HB-0956-0514

PO Box 297
Trenton, NJ 08625-0297

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits

PRIVATE PHARMACY BENEFIT MANAGER SURVEY

Please complete the survey by **July 1, 2014** and Fax to: (609) 341-3412, ATTN: Policy and Planning Unit

GENERAL DETAIL

Employer Name: _____

Employer ID: _____

Contact Name: _____

Phone Number: _____

Pharmacy Benefits Manager (PBM): _____

PBM Contact Name: _____

Phone Number: _____

Covered Population (Active, Retired, Other): _____

Number of Covered Members (including dependents): _____

PRESCRIPTION DRUG BENEFIT DETAIL

Generic/Brand/Preferred Brand Copays:

Retail: _____

Mail: _____

Coinsurance: _____

Deductible:Benefit Period (Calendar year or other – please specify): _____

Annual Prescription Drug Out-of-Pocket (OOP) Maximum (if applicable): _____

UTILIZATION DETAIL (IF AVAILABLE)

Average number of prescriptions per member per year: _____

Average member cost share per year: _____

Number of members who meet the OOP Maximum or have copays/deductibles/coinsurance that exceed $1000 in plan year 2013: _____