



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.

Where do the majority of eligible employees work?
 Oregon Washington Other _____

How many hours per week do you require for Health plan enrollment? _____

Average number of employees working in preceding calendar year _____

Do you intend to cover all employees? Yes No _____
(If yes, list class name)

Oregon Groups: Number of employees working 17.5 hours per week or greater on the requested effective date _____

Washington Groups: Average number of employees that you employed during the preceding calendar year _____

| | | | | | |
|--|----------------|---------------|--|--|--|
| 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 - 30) | | |

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? Yes No

If not COBRA eligible, will your group offer Washington continuation? Yes No

* 20 or more full-time and/or part-time employees on 50% or more of your business days in the preceding calendar year.

Are you interested in purchasing a Health Reimbursement Arrangement or Flexible Spending Account? Yes No

REQUEST BENEFITS TO BE QUOTED ON PAGE 2 - 4 AND COMPLETE CENSUS INFORMATION ON PAGE 5.

BENEFIT(S) PLAN SELECTION

INNOVA/ENGAGE PLAN SELECTIONS:

Quote all "Most popular for 2007 products"

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 \$5,000

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

Deductible for Brand Rx

\$0 \$250 \$500

Riders (optional)

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

Regence Engage

Deductible

\$0 \$500 \$1,000 \$2,000 \$5,000

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 / \$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

Deductible for Brand Rx

\$0 \$250 \$500

Riders (optional)

Vision Complementary Care (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, \$1,500 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, \$1,500 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)

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)

Disclosure Notice for Employers

If the employer has more than 50 employees, the employer may request a health insurance quote as a large group. If the group has more than 50 employees, but only 2-50 eligible employees **and** limits coverage under the health insurance plan to all eligible employees, **or** if the group has 26-50 eligible employees **and** limits coverage to a class of eligible employees, the employer may request a quote as a small employer. Health insurance carriers are required to provide a small employer quote to a qualifying employer upon request and must provide small employer coverage if an employer accepts that quote.

I am requesting a small employer quote for my group health plan _____ (Initials)

BENEFIT(S) PLAN SELECTION (continued)

BLUECHOICESSM MEDICAL PLANS SELECTIONS:

Quote all applicable BlueChoices options

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

- | <u>Participating</u> | <u>Preferred Provider Plan</u> | <u>Access</u> |
|--|--|--|
| <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible |
| <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible |
| <input type="checkbox"/> \$2000 Deductible | <input type="checkbox"/> \$2000 Deductible | <input type="checkbox"/> \$2000 Deductible |

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

- | <u>Participating</u> | <u>Preferred Provider Plan</u> | <u>Access</u> |
|--|--|--|
| <input type="checkbox"/> \$300 Deductible | <input type="checkbox"/> \$300 Deductible | <input type="checkbox"/> \$300 Deductible |
| <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible |
| <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible |
| <input type="checkbox"/> \$2000 Deductible | <input type="checkbox"/> \$2000 Deductible | <input type="checkbox"/> \$2000 Deductible |
| | <input type="checkbox"/> \$3000 Deductible | |

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

- | <u>Participating</u> | <u>Preferred Provider Plan</u> | <u>Access</u> |
|--|--|--|
| <input type="checkbox"/> \$300 Deductible | <input type="checkbox"/> \$300 Deductible | <input type="checkbox"/> \$300 Deductible |
| <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible | <input type="checkbox"/> \$500 Deductible |
| <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible | <input type="checkbox"/> \$1000 Deductible |

Basic Oregon Plan - Traditional

Regence HSA Healthplan
(includes prescription)

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Participating | <input type="checkbox"/> Preferred |
| <input type="checkbox"/> \$1,500 single / \$3,000 family * | |
| <input type="checkbox"/> \$2,500 single / \$5,000 family * | |
| <input type="checkbox"/> \$3,500 single / \$7,000 family * | |
| <input type="checkbox"/> \$3,000 single / \$5,000 family ** | |
| <input type="checkbox"/> \$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

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

Dentacare Plans (available to groups 100+ only)

- | | | |
|--|--|---|
| <input type="checkbox"/> DA (\$5 visit Copay) | <input type="checkbox"/> DD (\$10 visit Copay; \$180/\$200/\$60) | <input type="checkbox"/> DG (\$25 visit Copay; \$400/\$500/\$150) |
| <input type="checkbox"/> DB (\$10 visit Copay; \$50/\$50/\$40) | <input type="checkbox"/> DE (\$12 visit Copay; \$225/\$225/\$60) | <input type="checkbox"/> Dentacare Ortho rider (Groups 26+) |
| <input type="checkbox"/> DC (\$10 visit Copay; \$120/\$120/\$50) | <input type="checkbox"/> DF (\$15 visit Copay; \$275/\$275/\$60) | |

