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Group Prescription Drug Plan - Aggregate/Specific Stop Loss Coverage

RxReins. provides 100% Aggregate Stop Loss Insurance for employer paid self-insured freestanding or carve-out group prescription drug plans for employees and/or retirees. Specific Stop Loss Insurance is also available for Specialty Drugs in conjunction with Aggregate Stop Loss Insurance.

Groups of 100 more employees will be considered and there is a Minimum Annual Premium of \$1,500 for all Prescription Plans. Coverage is offered for the incurred and paid periods of 12/12 and 12/13.

The Stop Loss insurers for these programs are "Best" rated Insurance Companies, and our programs are available in all 50 states.

To obtain a quote for Prescription Drug Aggregate and Specific Stop Loss Insurance, please provide the following information.

Thank you.

QUOTE REQUEST FOR AGGREGATE STOP LOSS

A. REQUESTED BY:

Agent/Broker TPA PBM Other _____ Date: _____

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Fax: _____

Mobile: _____ E-mail: _____

B. EMPLOYER INFORMATION:

Company: _____ Type of Industry: _____ SIC Code: _____

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

C. NEW PLAN ADMINISTRATION:

Who will be the Plan Administrator? _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

	EE Only	EE + One	EE + Fam
What is their Admin Fee?	\$ _____ /Mo	\$ _____ /Mo	\$ _____ /Mo
Who is the PBM:	_____		

PBM Pricing

Retail:	Generic	MAC <input type="checkbox"/>	AWP <input type="checkbox"/>	Discount _____ %	Dispensing Fee \$ _____
	Brand			AWP Discount _____ %	Dispensing Fee \$ _____
Mail:	Generic	MAC <input type="checkbox"/>	AWP <input type="checkbox"/>	Discount _____ %	Dispensing Fee \$ _____
	Brand			AWP Discount _____ %	Dispensing Fee \$ _____
Specialty Drug:				AWP Discount _____ %	Dispensing Fee \$ _____

D. 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	\$ _____	
Maximum/Yr	\$ _____	
Mandatory Generic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Open Formulary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Closed Formulary*	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Step Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	

(2) Plan Design:

	Retail	Mail
Generic	\$ _____	\$ _____
(P) Brand	\$ _____	\$ _____
NP Brand	\$ _____	\$ _____
Specialty Drug Copay	\$ _____	\$ _____
Mail Order @ _____	Day Supply	
Deductible/Yr	\$ _____	
Maximum/Yr	\$ _____	
Mandatory Generic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Open Formulary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Closed Formulary*	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Step Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

(3) Enrolled Employee Census

	EE Only	EE + One	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 _____		

(4) Covered Drugs to INCLUDE:

Diabetic Supplies (including Insulin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-Acne Agents (to age 35)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prenatal Vitamins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contraceptives (Oral, Patches, Rings)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-Anxiety Agents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoking Deterrents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vitamins - All	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fertility Agents (Oral)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Specialty Drugs:		
Self Administered Injectables	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biotech Agents and Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fentanyl Citrate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy/Cancer Agents and Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Growth Hormones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia Agents and Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/AIDS Agents and Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please attach additional sheets for Multiple Bargaining Units.

E. CURRENT PLAN INFORMATION

Existing Carrier: _____

Renewal Date: _____

	EE Only	EE + One	EE + Fam
Current Enrollment			
Current Premium Rates	\$ _____	\$ _____	\$ _____
Renewal Premium Rates	\$ _____	\$ _____	\$ _____
Does this plan cover Retirees?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Open Formulary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Closed Formulary*	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Step Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please attach, on a separate sheet, the most recent month by month claims experience and the existing Summary Plan Document (SPD) or Certificate of Coverage.

F. EMPLOYEE ELIGIBILITY

An eligible FULL TIME employee is defined as:
working _____ hours per week, or Other _____

An eligible PART TIME employee is defined as:
working _____ hours per week, or Other _____

The initial waiting period:
(a) for current employees on effective date is None , or Other _____
(b) for future employees is _____ month(s) , or _____ days, or
Other _____

New Hires to be effective on the first of the month following waiting period Yes No , or
Other _____

Retiree Eligibility: Yes No
If Yes, Detail Eligibility _____

G. CONTINUING COVERAGE

Continuing coverage due to absence from work will be as follows:

<u>For Absence due to</u>	<u>Maximum Continuation Period</u>
Temporary Layoff	_____ Month(s)
Approved Leave of Absence	_____ Month(s)
Part-time Employment	_____ Month(s)
Injury or Sickness	_____ Month(s)

H. DEPENDENT ELIGIBILITY

An eligible dependent is defined as an eligible employee's
Spouse Yes No
Domestic Partner Yes No
Unmarried children from _____ to age _____ and each unmarried child to age _____ who is a full time student. A full time student is one who is enrolled for _____ semester hours for credit in an accredited junior college, college or university.

COMMENTS, NOTES, ADDITIONAL INFORMATION:

