235 East Broadway, Suite 960
Long Beach, CA 90802
Toll Free: (888) 797-3467
Website: www.rxreins.com

RxReins
The Prescription for Stop Loss Solutions

REQUEST FOR QUOTE (RFQ)

Stop Loss Coverage for Group Prescription Drug Plans

Please provide the following items to obtain a quote for prescription drug stop loss insurance:

1. RxReins RFQ form completed in its entirety
2. Most recent 12-24 months of month by month claims and enrollment data
3. Top 25 Drugs by cost
4. Copy of the Summary Plan Description (SPD).

A. TYPE OF QUOTE REQUESTING:

☐ Aggregate Only ☐ Guaranteed Cost ☐ Both Agg Only & Guaranteed Cost

B. REQUESTED BY:

☐ Agent/Broker ☐ TPA ☐ PBM ☐ Other _____ Date: _____

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Mobile: _____

E-mail: _____

C. EMPLOYER INFORMATION:

Company: _____ Type of Industry: _____

Address: _____ No. of Locations: _____

City: _____ State: _____ Zip: _____

Total Eligible Employees: _____ Total Enrolled Employees: _____

Employer's Contribution: _____ % of Employee Cost _____ % of Dependent Cost

Will the Plan(s) cover Retirees? ☐ Yes ☐ No

Will the Plan(s) cover Disabled Persons? ☐ Yes ☐ No

Will the Plan(s) cover Cobra Continuees? ☐ Yes ☐ No

D. NEW PLAN ADMINISTRATION:

Who will be the Plan Administrator? _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

	EE Only	EE + One/Spouse	EE + Child/(ren)	EE + Fam
What is their Admin Fee?	$ _____ /Mo	$ _____ /Mo	$ _____ /Mo	$ _____ /Mo

Who is the PBM: _____

PBM Pricing

Retail:	Generic	MAC ☐	AWP ☐	Discount	_____ %	Dispensing Fee $ _____
	Brand			AWP Discount	_____ %	Dispensing Fee $ _____
Mail:	Generic	MAC ☐	AWP ☐	Discount	_____ %	Dispensing Fee $ _____
	Brand			AWP Discount	_____ %	Dispensing Fee $ _____
Specialty Drug:				AWP Discount	_____ %	Dispensing Fee $ _____

E. REQUESTED COVERAGE:

Proposed Effective Date: _____

(1) Plan Design:

	Retail	Mail
Generic Copay		
(P) Brand Copay		
NP Brand Copay		
Specialty Drug Copay		
Mail Order @	____ Day Supply	
Deductible/Yr		
Benefit Maximum/Yr		
M.O.O.P Maximum/Yr		
Mandatory Generic	☐ Yes	☑ No
Mandatory Mail Maintenance	☐ Yes	☑ No
Step Therapy	☐ Yes	☑ No
Open Formulary	☐ Yes	☑ No
Closed Formulary*	☐ Yes	☑ No
Over-the-Counter	☐ Yes	☑ No

* If checked "Yes", we will require a copy of the Closed Formulary.

(2) Enrolled Employee Census

	EE Only	EE + 1/Spouse	EE + Child/ren	EE + Fam
Under 30				
30 - 39				
40 - 44				
45 - 49				
50 - 54				
55 - 59				
60 - 64				
65 +				
Total	-	-	-	-
				-

Total Total

Female EE's _____ Male EE's _____

Additional plan outlines are available on sheet 2 & 3 of this workbook.
Please utilize for multiple bargaining units.

(3) Covered / Excluded Drugs:

Traditional Drugs		
Diabetic Supplies (including Insulin)	☐ Yes	☐ No
Anti-Acne Agents (to age 35)	☐ Yes	☐ No
Anti-Anxiety Agents	☐ Yes	☐ No
Sexual Dysfunction	☐ Yes	☐ No
Vitamins (not covered under ACA)	☐ Yes	☐ No
Fentanyl Citrate	☐ Yes	☐ No
Oxycontin	☐ Yes	☐ No

Specialty Drugs		
Specialty Drugs are self administered injectable, oral or inhaled drugs for the ongoing treatment of a chronic condition.		
Self Administered Injectables	☐ Yes	☐ No
Oral Chemotherapy/Cancer Agents and Drugs	☐ Yes	☐ No
Fertility Agents	☐ Yes	☐ No
Growth Hormones	☐ Yes	☐ No
HIV/AIDS Agents and Drugs	☐ Yes	☐ No

ACA Medication Included:	☐ Yes	☐ No
Tobacco cessation	Contraceptives (all types)	
Aspirin (men ages 45-79 / women ages 55 to 79)	Supplementation with folic acid	
Folic acid supplements for women who may become pregnant		
Fluoride chemoprevention supplements for children without fluoride in their water source		
Prophylactic medication for gonorrhea (ocular topical medication is covered for all newborns)		
Iron Supplementation (children aged 6 to 12 months or are at increased risk for an iron deficiency)		

F. CURRENT PLAN INFORMATION

Existing Carrier: _____

Renewal Date: _____

	EE Only	EE + 1/Spouse	EE + Child/ren	EE + Fam
Current Enrollment				
Current Premium Rates	$	$	$	$
Renewal Premium Rates	$	$	$	$

Does this plan cover Retirees? ☐ Yes ☐ No

Please attach separately:

1. Most recent 12-24 months claims & enrollment data
2. Top 25 Drugs by cost
3. Existing Summary Plan Description (SPD) or Certificate of Coverage.

Plan Design:	Retail	Mail
Generic Copay		
(P) Brand Copay		
NP Brand Copay		
Specialty Drug Copay		
Mail Order @	____ Day Supply	
Deductible/Yr		
Maximum/Yr		
Mandatory Generic	☐ Yes	☑ No
Mandatory Mail Maintenance	☐ Yes	☑ No
Step Therapy	☐ Yes	☑ No
Open Formulary	☐ Yes	☑ No
Closed Formulary*	☐ Yes	☑ No
Over-the-Counter	☐ Yes	☑ No

COMMENTS, NOTES, ADDITIONAL INFORMATION: