Instruction to Complete the Section 204 Pharmacy Reporting Survey

Overview

Section 204 of the Consolidated Appropriations Act (CAA) requires group health plans and health insurance issuers offering group or individual health insurance coverage to report certain annual data to the federal government. As part of our ongoing efforts to fulfill this requirement, we're asking you to **submit the data via an online survey by March 1, 2024**.

For the upcoming reporting phase in 2024, we will necessitate the acquisition of data through a survey amongst you, our employer groups starting **on January 31, 2024,** which is intended for federal submission within this filing year. All requisite data will be submitted to CMS by June 1, 2024.

Within an email that you will receive, we will have a special link that you will click on to get to your survey.

Fully Insured Group or MPP Group

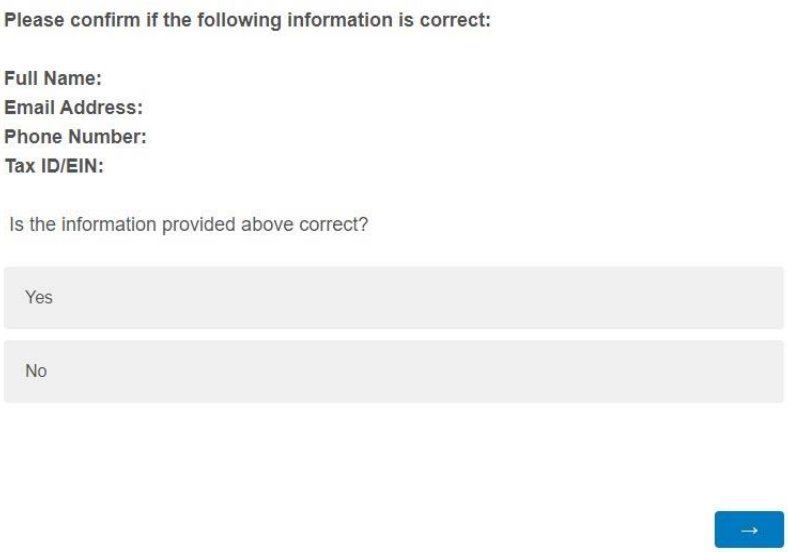
The instructions for completing the survey are below:

Once you click on the link, you will come to the first page of your survey.

Completing the Survey:

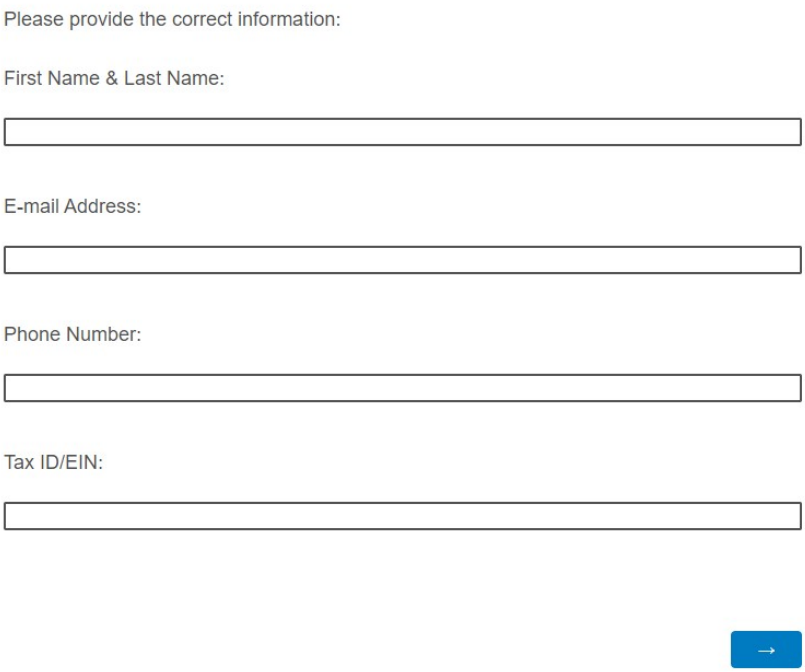
1. The first page of the survey will list the following:
    a. Full Name
    b. Email Address
    c. Phone number
    d. Tax ID/EIN number
2. These field's will be prefilled with the current information we have on file. Please click YES if the information is correct or NO if the information is not correct.
    a. If information is correct, it will take you to the next screen.
    b. If information is not correct, the fields will be available for you to put in the correct information.

