

Western PA Quote Request Form



Please complete and email to
GroupQuote@armsins.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)
4. Most recent renewal calculation & rate history with corresponding benefit grids
5. Collective Bargaining Agreement (CBA) - if applicable
6. Certificates of Insurance - only required if CBA applies

Producer Information

Name of Producer: Contact Phone:
Agency Name: ARMS INSURANCE GROUP LLC 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:
Address:
City:
State: PA
Zip:
County:
SIC Code:
Industry Description:
Contact Email:
Contact Phone Number:
EIN - Employer ID #s:
Group Currently Offers:
Medical/Rx (See page 3 - 5 for available options)
Vision (See page 6 for available options)
Dental (See page 7 for available options)
Stop Loss
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
Individual
Family
Other
Is there an incentive for opting out?
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: Effective Date:
If no, please select from the following:

Funding Arrangement: Date Needed:
#1:
#2:

Current/Prior Carrier Information

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

Carrier History

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

If Yes, Effective Date:

Carrier

Effective Date

Funding Arrangement

Cancel Date:

Current

Former Highmark Client/Group #s:

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)

Community Blue Flex Premium
100/70/50; \$0/\$500/\$1,000 Ind Ded; \$20 Enhan INN OV Copay
Community Blue Flex Sharing
100/70/50; \$500/\$1,500/\$3,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
100/70/50; \$750/\$2,250/\$4,500 Ind Ded; \$10/\$25 Enhan INN OV Copay
100/70/50; \$1,000/\$3,000/\$6,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
100/70/50; \$1,250/\$3,750/\$7,500 Ind Ded; \$10/\$25 Enhan INN OV Copay
100/70/50; \$1,500/\$4,500/\$9,000 Ind Ded; \$10/\$25 Enhan INN OV Copay
100/70/50; \$2,500/\$5,000/\$10,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
100/70/50; \$3,000/\$4,500/\$9,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
100/70/50; \$3,500/\$5,000/\$10,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
Community Blue Flex Smart
90/70/50; \$1,500/\$4,500/\$9,000 Ind Ded; \$10/\$25 Enhan INN OV Copay
90/70/50; \$2,500/\$5,000/\$10,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
90/70/50; \$3,000/\$4,500/\$9,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
80/70/50; \$500/\$1,500/\$3,000 Ind Ded; \$25/\$35 Enhan INN OV Copay
80/60/50; \$1,500/\$4,500/\$9,000 Ind Ded; \$10/\$25 Enhan INN OV Copay
80/60/50; \$2,500/\$5,000/\$10,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
80/60/50; \$3,000/\$4,500/\$9,000 Ind Ded; \$30/\$40 Enhan INN OV Copay
Community Blue 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 Flex Choice Savings
Integrated Rx DC - \$15/\$30/\$60 Retail; \$30/\$60/\$120 MO; Comprehensive
100/70/50; \$4,000/\$6,000/\$12,000 Ind; \$30/\$40 Enhan INN OV Copay
Community Blue Flex Healthy Savings with Integrated Rx D
100/70/50; \$1,500/\$4,500/\$9,000 Ind Ded; 0% Enhan INN OV Coinsurance
100/70/50; \$3,500/\$5,500/\$11,000 Ind Ded; 0% Enhan INN OV Coinsurance
100/70/50; \$4,000/\$6,000/\$12,000 Ind Ded; 0% Enhan INN OV Coinsurance
Community Blue Flex Healthy Savings (Integrated Rx)
Rx DC - \$15/\$30/\$60 Retail; \$30/\$60/\$120 MO; Comprehensive
100/70/50; \$4,000/\$6,000/\$12,000 Ind; \$30/\$40 Enhan INN OV Copay
Connect Blue EPO Sharing
100/70/60; \$150/\$600/\$1,200 Ind Ded; 0% Pref INN OV Coinsurance
100/70/60; \$250/\$1,000/\$2,000 Ind Ded; 0% Pref INN OV Coinsurance
100/70/60; \$500/\$2,000/\$4,000 Ind Ded; 0% Pref INN OV Coinsurance
100/70/60; \$750/\$2,250/\$4,500 Ind Ded; 0% Pref INN OV Coinsurance
100/70/60; \$1,000/\$2,000/\$4,000 Ind Ded; 0% Pref INN OV Coinsurance
100/70/60; \$1,250/\$2,500/\$5,000 Ind Ded; 0% Pref INN OV Coinsurance
Connect Blue EPO Rx Benefits with National Network
Rx H - \$10/\$55/\$80/30% Retail; \$20/\$110/\$160/30% MO; Comprehensive
Rx K - \$8/\$35/\$60/30% Retail; \$16/\$70/\$120/30% MO; Comprehensive
Conemaugh Region Connect Blue EPO**
Rx L - \$3/\$10/\$40/\$65 Retail; \$6/\$20/\$80/\$130 MO; Comprehensive
100/80/60; \$750/\$1,500/\$3,000 Ind Ded; \$10/\$20 Pref INN OV Copay
90/70/60; \$1,500/\$3,000/\$6,000 Ind Ded; \$10/\$20 Pref INN OV Copay
Additional Benefits
HRA Administration
HSA Administration
FSA Administration

