



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR GROUP PROPOSAL

EMPLOYER AND AGENT INFORMATION:				Agent Name and Agent Number				
Legal Name of Employer		Requested Effective Date		Tax Identification Number				
Business Street Address (Not P.O. Box)			Industry Description		Industry Code: <input type="checkbox"/> SIC Code <input type="checkbox"/> NAICS			
City		State	ZIP Code		Fax Number			
Group Administrator Name		Group Administrator E-mail Address		Group's Phone Number		Renewal Date (mm/dd/yyyy)		
CURRENT CARRIER(S)				RATES				
	Type*	# of Emp	# of Dep		Emp Only	Emp and Spouse/DP**	Emp and Child(ren)	Family
Carrier Name				Current				
Benefit Description				Renewal				
Carrier Name				Current				
Benefit Description				Renewal				

* M=Medical, D=Dental, V=Vision, R=Prescription, H=HRA

** Domestic Partner

GROUP INFORMATION:

Company Headquartered in: Oregon Washington Other _____

Participation: Group is subject to underwriting guidelines currently in effect.

Are you enrolling more than one business on this insurance plan? Yes No

Oregon based groups in the 2-99 rating pools:

Groups may choose to enroll only one of two businesses. If group wants to insure two businesses together, it requires them to be affiliated and qualify under section 414 of the Internal Revenue Code of 1986 in order to do so.

Oregon based groups in 100+ rating pools:

Groups may choose to enroll only one of two businesses. If group wants to insure two businesses together, it requires them to be eligible to file a consolidated tax return.

Clark County, Washington based groups of all sizes:

Groups that are affiliated or eligible to file a consolidated tax return MUST enroll together in the 2-50 rating pool, insurance regulations prohibit only one of the two businesses to enroll. Groups in the 51-99 or 100+ rating pools may choose to enroll only one business.

Employer Contribution to Premium:		Full-Time Employees: (Number of hours required for coverage)	
Medical	Dental		
Employee _____ %	_____ %	Oregon _____ Hours (17.5 - 40)	
Dependent _____ %	_____ %	Washington _____ Medical Hours (20 - 40)	

Carrier Split Information

If applicable, other carrier(s) offered to employees*:

Medical _____

Dental _____

Health Reimbursement Arrangement _____

* Groups 51 - 99 eligible employees, allowed to split with Kaiser only; groups 100+ eligible employees, allowed to split with any carrier.

Is your group COBRA* eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you interested in purchasing a Health Reimbursement Arrangement or Flexible Spending Account? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not COBRA eligible, will your group offer Washington continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
* 20 or more full-time and/or part-time employees on 50% or more of your business days in the preceding calendar year.	

REQUEST BENEFITS TO BE QUOTED ON PAGE 2 - 5 AND COMPLETE CENSUS INFORMATION ON PAGE 6.

BENEFIT(S) PLAN SELECTION

Quote all "Most Popular New Product Options"

Regence Innova

Office Call

4 Visits 6 Visits Unlimited Visits

Copay (category 1 / category 2)

\$20/35 Copay \$30/45 Copay \$40/55 Copay (OR only)

Deductible

\$250 \$500 \$750 \$1,000 \$1,500 \$2,000 \$3,000 \$5,000 \$7,500

Coinsurance

90/70/70 80/60/60 70/50/50

Coinsurance Max

\$2,000 \$3,000 \$4,000 \$6,000

Prescription

Rx Copay

- \$5 Generic / \$25 Formulary / \$50 Nonformulary / \$3,000 Out-of-Pocket Max Rx
 \$7 Generic / 25% Formulary / 50% Nonformulary / \$4,000 Out-of-Pocket Max Rx
 \$10 Generic / 35% Formulary / 50% Nonformulary / \$5,000 Out-of-Pocket Max Rx
 \$10 Generic / \$35 Formulary / \$75 Nonformulary / \$0 Out-of-Pocket Max Rx

Deductible for Brand Rx

\$0 \$250 \$500

Riders (optional)

- Vision Complementary Care - \$500 (OR only) Complementary Care - \$1,000 (OR only)
 Spinal Manipulation Buy-Up (WA only) EAP - 4 visits