See Screen Print below:

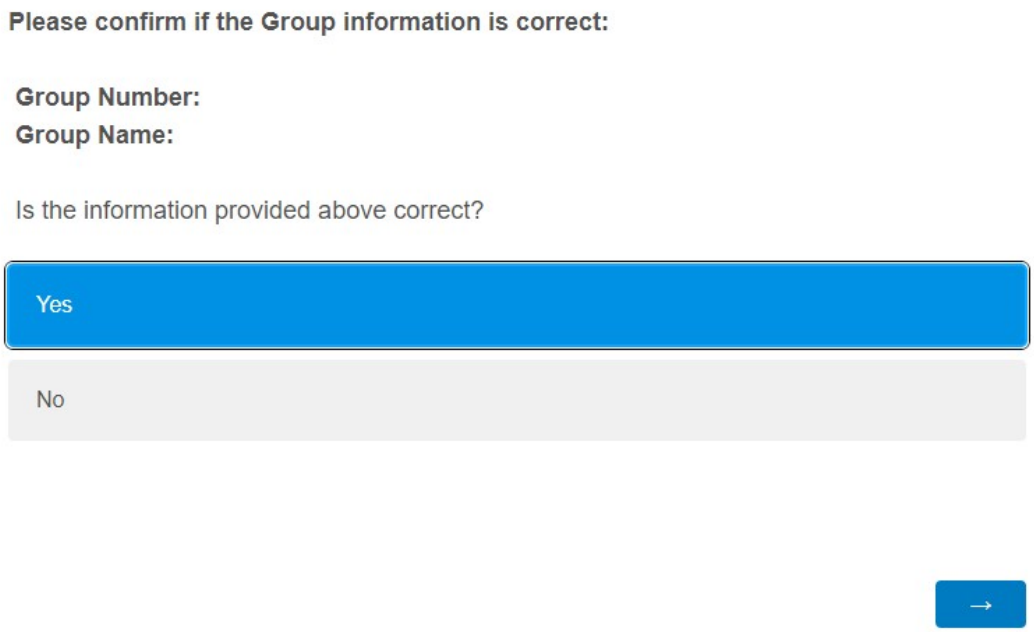


If the information is correct, click yes and click on the arrow button to go to the next screen.

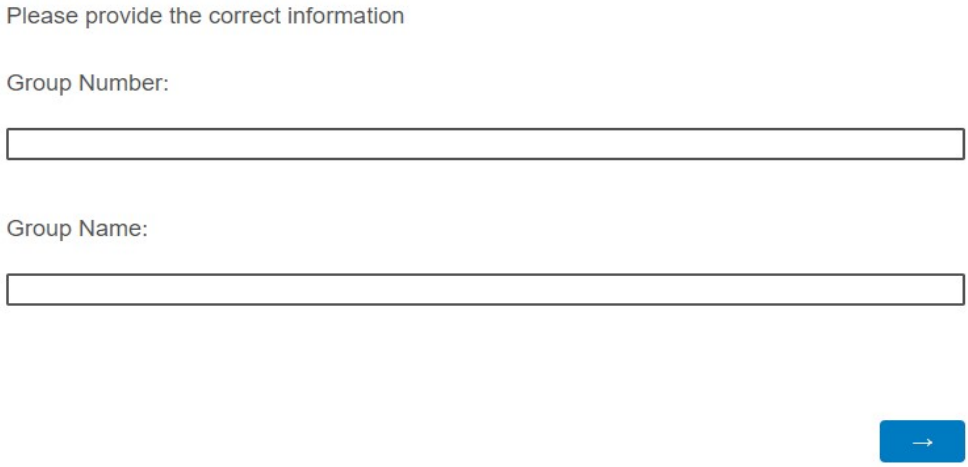
If the information listed is not correct, click on No and select the arrow to go to the next screen. You will be asked to put in the correct information in the text fields.



