Central PA Quote Request Form

Please complete and email to
HBSQuotes@highmark.com

Please Include the Following:

1. Census of all EEs with the following minimum information
   - EE first
   - EE last name
   - Gender
   - Date of birth
   - Home zip code
   - Employee status (FT, PT, COBRA, disability, waiver)
   - Contract type (Individual, Parent & Child, Parent & Children, Husband & Wife, Family) - identify medical, dental, and vision contract types separately if the enrollment in ancillary lines differs from the enrollment in medical coverage
   - Enrolled plan identification (if employees are currently offered more than one plan) - identify medical, dental, and vision plan selections separately for any line of coverage where multiple plans are offered
2. Detailed benefit grid for all current plan options (Med/Rx, Dental and/or Vision)
3. Monthly claims (2-3 yrs) separated by Medical/Rx with high claims info (Claim utilization is required for all groups >100 enrolled employees. For ASO requests, an Rx detail report showing claims-level prescribing patterns is preferred.)
4. Most recent renewal calculation & rate history with corresponding benefit grids
5. Producer Authorization Letter
6. Collective Bargaining Agreement (CBA) **-** if applicable
7. Certificates of Insurance **-** only required if CBA applies

Producer Information

Name of Producer:
Contact Phone:
Agency Name:
Preferred Producer (if applicable):
Contact:
Today's Date:
Contact Email Address:
Are you the incumbent Producer?
Producer Commission (1-6%/PCPM)
(Applies to groups with 100+ enrolled, subject to Pref/Std split; 51-99 Market Standard Commission Applies)

Group Information

Group Name:
Contact Name:
Address:
Contact Email:
Address:
Contact Phone Number:
City:
EIN - Employer ID #s:
State: PA
Group Currently Offers:
Zip:
- ☐ Medical/Rx (See page 3 & 4 for available options)
- ☐ Vision (See page 5 for available options)
- ☐ Dental (See page 6 for available options)
- ☐ Stop Loss

County:
SIC Code:
Industry Description:

How long has the client been in business:

Union:
If **Yes**, Union Name/Local Number:

Is this the Corporate Headquarters?
If **No**, Location:

Is the client part of an Association or Trust Fund?
If **Yes**, Name:

Does the group currently offer group health insurance to its employees?

What is the new hire waiting period for group health benefits?
(i.e. date of hire, 30 days, 60 days; **cannot exceed 90 days**)

Does the employer cover Retirees over 65?

Employer Contributions

Choose a contribution method:
○ Monthly Dollar Amount ○ Percentage

Is there an incentive for opting out?

Individual
Family
Other

Is the group planning changes to contributions?
If **Yes**, please explain

Client Size/Participation

Is the above company affiliated with other entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules (e.g., (b) controlled group of corporations, (c) partnership or proprietorship, etc., under common control or, (m) employees of an affiliated service group, or (o) other regulations)?

☐ Yes – **Attach a Certification of Eligibility to Combine and Employer Group Size Form completed by an authorized representative of the company. The form must include all affiliated entity names and Employer Identification Numbers (EIN).**

☐ No

Average Number of Employees: (Numeric Response)

For the purposes of determining your average total number of employees and proper market placement, count all employees for each month in the preceding calendar year. This includes full-time, part-time, seasonal/intermittent, in/out-of-area employees – who were issued a W-2; regardless of whether they were eligible to enroll, and/or participated in the group health plan. Exclude owners and working family members (who do not qualify as common law employees), 1099 independent contractors and retirees.

IMPORTANT: If you answered Yes above, please count all employees collectively for all related entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules.

Number of Employees Eligible for Medical Coverage: (Numeric Response)

Number of Employees Covered under Medical Plan: (Numeric Response)

Proposal Information

Match Current Rate Tiers:
If no, please select from the following:

Effective Date:

Funding Arrangement:
#1:
#2:

Date Needed:

Current/Prior Carrier Information

Has any portion of the client ever been insured with Highmark?

If **Yes**, Effective Date:

Cancel Date:

Former Highmark Client/Group #s:

Carrier History

Please list for the previous 5 years (most recent first)

	Carrier	Effective Date	Funding Arrangement
Current			
Previous			
Previous			
Previous			
Previous			

Supplemental Products

List supplemental coverage

	Dental	Vision
Employer Sponsored:	☐	☐
Voluntary:	☐	☐
Carrier:		
Renewal Month:		
Are you the Incumbent Producer:		
Number of Employees Eligible for Coverage:		
Number of Employees Covered under Plan:		

Authorized Signature

The undersigned acknowledges to the best of their knowledge that all information provided is true and accurate. They understand that this information will be relied upon in determining premium rates within the applicable health care laws and regulations. Any misrepresentations or inaccurate information provided above may impact the health plans quoted and result in adjustments to final rates.