Regence Engage

Deductible

\$0 \$250 \$500 \$1,000 \$2,000 \$3,000 \$5,000 \$7,500

Coinsurance

80/80/80 70/70/70 50/50/50

Coinsurance Max

\$2,000 \$3,000 \$4,000 \$6,000

Prescription

Rx Copay

- \$5 Generic / \$25 Formulary / \$50 Nonformulary / \$3,000 Out-of-Pocket Max Rx
 \$7 Generic / 25% Formulary / 50% Nonformulary / \$4,000 Out-of-Pocket Max Rx
 \$10 Generic / 35% Formulary / 50% Nonformulary / \$5,000 Out-of-Pocket Max Rx
 \$10 Generic / \$35 Formulary / \$75 Nonformulary / \$0 Out-of-Pocket Max Rx

Deductible for Brand Rx

\$0 \$250 \$500

Riders (optional)

- Vision Complementary Care - \$500 (OR only) Complementary Care - \$1,000 (OR only)
 Spinal Manipulation Buy-Up (WA only) EAP - 4 visits Preventive Care

BENEFIT(S) PLAN SELECTION (continued)

Quote all "Most Popular New Product Options"

Regence HSA Healthplan 2.0

Deductible

- \$1,500 single / \$3,000 family
- \$2,500 single / \$5,000 family
- \$3,500 single / \$7,000 family
- \$5,000 single / \$10,000 family (100% coinsurance)
- \$3,000 single / \$5,000 family (embedded family deductible)
- \$3,000 single / \$7,000 family (embedded family deductible)

Coinsurance

80/60/60

Coinsurance Max

\$5,000 single / \$10,000 family

Prescription (included in medical plan)

Riders (optional)

- Vision
- Spinal Manipulation Buy-Up (WA only)
- EAP - 4 visits

Regence Activate

Deductible

- \$1,500
- \$2,000
- \$3,000

Coinsurance

- 80/80/80
- 70/70/70
- 50/50/50

Coinsurance Max

- \$2,000
- \$3,000
- \$4,000
- \$6,000

Prescription

Rx Copay

- \$5 Generic / \$25 Formulary / \$50 Nonformulary
- \$7 Generic / 30% Formulary / 50% Nonformulary
- \$10 Generic / 35% Formulary / 75% Nonformulary
- 10% Generic / 30% Formulary / 50% Nonformulary

Deductible for Brand Rx

- \$250
- \$500
- \$1,000

Riders (optional)

- Vision
- Complementary Care - \$500 (OR only)
- Complementary Care - \$1,000 (OR only)
- Spinal Manipulation Buy-Up (WA only)
- EAP - 4 visits

BENEFIT(S) PLAN SELECTION (continued)

DENTAL PLAN SELECTIONS:

Regence Dental

- Radiance Class I-III \$25 Deductible, 100/80/50 Coins, \$1,000 Annual Max *
- Radiance Class I-III \$50 Deductible, 100/80/50 Coins, \$1,000 Annual Max *
- Radiance Class I-III \$75 Deductible, 100/80/50 Coins, \$1,000 Annual Max *
- Radiance Class I-III \$75 Deductible, 100/80/50 Coins, \$1,500 Annual Max *
- Expressions Class I-III \$25 Deductible, 100/80/50 Coins, \$1,000 Annual Max
- Expressions Class I-III \$25 Deductible, 100/80/50 Coins, \$1,500 Annual Max
- Expressions Class I-III \$25 Deductible, 100/80/50 Coins, \$2,000 Annual Max
- Expressions Class I-III \$50 Deductible, 100/80/50 Coins, \$1,000 Annual Max
- Expressions Class I-III \$50 Deductible, 100/80/50 Coins, \$1,500 Annual Max
- Expressions Class I-III \$50 Deductible, 100/80/50 Coins, \$2,000 Annual Max

Orthodontia

- Orthodontia \$1,000 Lifetime Max
- Orthodontia \$1,500 Lifetime Max

TMJ

- TMJ \$1,000 Annual Max (WA only)

* Only available for Oregon Groups

Regence Value Dental

- Encore Class I-II \$0 Deductible, 80/50/0 Coins, \$500 Annual Max
- Encore Class I-II \$25 Deductible, 80/50/0 Coins, \$750 Annual Max
- Encore Class I-II \$50 Deductible, 80/50/0 Coins, \$500 Annual Max
- Encore Class I-II \$50 Deductible, 80/50/0 Coins, \$750 Annual Max

TMJ

- TMJ \$1,000 Annual Max (WA only)

Oregon Disclosure Notice for Employers

If the employer has an average of more than 50 employees during the preceding calendar year, the carrier may provide the employer a health insurance quote as a large group. However, the carrier must treat an employer as a small employer and must provide a quote on that basis if both of the following conditions apply:

- ◆ The employer's workforce consists of at least two but not more than 50 eligible employees as of the date coverage is to take effect; and
- ◆ Coverage is limited to eligible employees.