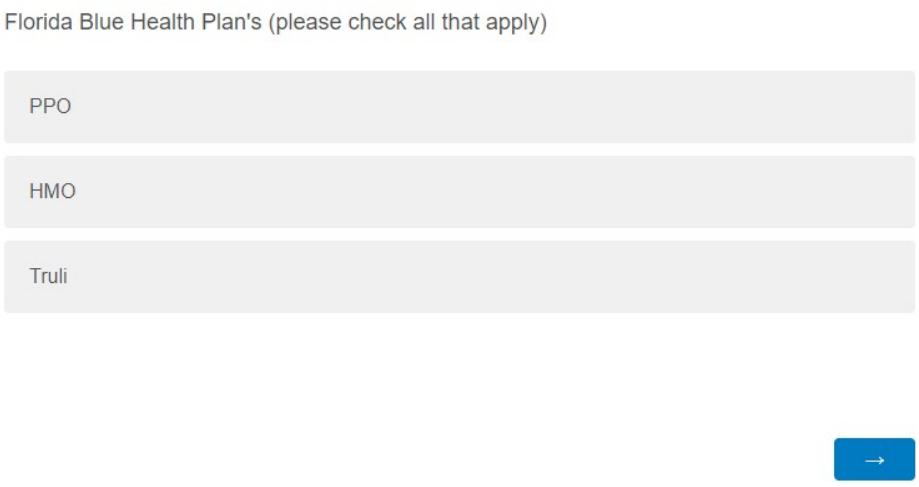
3. The next screen will show the prepopulated fields for Group Name and Group Number
    a. If correct, click YES



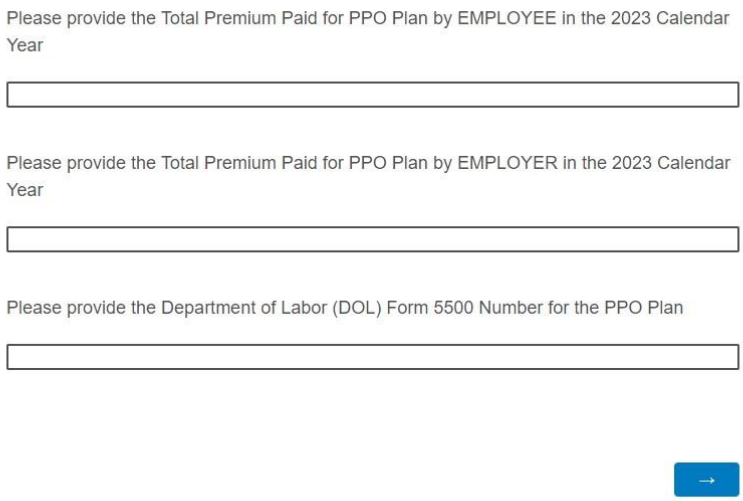
    b. If incorrect, click NO
    c. Please fill in the correct information in the available fields



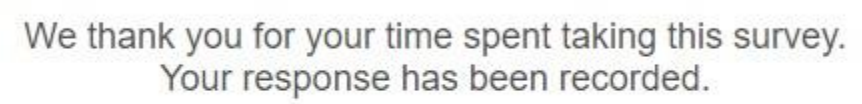
4. On the next screen you will be asked to verify your health plans. Your choices are PPO, HMO or Truli. Please check all that apply:
    a. If you have one plan, for example a PPO, you will only select that plan.
    b. If you have two different plans such as a PPO and HMO, you will select both plans.
    c. If you have 2 or more of one plan such as 2 PPOs, you only select the PPO plan. The same applies to the other health plans.



5. Once you have selected your plans, you will be asked to provide the following for each plan:
    a. Please provide the total premium paid for XXX Plan by EMPLOYEE in the 2023 calendar year.
    b. Please provide the total premium paid for XXX Plan by EMPLOYER in the 2023 calendar year.
    c. Please provide the Department of Labor (DOL) form 5500 number for the XXX Plan.



6. Once completed, you will click on the arrow button at the bottom right to submit the survey. You will receive the following message:



You will be able to leave the survey by clicking on the xxxxxx button.