Name _____

(Signature of Authorized Representative)

Title _____ Date _____

51+ Total employee count (Please Try to Select 3-4 Medical/Rx Combinations)

PPO Blue Premium
- ☐ 100/80; $0 INN Ded; $10 OV Copay; $150 ER Copay
- ☐ 100/80; $0 INN Ded; $20/$40 OV Copay; $150 ER Copay

PPO Blue Sharing
- ☐ 100/80; $250/$500 INN Ded; $20 OV Copay; $150 ER Copay
- ☐ 100/80; $500/$1,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $1,000/$2,000 INN Ded; $10/$25 OV Copay; $150 ER Copay
- ☐ 100/80; $1,000/$2,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $1,500/$3,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $2,000/$4,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $2,500/$5,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $3,000/$6,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $4,000/$8,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $5,000/$10,000 INN Ded; $20/$35 OV Copay; $150 ER Copay

PPO Comprehensive Care
- ☐ 90/70; $500/$1,000 INN Ded; 10% OV/ER Coins

PPO Blue Smart
- ☐ 90/70; $500/$1,000 INN Ded; $20/$35 OV Copay; $150 ER Copay
- ☐ 80/60; $1,000/$2,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 80/60; $2,500/$5,000 INN Ded; $30/$40 OV Copay; $150 ER Copay

EPO Blue
- ☐ 100; $2,000/$4,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 80; $750/$1,500 INN Ded; 20% OV/ER Coins

PPO Blue and EPO Blue Rx Benefits with National Network
- ☐ Rx G - $8/$40/$70 Retail; $20/$100/$175 MO; Comprehensive
- ☐ Rx L - $3/$10/$40/$65 Retail; $6/$20/$80/$130 MO; Comprehensive
- ☐ *Rx M - $10/$60/$85 Retail; $25/$150/$215 MO; Comprehensive
- ☐ *Rx ML - $3/$10/$60/$85 Retail; $8/$25/$150/$215 MO; Comprehensive

PPO Blue Healthy Savings with Integrated Rx D
- ☐ 100/80; $1,500/$3,000 INN Ded; 0% OV/ER Coins
- ☐ 100/80; $2,000/$4,000 INN Ded; $25 OV Copay; $150 ER Copay
- ☐ 100/80; $3,200/$6,400 INN Ded; 0% OV/ER Coins
- ☐ 100/80; $3,500/$7,000 INN Ded; 0% OV/ER Coins
- ☐ 100/80; $5,000/$10,000 INN Ded; 0% OV/ER Coins
- ☐ 100/80; $6,350/$12,700 INN Ded; 0% OV/ER Coins
- ☐ 90/70; $1,500/$3,000 INN Ded; 10% OV/ER Coins
- ☐ 90/70; $2,000/$4,000 INN Ded; 10% OV/ER Coins
- ☐ 90/70; $3,500/$7,000 INN Ded; 10% OV/ER Coins

PPO Blue Healthy Savings
Rx DC - $15/$30/$60 Retail; $30/$60/$120 MO; Comprehensive
- ☐ 100/80; $3,000/$6,000 INN Ded; $30/$40 OV Copay; $150 ER Copay

PPO Blue Choice Savings (Integrated Rx)
Rx DC - $15/$30/$60 Retail; $30/$60/$120 MO; Comprehensive
- ☐ 100/80; $2,000/$4,000 INN Ded; $30/$40 OV Copay; $150 ER Copay
- ☐ 100/80; $4,000/$8,000 INN Ded; $30/$40 OV Copay; $150 ER Copay

**EPO Blue Easy Plans
Rx L - $3/$10/$40/$65 Retail; $6/$20/$80/$130 MO; Comprehensive
- ☐ 100; $0/$0 INN Ded; $20/$40 OV Copay; $150 ER Copay
- ☐ 100; $0/$0 INN Ded; $30/$50 OV Copay; $200 ER Copay
- ☐ 100; $0/$0 INN Ded; $35/$55 OV Copay; $300 ER Copay

