Reporting on Pharmacy Benefits & Drug Costs
2023 Information Request Form

Please complete the fields on the right side of the table below.

Information Requested	Employer Response
Employer Name/Plan Sponsor	
Plan Name (e.g.: ABC Company Health & Welfare Plan)	
Plan Year (e.g.: July – June)	
Calendar year total Premium Equivalent*	
Calendar year total stop loss premium	
2023 employer portion of Premium Equivalent (total Premium Equivalent minus employee cost share, if any)	
5500 Plan Number (If applicable)	
Pharmacy Benefit Manager Name & EIN (if other than Independent Health's Pharmacy Benefit Dimensions)	
Total number of employees who are eligible for medical benefits under your group health plan	◉ Under 50 employees ○ Over 50 employees

*"Premium Equivalent" means the total costs of providing and maintaining medical coverage, including claim costs, administrative costs, and stop loss premiums, if applicable. Stop loss reimbursements and any pharmacy rebates should be factored into the calculations and subtracted from the total prior to calculating the premium equivalent.

ATTESTATION FOR EMPLOYER/BROKER:

I understand that Independent Health's Self-Funded Services will complete the D1 & D2 data files based on the information provided on this form and data from Independent Health's claim system and the P2 data files as it relates to the medical plan services, aggregated, on behalf of the above-referenced Plan. Independent Health's Self-Funded Services is not responsible for the remainder of the data files that will be included in the Plan's annual data submission of prescription drug and health care spending required under to the Section 204 of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) enacted on December 27, 2020, and the regulations enacted thereunder at 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Part 149, nor will Independent Health's Self-Funded Services submit those items on the above-referenced Plan's behalf.

I completed this form as a representative of the above-named employer group. I am duly authorized to provide this information to Independent Health's Self-Funded Services. I attest that the information I provide is correct, accurate, and complete to the best of my knowledge. If there are errors or omissions in the information I provide, Independent Health's Self-Funded Services shall not be held legally responsible for such errors of omissions, or the accuracy or inaccuracy of any reports Independent Health's Self-Funded Services prepares for the above-named employer under the above-referenced law or regulations. I agree and accept these terms and conditions when I sign below and send Independent Health's Self-Funded Services this completed form.

EMPLOYER

By: _____

Signature

_____

Employer Representative's Name

_____ Date: _____

Employer Representative's Title

OR

BROKER

By: _____

Signature

_____

Broker's Name

_____ Date: _____

Broker's Title