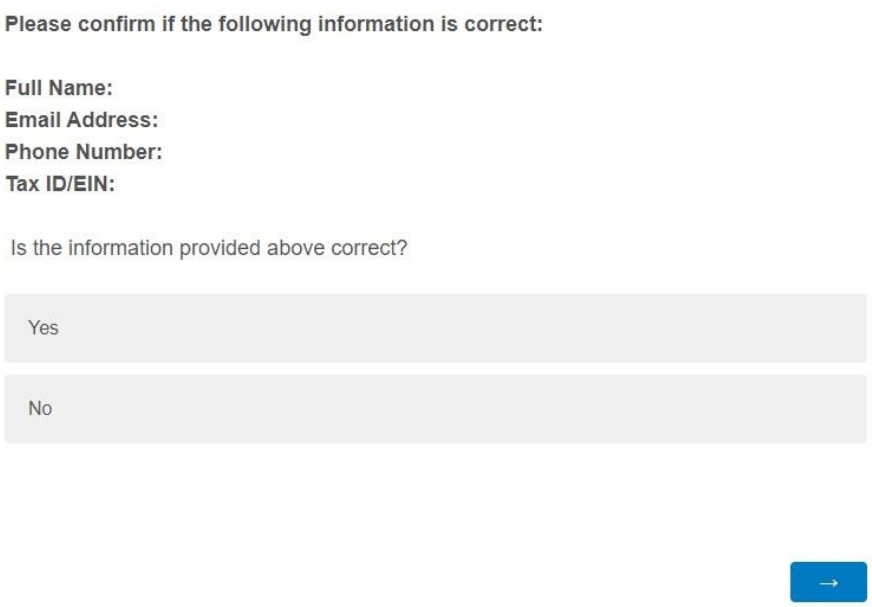
ASO Group

The instructions for completing the survey are below:

Once you click on the link, you will come to the first page of your survey.

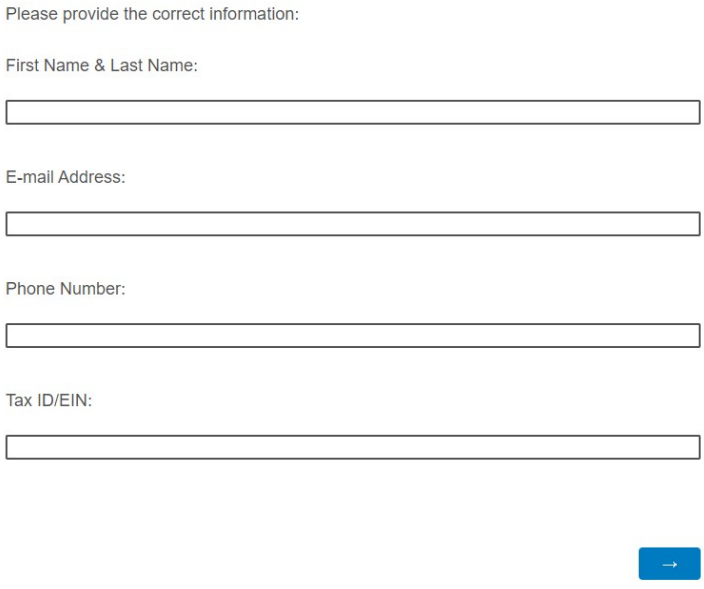
Completing the Survey:

7. The first page of the survey will list the following:
    a. Full Name
    b. Job Title
    c. Email Address
    d. Phone number
    e. Tax ID number
8. These field will be prefilled with the current information we have on file. Please click YES if the information is correct or NO if the information is not correct.
    f. If information is correct, it will take you to the next screen.
    g. If information is not correct, the fields will be available for you to put in the correct information.