Community Blue Premier Flex Sharing
INN Enhanced/INN Standard/OON
- ☐ 100/80/60; $500/$1,000/$2,000 Ind; $1,000/$2,000/$4,000 Fam Ded
- ☐ 100/80/60; $1,000/$2,000/$4,000 Ind; $2,000/$4,000/$8,000 Fam Ded

Community Blue Premier Flex Smart
INN Enhanced/INN Standard/OON
- ☐ 90/70/50; $1,250/$2,500/$5,000 Ind; $2,500/$5,000/$10,000 Fam Ded

Community Blue Premier Flex Take Charge
INN Enhanced/INN Standard/OON
- ☐ 80/70/50; $500/$1,000/$2,000 Ind; $1,000/$2,000/$4,000 Fam Ded

Community Blue Premier Flex Rx Benefits with National Network
- ☐ Rx G - $8/$40/$70 Retail; $20/$100/$175 MO; Comprehensive
- ☐ Rx L - $3/$10/$40/$65 Retail; $6/$20/$80/$130 MO; Comprehensive
- ☐ *Rx M - $10/$60/$85 Retail; $25/$150/$215 MO; Comprehensive
- ☐ *Rx ML - $3/$10/$60/$85 Retail; $8/$25/$150/$215 MO; Comprehensive

Community Blue Premier Flex Healthy Savings with Integrated Rx D
INN Combined/OON
- ☐ 100/80/60; $2,000/$4,000 Ind; $4,000/$8,000 Fam Ded

Community Blue Premier Flex PPO Choice Savings (Integrated Rx)
INN Enhanced/INN Standard/OON
Rx DC - $15/$30/$60 Retail; $30/$60/$120 MO; Comprehensive
- ☐ 100/70/50; $4,000/$6,000/$12,000 Ind; $8,000/$12,000/$24,000 Fam Ded

Lehigh Valley Flex Blue Sharing
INN Enhanced/INN Standard/OON
Rx H - $10/$55/$80/30% Retail; $20/$110/$160/30% MO; Comprehensive
- ☐ 100/80/60; $500/$1,500/$3,000 Ind Ded; 2x Fam Ded; $175 ER Copay
- ☐ 100/70/50; $1,000/$3,000/$6,000 Ind Ded; 2x Fam Ded; $175 ER Copay
- ☐ 100/80/60; $2,000/$4,000/$8,000 Ind Ded; 2x Fam Ded; $175 ER Copay

Lehigh Valley Flex Blue Healthy Savings with Integrated Rx D
INN Enhanced/INN Standard/OON
- ☐ 100/80/60; $4,000/$6,000/$12,000 Ind Ded; 2x Fam Ded; 0% ER Coinsurance
- ☐ 100/70/50; $1,500/$3,000/$6,000 Ind Ded; 2x Fam Ded; 0% ER Coinsurance

Lehigh Valley Flex Blue PPO Choice Savings (Integrated Rx)
INN Enhanced/INN Standard/OON
Rx DC - $15/$30/$60 Retail; $30/$60/$120 MO; Comprehensive
- ☐ 100/70/50; $4,000/$6,000/$12,000 Ind; $8,000/$12,000/$24,000 Fam Ded

Additional Customized Benefits
- ☐ $3 Generic Drug Feature
- ☐ HRA Administration
- ☐ HSA Administration
- ☐ FSA Administration
- ☐ Total Health***

*__Rx M & Rx ML__ features exclusive home delivery (EHD) (otherwise referred to as mandatory mail order).

**__EPO Blue Easy Plan__ is designed to provide clear, predictable cost-sharing in the form of copayments (designed to eliminate member confusion about what their costs are for services). There is no deductible or coinsurance on any service. Easy Plan is a non-tiered product designed around the basic premise of simplicity and foreseeable out-of-pocket costs. Since these are EPO Blue Plans - members have access to our extensive local network, as well as access to BlueCard providers across the country.

***__Total Health__ is our benefit design built on Highmark's patient-centered care program, combined with value-based benefits. It offers you an affordable coverage solution that focuses on coordinated care for better health outcomes. The patient-centered care program focuses on coordinated care in an environment where care teams can support a patient using the latest and most relevant data to drive the best clinical outcomes without driving up costs. Value-based benefits offers cost-sharing incentives to make it easier for your employees with chronic conditions to follow the medical guidelines related to their condition.

