TRINIDAD NAVARRO
COMMISSIONER



STATE OF DELAWARE
DEPARTMENT OF INSURANCE

Delaware Annual Pharmacy Benefits Manager Report

PBM Company Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Annual Year Reported: _____ Date Submitted: _____

Insurer: _____ NAIC# _____

a. The aggregate amount of rebates distributed to the appropriate insurer $_____

b. The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount $_____

c. The aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services $ _____

d. The aggregate amount a pharmacy benefits manager paid for pharmacy goods or services $ _____

***** *For any zero entries please attach a statement explaining the zero entry*

Attestation

By submitting this Annual Pharmacy Benefits Manager Report, I certify, under penalties provided by the laws of Delaware, that the information contained in the attached Excel spreadsheet has been reviewed and is complete and correct, and the Report is made in good faith for the period indicated.

Contact Name: _____ Title: _____

Email: _____ Phone: _____

Submitted by: _____ Title: _____

Verified by: _____ Title: _____