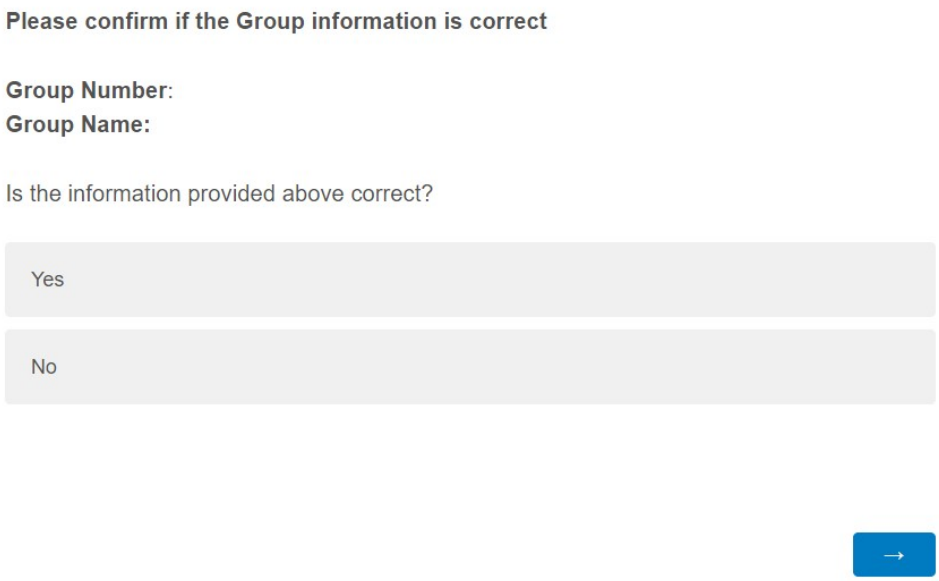


9. If the information is correct, click yes and click on the arrow button to go to the next screen.

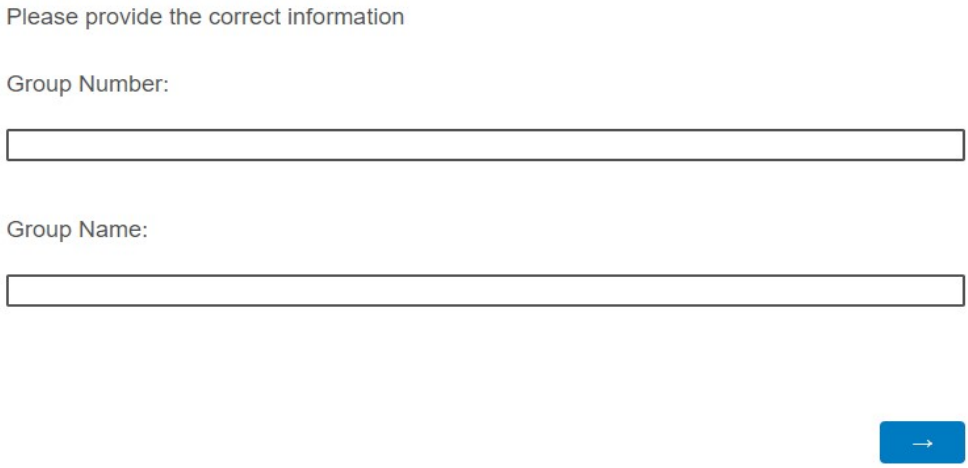
   If the information listed is not correct, click on No and select the arrow to go to the next screen. You will be asked to put in the correct information in the text fields.



10. The next screen will show the prepopulated fields for Group Name and Group Number
    h. If correct, click YES

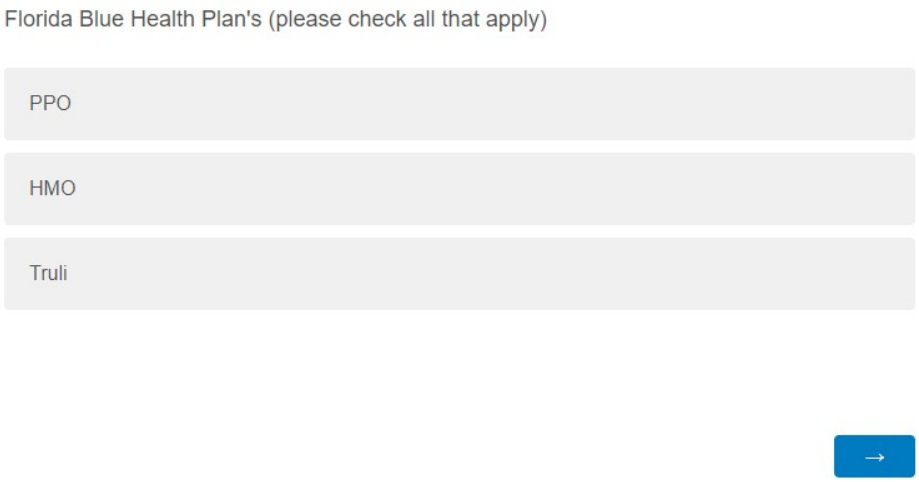


    i. If incorrect, click NO
    j. Please fill in the correct information in the available fields