Standard Vision Options

	Vision Plans				
Participation	☐ Fashion Value Choose an item	☐ Fashion Basic Choose an item	☐ Designer Value Choose an item	☐ Designer Basic Choose an item	☐ Premier Choose an item
	Frequency - Eye examination, spectacle lenses, frames and contact lenses				
	Once every 12 months (frames once every 24 months)	Once every 12 months	Once every 12 months (frames once every 24 months)	Once every 12 months	Once every 12 months
	Eye Examination - Copays (In-Network)				
	$15	$15	$10	$10	$0
	Spectacle Lenses - Copays (In-Network)				
	$15	$15	$10	$10	$0
	Frames - "The Collection"* (In-Network)				
Fashion Level	Included	Included	Included	Included	Included
Designer Level	$15	$15	Included	Included	Included
Premier Level	$40	$40	$25	$25	Included
Non-Collection	Up to $100 allowance Visionworks up to $150 allowance	Up to $100 allowance Visionworks up to $150 allowance	Up to $120 allowance Visionworks up to $170 allowance	Up to $120 allowance Visionworks up to $170 allowance	Up to $150 allowance Visionworks up to $200 allowance
	Contact Lenses - "The Collection"* (In-Network)				
Evaluation & Fitting	Included	Included	Included	Included	Included
Contact Lenses	4 boxes - disposable 2 boxes - planned replacement	4 boxes - disposable 2 boxes - planned replacement	4 boxes - disposable 2 boxes - planned replacement	4 boxes - disposable 2 boxes - planned replacement	8 boxes - disposable 4 boxes - planned replacement
	Contact Lenses - Non-Collection (In-Network)				
Evaluation & Fitting	Not Covered	Not Covered	Standard - Included Specialty - Up to $60 allowance	Standard - Included Specialty - Up to $60 allowance	Standard - Included Specialty - Up to $60 allowance
Contact Lens	Up to $100 allowance	Up to $100 allowance	Up to $120 allowance	Up to $120 allowance	Up to $150 allowance

*Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

☐ Match Current Benefits - available to groups with 300+ enrolled contracts (attach plan design):

Commission for Groups with 51-299 enrolled contracts: 6%

Commission for Groups with 300+ enrolled contracts:

Standard Dental Options

Plan	Deductible	Annual Max	Class I/Class II/Class III/Orthodontics	Orthodontic Max
☐Flex 2W			100/80/Not Covered/Not Covered *	Not Applicable
☐Flex 3W			100/80/50/Not Covered *	Not Applicable
☐Flex 4W			100/100/Not Covered/Not Covered *	Not Applicable
☐Flex 3Wo			100/80/50/50 *	
☐Flex 8W			100/100/50/Not Covered *	Not Applicable
☐Preferred 10Wo			100/80/50/50 INN; 80/60/50/50 OON *	
☐Flex Value 1	$0/$0	$1,000	100/0/0/Not Covered **	Not Applicable
☐Flex Value 2	$100/$300	$1,000	80/50/20/Not Covered **	Not Applicable
☐Flex Value 3	$25/$75	$1,000	100/50/0/Not Covered **	Not Applicable
☐Flex Value 4	$100/$300	$1,000	100/50/20/Not Covered **	Not Applicable

☐Match Current Benefits (attach plan design):

Full Time Equivalents vs. Enrolled Contracts:

Current rates:

Renewal rates:

Commission:

Dental claims are required for groups with 150+ enrolled contracts.

* Class I - exams, cleanings, fluoride treatments, x-rays, sealants, space maintainers and palliative treatment (emergency)

Class II - basic restorative (fillings), repairs (crowns, inlays onlays, bridges, dentures), oral surgery (including simple and surgical extractions), general anethesia, endodontics, periodontics (surgical and nonsurgical) and posterior resins

Class III - Inlays, onlays, crowns and prosthetics (bridges, dentures)

Orthodontics - diagnostic, active, retention treatment

** Class I - exams, cleanings, fluoride treatments, x-rays, sealants, space maintainers and palliative treatment (emergency)

Class II - simple extractions, basic restorative (fillings), posterior resins, repairs (crowns, inlays onlays, bridges, dentures) and general anethesia

Class III - oral surgery (including surgical extractions), endodontics, periodontics (surgical and nonsurgical), Inlays, onlays, crowns and prosthetics (bridges, dentures)

Orthodontics - diagnostic, active, retention treatment