checkbox"/> Caremark | <input type="checkbox"/> Rx America |
| <input type="checkbox"/> Express Scripts | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other _____ | |

V. Plan Expenses Information-for INSURED Plans

16. For Covered Retirees **age 65 or older**, is the monthly premium paid by the Plan Sponsor to the insurer separately stated for medical coverage and for drug coverage?
_____ Yes, the drug premium is _____ per month
_____ No, the drug + medical premium is _____ per month



17. Are Covered Retirees **age 65 or older** required to make periodic contributions to get drug coverage under the insured Plan? _____
18. If you answered yes to Question 17, what is the amount that Covered Retirees **age 65 or older** must contribute in order to have drug coverage under the Plan?
(Circle one) Monthly / Quarterly / Semi-Annual / Annual payment of _____
19. Choose which best describes the amount in Question 18.
- _____ The amount relates only to drug coverage.
- _____ The amount relates to drug and medical coverage.