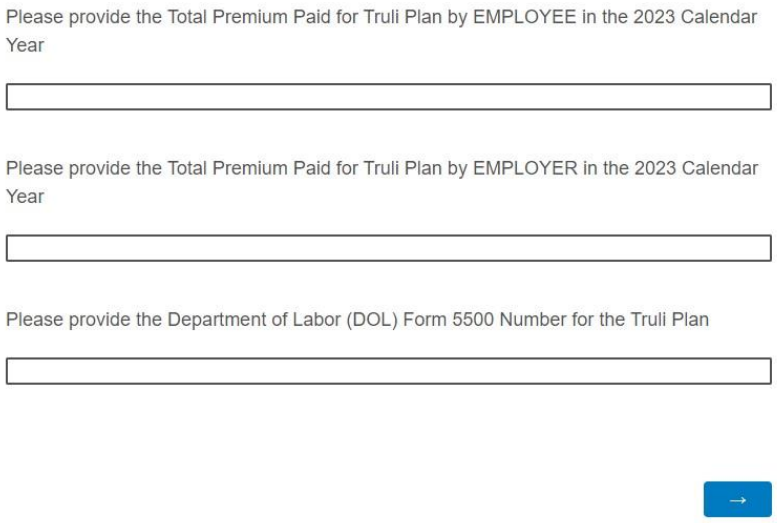


11. On the next screen you will be asked to verify your health plans. Your choices are PPO, HMO or Truli. Please check all that apply:

k. If you have one plan, for example a PPO, you will only select that plan.
l. If you have two different plans such as a PPO and HMO, you will select both plans.
m. If you have 2 or more of one plan such as 2 PPOs, you only select the PPO plan. The same applies to the other health plans.

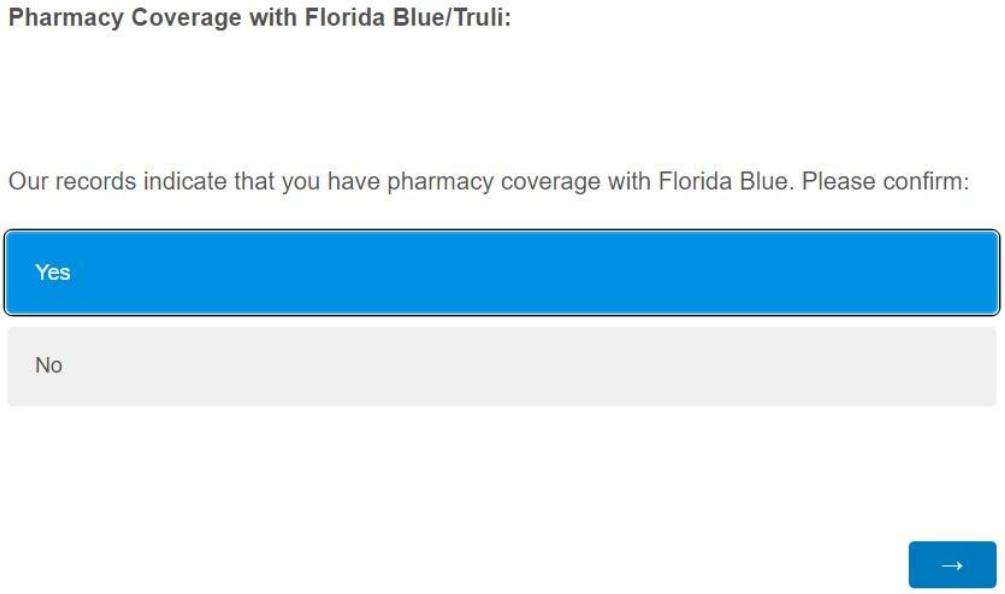


12. Once you have selected your plans, you will be asked to provide the following for each plan:
    n. Please provide the total premium paid for XXX Plan by EMPLOYEE in the 2023 calendar year.
    o. Please provide the total premium paid for XXX Plan by EMPLOYER in the 2023 calendar year.
    p. Please provide the Department of Labor (DOL) form 5500 number for the XXX Plan.