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 Blue Family Savings
100/80; \$2,500C INN Ded; \$25/\$35 OV Copay; \$150 ER Copay
PPO Comprehensive Care
90/70; \$500/\$1,000 INN Ded; 10% OV/ER Coinsurance
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
PPO 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 Coinsurance
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 Coinsurance
100/80; \$3,500/\$7,000 INN Ded; 0% OV/ER Coinsurance
100/80; \$5,000/\$10,000 INN Ded; 0% OV/ER Coinsurance
100/80; \$6,350/\$12,700 INN Ded; 0% OV/ER Coinsurance
90/70; \$1,500/\$3,000 INN Ded; 10% OV/ER Coinsurance
90/70; \$2,000/\$4,000 INN Ded; 10% OV/ER Coinsurance
90/70; \$3,500/\$7,000 INN Ded; 10% OV/ER Coinsurance
PPO Blue Healthy Savings QHDP (Integrated Rx)
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
100; \$2,000/\$4,000 INN Ded; \$30/\$40 OV Copay; \$150 ER Copay
80; \$750/\$1,500 INN Ded; 20% OV/ER Coinsurance
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

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

**Conemaugh Region Connect Blue EPO a Community Blue Plan is a collaborative product with Conemaugh Health System that's designed to improve the value of employers and employees health care dollars. It offers three levels of network benefit coverage for most services: Preferred Value benefits where members have the lowest out-of-pocket costs when they receive care from providers affiliated with Conemaugh Health System, Allegheny Health Network and Children's Hospital of Pittsburgh, Enhanced Value benefits where members have higher out-of-pocket costs when they receive care at most other in-network providers, including the entire nationwide Blue Card® network, and Standard Value benefits where members have the highest out-of-pocket costs when they receive care from select UPMC providers.

Customized 51+ enrolled Contracts - (Please Try to Select 3-4 Medical/Rx Combinations)

Customized Benefit Options - 51+ Contracts

OPTION 1	Deductible		Coinsurance		TMOOP		PCP	SP	
	Product	INN	OON	INN	OON	INN			OON
	ER	MRI	Spinal Manipulation		Prescription Drug - Retail				
			Benefit	Limit	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty
	Prescription Drug - Mail Order					Mandatory Generic	Pharmacy Network		
	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty				
OPTION 2	Deductible		Coinsurance		TMOOP		PCP	SP	
	Product	INN	OON	INN	OON	INN			OON
	ER	MRI	Spinal Manipulation		Prescription Drug - Retail				
			Benefit	Limit	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty
	Prescription Drug - Mail Order					Mandatory Generic	Pharmacy Network		
	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty				
OPTION 3	Deductible		Coinsurance		TMOOP		PCP	SP	
	Product	INN	OON	INN	OON	INN			OON
	ER	MRI	Spinal Manipulation		Prescription Drug - Retail				
			Benefit	Limit	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty
	Prescription Drug - Mail Order					Mandatory Generic	Pharmacy Network		
	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty				
OPTION 4	Deductible		Coinsurance		TMOOP		PCP	SP	
	Product	INN	OON	INN	OON	INN			OON
	ER	MRI	Spinal Manipulation		Prescription Drug - Retail				
			Benefit	Limit	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty
	Prescription Drug - Mail Order					Mandatory Generic	Pharmacy Network		
	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty				
OPTION 5	Deductible		Coinsurance		TMOOP		PCP	SP	
	Product	INN	OON	INN	OON	INN			OON
	ER	MRI	Spinal Manipulation		Prescription Drug - Retail				
			Benefit	Limit	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty
	Prescription Drug - Mail Order					Mandatory Generic	Pharmacy Network		
	Low Cost Generic	Generic	Form Brand	Non-form Brand	Specialty				

Standard Vision Options

Vision Plans					
Participation	Fashion Value	Fashion Basic	Designer Value	Designer Basic	Premier
	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
	Frames - "The Collection" (In-Network)				
Fashion Level	\$0	\$0	\$0	\$0	\$0
Designer Level	\$15	\$15	\$0	\$0	\$0
Premier Level	\$40	\$40	\$25	\$25	\$0
Non-Collection - Allowance	Up to \$100 VisionWorks up to \$150	Up to \$100 VisionWorks up to \$150	Up to \$120 VisionWorks up to \$170	Up to \$120 VisionWorks up to \$170	Up to \$150 VisionWorks up to \$200
	Contact Lenses - Formulary Plan (In-Network)				
Evaluation & Fitting	\$0*	\$0*	\$0 - Standard Up to \$60 - Specialty	\$0 - Standard Up to \$60 - Specialty	\$0 - Standard Up to \$60 - Specialty
Collection	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
Non-Collection	Up to \$100	Up to \$100	Up to \$120	Up to \$120	Up to \$150

*When the performing provider dispenses formulary contact lenses.

**The non-collection and non-formulary contacts are subject to the same allowances

Match Current Benefits (attach plan design):

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			100/50/Not Covered/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 anesthesia, 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 anesthesia
 Class III - oral surgery (including surgical extractions), endodontics, periodontics (surgical and nonsurgical), Inlays, onlays, crowns and prosthetics (bridges, dentures)
 Orthodontics - diagnostic, active, retention treatment