Health insurance carriers are required to provide quotes and issue coverage to small employers pursuant to ORS 743.733 to ORS 743.737.

NOTE: Regence BlueCross BlueShield of Oregon is providing a small group quote based upon the State's definition of a Small Employer.

For employers who are affiliated with a group of employers for the purpose of pension plans under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, and are:

- ◆ Requesting coverage as a single group of affiliated employers, we will quote the group as a single group. In this case, the entire affiliated group(s) must complete the questions on the group classification link.
- ◆ Requesting coverage as a single group (unrelated to affiliated employers), each employer requesting a quote must complete the questions on the group classification link.

BENEFIT(S) PLAN SELECTION (continued)

The following is only available for Oregon and Clark County, WA Groups of 100+

BLUECHOICESSM MEDICAL PLANS SELECTIONS:

Quote all applicable BlueChoices options

BlueEssentialsSM Plan Selection - Coinsurance: 70% In-Network, 50% Out-of-Network

Participating

- \$500 Deductible
- \$1000 Deductible
- \$2000 Deductible

Preferred Provider Plan

- \$500 Deductible
- \$1000 Deductible
- \$2000 Deductible

BluePreferred[®] Plan Selection - Coinsurance: 80% In-Network, 60% Out-of-Network

Participating

- \$300 Deductible
- \$500 Deductible
- \$1000 Deductible
- \$2000 Deductible

Preferred Provider Plan

- \$300 Deductible
- \$500 Deductible
- \$1000 Deductible
- \$2000 Deductible
- \$3000 Deductible

BlueClassicSM Plan Selection - Coinsurance: 90% In-Network, 70% Out-of-Network (Groups 51+ eligible employees only)

Participating

- \$300 Deductible
- \$500 Deductible
- \$1000 Deductible

Preferred Provider Plan

- \$300 Deductible
- \$500 Deductible
- \$1000 Deductible

Basic Oregon Plan - Traditional

Regence HSA Healthplan
(includes prescription)

Participating Preferred

- \$1,500 single / \$3,000 family *
- \$2,500 single / \$5,000 family *
- \$3,500 single / \$7,000 family *
- \$3,000 single / \$5,000 family **
- \$3,000 single / \$7,000 family **

*Family consists of more than one member. Entire family deductible must be met before benefits begin for any family member.

**Benefits begin for a member once \$3,000 amount is met or once the family deductible is met, whichever occurs first.

Prescription Medication Benefit Selections *

- \$10/\$20/\$40 \$10/30%/50% \$10/\$35/\$50 50% *Not available with Regence HSA Healthplan

Vision Benefit Selection

- Full Service Vision, \$20 Copay Regence HSA Healthplan Vision Plan

Alternative Care Benefit Selections

- Managed Chiropractic, \$20 Copay Complementary Care, \$20 Copay, \$500 Max Complementary Care, \$20 Copay, \$1000 Max

DENTAL PLAN SELECTIONS:

Dental Plans

- Classic 84B (\$25 100/80/50; \$1500 Max)
- Classic 85A (\$50 100/80/50; \$1000 Max)
- Classic 86B (\$50 80/80/50; \$1500 Max)
- Value Plan 65 (\$50 100/80/50)
- Value Plan 66 (\$50 80/80/50)
- Blue Care 51 (\$0 Ded, \$1000 Max)
- Ortho Rider (\$1500) (Groups 26+)
(6 month waiting period)

Dentacare Plans

- DA (\$5 visit Copay)
- DB (\$10 visit Copay; \$50/\$50/\$40)
- DC (\$10 visit Copay; \$120/\$120/\$50)
- DD (\$10 visit Copay; \$180/\$200/\$60)
- DE (\$12 visit Copay; \$225/\$225/\$60)
- DF (\$15 visit Copay; \$275/\$275/\$60)
- DG (\$25 visit Copay; \$400/\$500/\$150)
- Dentacare Ortho rider (Groups 100+)