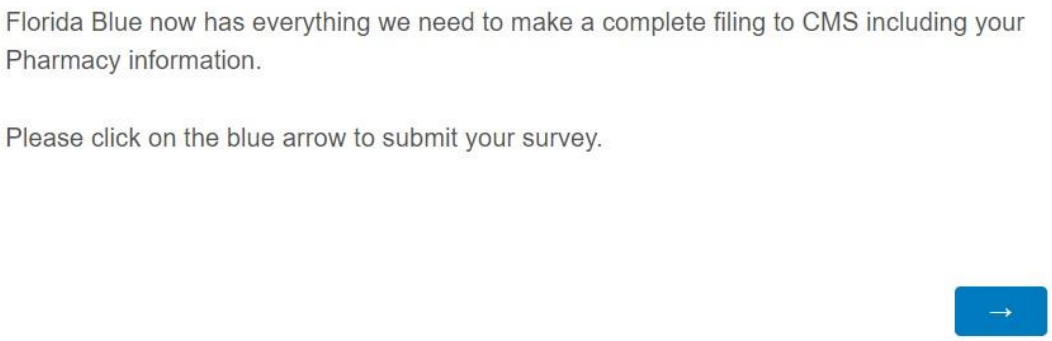


12. On the next screen, you must enter the Employee Count Field which includes the Average Total Number of Employees Including Seasonal & Part Time. Click on the blue arrow to proceed.

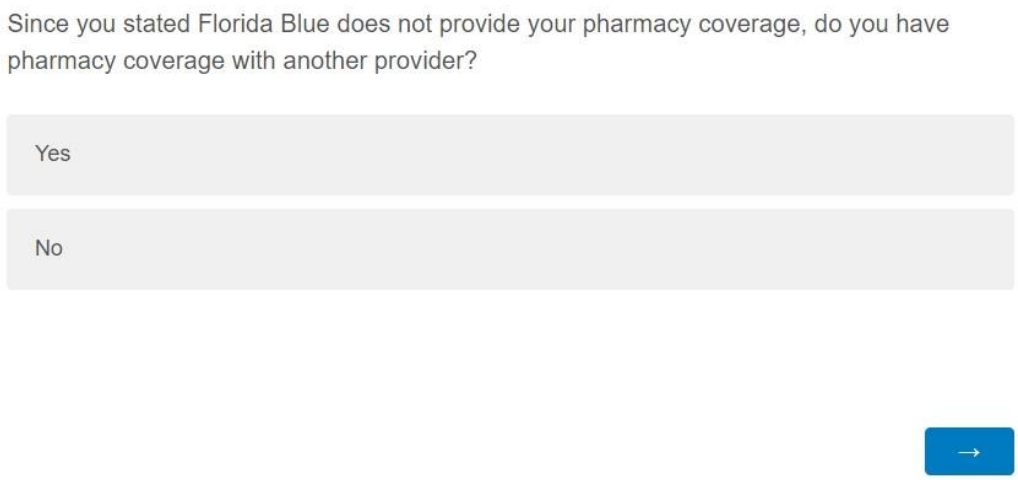
13. On the next screen, the pharmacy carveout page will appear which will be prepopulated and state "Our records indicate that you have pharmacy coverage with Florida Blue". You will be asked to confirm with Yes Or No.



