



Partial Self-Funding Request for Proposal Form

For Traditional PPO and Non-H S A Qualified High Deductible Plans
(Please print all requested information)

Group Name:		DBA:	
City / State / Zip:			
Subsidiary/Affiliate: (Please indicate)		Requested Effective Date:	
SIC / NAICS Code:		Type of Business:	
TPA /Producer:		Broker:	
Current Carrier:		Renewal Date:	
Current Rates:		EE:	ES: EC: EF:
Renewal Rates:		EE:	ES: EC: EF:
Specific Deductible: Not all deductibles available in all areas		<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000
		<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$30,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$45,000 <input type="checkbox"/> \$50,000
Specific Family Limit:		<input type="checkbox"/> None <input type="checkbox"/> 2X	Specific Contract: <input type="checkbox"/> 12/12 <input type="checkbox"/> 12/15 <input type="checkbox"/> 12/18
Aggregate Contract: (Exclude for Spec Only Plans)		<input type="checkbox"/> Excluded <input type="checkbox"/> 12/12 <input type="checkbox"/> 12/15 <input type="checkbox"/> 12/18 <input type="checkbox"/> 15/12	12/12 and 15/12 Aggregate contracts include optional Terminal Liability Coverage
Rate Structure:		<input type="checkbox"/> 2-Tier <input type="checkbox"/> 4-Tier	PPO Network:
Major Medical Deductible:		<input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> _____
Non-Network Major Medical Deductible Multiplier:		<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X	Emergency Room Co-pay: <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150
Coinsurance Level:		<input type="checkbox"/> 100/70 <input type="checkbox"/> 100/60 <input type="checkbox"/> 100/50 <input type="checkbox"/> 90/80 <input type="checkbox"/> 90/70	<input type="checkbox"/> 90/60 <input type="checkbox"/> 80/70 <input type="checkbox"/> 80/60 <input type="checkbox"/> 80/50
Family Medical Deductible Multiplier:		<input type="checkbox"/> 2X <input type="checkbox"/> 3X	24 Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No (Owner/Officers Only)
Out-of-Pocket:		<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000	
Non-Network OOP Multiplier:		<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X	Family OOP Multiplier <input type="checkbox"/> 2X <input type="checkbox"/> 3X
Office Visit Copay:		<input type="checkbox"/> Excluded <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$25 <input type="checkbox"/> \$35 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	
Specialist Multiplier:		<input type="checkbox"/> 1X <input type="checkbox"/> 2X	Separate X-Ray/Lab Co-pay: <input type="checkbox"/> Included <input type="checkbox"/> Excluded
In-Network Hospital Copay: (In addition to deductible; not available on H S A Plans)		<input type="checkbox"/> None <input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Non-Network Hospital Copay: (In addition to deductible; not available on H S A Plans) <input type="checkbox"/> None <input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
Medical Maximum Limit:		<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000	Full-time Student Age: <input type="checkbox"/> 23 years <input type="checkbox"/> 25 years
Supplemental Accident:		<input type="checkbox"/> Excluded <input type="checkbox"/> \$300 <input type="checkbox"/> \$500	
Wellness Benefit:		<input type="checkbox"/> Excluded <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	
Mental Health:		<input type="checkbox"/> Excluded <input type="checkbox"/> Included	Alcohol / Substance Abuse: <input type="checkbox"/> Excluded <input type="checkbox"/> Included
Maternity:		<input type="checkbox"/> Excluded <input type="checkbox"/> Included (Required on groups with 15 or more lives)	
Prescription Drug Benefits			
<input type="checkbox"/> Deductible Card - (Applies to Deductible and Coinsurance)			
<input type="checkbox"/> Copay Card:		<input type="checkbox"/> \$7 / \$20 / \$35 <input type="checkbox"/> \$7 / \$30 / \$50 <input type="checkbox"/> \$10 / \$25 / \$40 <input type="checkbox"/> \$10 / \$30 / \$50	<input type="checkbox"/> \$20/\$40/\$65 <input type="checkbox"/> 10% / 30% / 50% <input type="checkbox"/> 50%
Calendar Year Limit:		<input type="checkbox"/> None <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000	



Dental Coverage

No ASO Self-Funded Fully Insured

<input type="checkbox"/> Plan B – PPO 1	Deductible		Coinsurance		Annual Maximum
	In-Network	Out-of-Network	In-Network	Out-of-Network	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	Same as In-Network	100%	80%	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type II	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	Same as In-Network	80%	60%	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> Type III	<input type="checkbox"/> \$75 <input type="checkbox"/> \$100	Same as In-Network	50%	50%	<input type="checkbox"/> \$3,000
<input type="checkbox"/> Plan B – PPO 2	Deductible		Coinsurance		Annual Maximum
	In-Network	Out-of-Network	In-Network	Out-of-Network	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75	100%	Same as In-Network	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type II	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	80%	Same as In-Network	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> Type III	<input type="checkbox"/> \$75 <input type="checkbox"/> \$100		50%	Same as In-Network	<input type="checkbox"/> \$3,000
<input type="checkbox"/> Plan B – Indemnity Plan	Deductible		Coinsurance		Annual Maximum
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50		100%		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type II	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100		80%		<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type III			50%		<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> Plan C – PPO 1	Deductible		Coinsurance		Annual Maximum
	In-Network	Out-of-Network	In-Network	Out-of-Network	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	Same as In-Network	100%	80%	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type II	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	Same as In-Network	90%	70%	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> Type III	<input type="checkbox"/> \$75 <input type="checkbox"/> \$100	Same as In-Network	60%	50%	<input type="checkbox"/> \$3,000
<input type="checkbox"/> Plan C – PPO 2	Deductible		Coinsurance		Annual Maximum
	In-Network	Out-of-Network	In-Network	Out-of-Network	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75	100%	Same as In-Network	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type II	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	90%	Same as In-Network	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> Type III	<input type="checkbox"/> \$75 <input type="checkbox"/> \$100		60%	Same as In-Network	<input type="checkbox"/> \$3,000
<input type="checkbox"/> Plan C – Indemnity Plan	Deductible		Coinsurance		Annual Maximum
<input type="checkbox"/> Type I	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50		100%		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250
<input type="checkbox"/> Type II	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100		90%		<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750
<input type="checkbox"/> Type III			60%		<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
					<input type="checkbox"/> \$3,000
Ortho Coverage:	<input type="checkbox"/> No <input type="checkbox"/> \$1,000 Lifetime Maximum		<input type="checkbox"/> \$1,500 Lifetime Maximum		

Vision Coverage

No ASO Self-Funded Fully Insured

Deductible Options:	<input type="checkbox"/> No Deductible <input type="checkbox"/> \$15 <input type="checkbox"/> \$30			
Frequency Options:		Vision Exam	Lenses	Frames
	<input type="checkbox"/> Option 1	Every 12 months	Every 12 months	Every 12 months
	<input type="checkbox"/> Option 2	Every 12 months	Every 12 months	Every 24 months
	<input type="checkbox"/> Option 3	Every 12 months	Every 24 months	Every 24 months
	<input type="checkbox"/> Option 4	Every 24 months	Every 24 months	Every 24 months