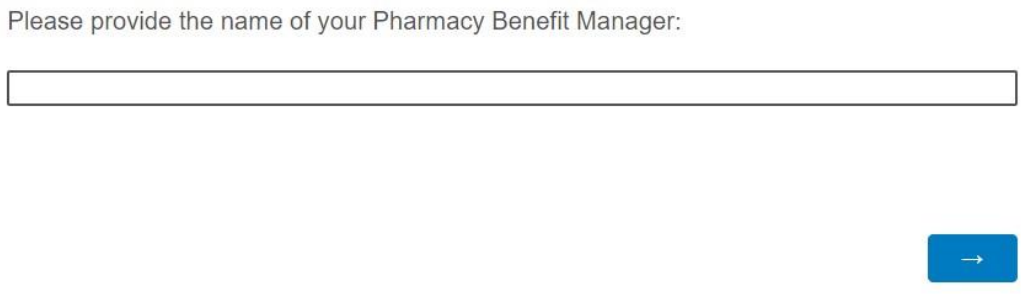
If Yes is selected, then Florida Blue has everything they need to make a complete filing to CMS including the Pharmacy information. The blue arrow must be clicked to submit the survey.



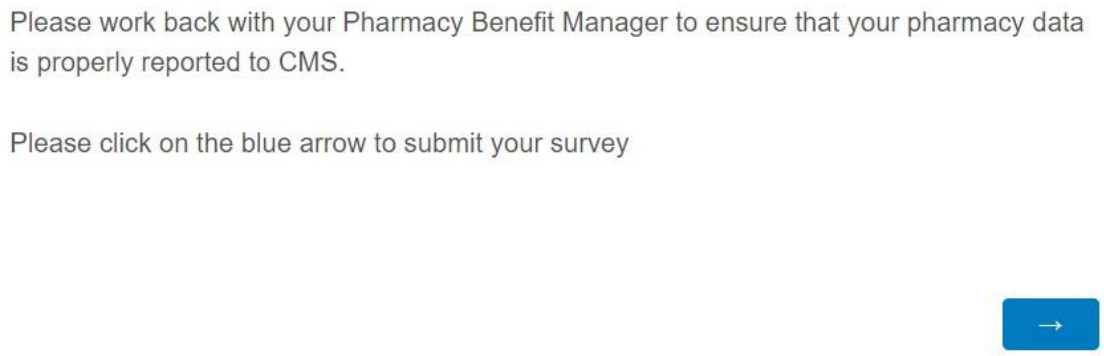
14. If No is selected at the Pharmacy Carveout page, then Florida Blue does not provide the coverage and it will be asked if pharmacy coverage is with another provider.



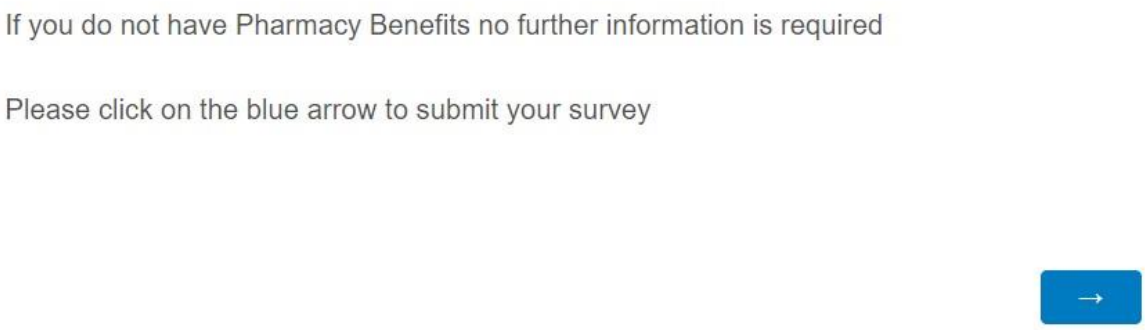
15. If Yes is selected to having pharmacy coverage with another provider, then the name of the Pharmacy Benefit Manager is required.



16. Once the Pharmacy Benefit Manager is entered, the next screen will display a message stating to "Please work back with your Pharmacy Benefit Manager to ensure that your pharmacy data is properly reported to CMS". The blue arrow must be clicked to submit the survey.



17. If No is selected to having pharmacy coverage with another provider, then no further information is required because there are no Pharmacy Benefits. The blue arrow must be clicked on to submit the survey.



18. The following message will confirm that the survey has been recorded and submitted.