

Small-Group Proposal Request – Connecticut Plans

This form must be filled out completely to prevent delays in processing your proposal. Please **fax to (860) 674-2011** or mail: Small-Group Sales Department, 175 Scott Swamp Road, Farmington, CT 06034-4050.

Today's Date: _____ Date Needed: _____ (allow 5 days) Your ConnectiCare Rep: _____ (if known)

I. Agent Information

Agent Name _____ Email Address _____
 Agency Name _____ Tel./Fax _____
 Street _____ City _____ State _____ Zip _____

II. Prospect Information

Company Name _____ Effective Date _____
 Street _____ City _____ State _____ Zip _____
 (must complete for correct Region rating)
 SIC Code _____ # Of Eligible Employee(s) _____

III. Rating

Composite Rated (Groups 25-50 in CT) List Rated (CT groups only)

IV. Requested Plans (call CIT at 1-800-953-4467 for quoting Chamber plans)

Connecticut HMO Plans (Calendar Year)	In-Network Upfront Deductible	In-Network Hospital Cost Share
<input type="checkbox"/> HMO-0A-10-20-AHOA	N/A	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-15-25-AHOA	N/A	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-20-30-AACA	N/A	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-20-30-AADA	N/A	\$500/day \$2,000 max.
<input type="checkbox"/> HMO-0A-30-45-AAHA	N/A	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-30-45-AADA	N/A	\$500/day \$2,000 max.
<input type="checkbox"/> HMO-0A-15-25-DHQA	N/A	\$1,500 deductible
<input type="checkbox"/> HMO-0A-20-30-DHRA	N/A	\$2,500 deductible
<input type="checkbox"/> HMO-0A-30-45-DHQA	N/A	\$1,500 deductible
<input type="checkbox"/> HMO-0A-30-45-DHRA	N/A	\$2,500 deductible
<input type="checkbox"/> HMO-0A-30-45-DHSA	N/A	\$5,000 deductible
<input type="checkbox"/> HMO-0A-30-45-UAJA	\$1,500/\$3,000	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-30-45-UAFA	\$2,500/\$5,000	\$100/day \$500 max.
<input type="checkbox"/> HMO-0A-30-45-UAGA	\$5,000/\$10,000	\$100/day \$500 max.

Connecticut POS Plans (Calendar Year)	In-Network Hospital Cost Share	Out-of-Network Deductible
<input type="checkbox"/> POS-0A-10-20-AHNA	\$100/day \$500 max.	\$500/\$1,500
<input type="checkbox"/> POS-0A-15-25-AHNA	\$100/day \$500 max.	\$500/\$1,500
<input type="checkbox"/> POS-0A-20-30-AAXA	\$100/day \$500 max.	\$750/\$2,250
<input type="checkbox"/> POS-0A-20-30-AHPA	\$500/day \$2,000 max.	\$2,000/\$6,000
<input type="checkbox"/> POS-0A-30-45-AAYA	\$500/day \$2,000 max.	\$2,000/\$6,000
<input type="checkbox"/> POS-0A-15-25-DAUA	\$1,500/\$3,000	\$2,500/\$7,500
<input type="checkbox"/> POS-0A-20-30-DAWA	\$2,500/\$5,000	\$3,500/\$10,500
<input type="checkbox"/> POS-0A-30-45-DAUA	\$1,500/\$3,000	\$2,500/\$7,500
<input type="checkbox"/> POS-0A-30-45-DAWA	\$2,500/\$5,000	\$3,500/\$10,500

Connecticut POS Plans (Contract Year)	In-Network Upfront Deductible	Out-of-Network Deductible
<input type="checkbox"/> POS-0A-30-45-UJJA	\$1,500/\$3,000	\$2,500/\$7,500
<input type="checkbox"/> POS-0A-30-45-UJKA	\$2,500/\$5,000	\$3,500/\$10,500

Pharmacy Options — One per Benefit Plan		
<input type="checkbox"/> \$10/\$20/\$35	<input type="checkbox"/> \$15/\$30/\$40	<input type="checkbox"/> \$200 Deductible-\$15/\$30/\$40

Connecticut FlexPOS Plans (Contract Year)	In-Network Hospital Cost Share	Out-of-Network Deductible
<input type="checkbox"/> FlexPOS-20-30-500-500D	\$500/day \$2,000 max.	\$2,000/\$6,000
<input type="checkbox"/> FlexPOS-30-45-500-500D	\$500/day \$2,000 max.	\$2,000/\$6,000
<input type="checkbox"/> FlexPOS-20-35-2500H	\$2,500/\$5,000	\$3,500/\$10,500
<input type="checkbox"/> FlexPOS-30-45-1500H	\$1,500/\$3,000	\$2,500/\$7,500

Connecticut FlexPOS Plans (Contract Year)	In-Network Hospital Cost Share	Out-of-Network Deductible
<input type="checkbox"/> FlexPOS-30-45-250/500-80%	\$250/\$500	\$1,000/\$2,000
<input type="checkbox"/> FlexPOS-30-45-500/1000-80%	\$500/\$1,000	\$1,000/\$2,000
<input type="checkbox"/> FlexPOS-30-45-750/1500-80%	\$750/\$1,500	\$2,000/\$4,000
<input type="checkbox"/> FlexPOS-30-45-1000/2000-80%	\$1,000/\$2,000	\$2,500/\$5,000

Pharmacy Option		
<input type="checkbox"/> \$15/\$30/\$40 (50% Out-of-Network Coinsurance)		

HSA Compatible Plans (Calendar Year)	In-Network Upfront Deductible	Out-of-Network Deductible	In-Network Pharmacy Drug Cost Share
<input type="checkbox"/> HMO-0A-00-00 HEVI/HEWF	\$1,500/\$3,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> HMO-0A-00-00 HEZI/HFAF	\$2,500/\$5,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> HMO-0A-00-00 HFBI/HFCF	\$3,500/\$7,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> HMO-0A-00-00 HFDI/HFEF	\$5,000/\$10,000	N/A	100%
<input type="checkbox"/> POS-0A-00-00 HDZI/HEAF	\$1,500/\$3,000	\$2,500/\$5,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-00-00 HEDI/HEEF	\$2,500/\$5,000	\$4,000/\$8,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-00-00 HEHI/HEIF	\$3,500/\$7,000	\$5,000/\$10,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-00-00 HEJI/HEKF	\$5,000/\$10,000	\$7,500/\$15,000	100%

HSA Compatible Plans (Contract Year)	In-Network Upfront Deductible	Out-of-Network Deductible	In-Network Pharmacy Drug Cost Share
<input type="checkbox"/> HMO-0A-00-00 HIKI/HILF	\$2,000/\$4,000	N/A	100%
<input type="checkbox"/> HMO-0A-30-45 HGZI/HHAF	\$1,500/\$3,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> HMO-0A-30-45 HHBI/HHCF	\$2,000/\$4,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> HMO-0A-30-45 HHDI/HHEF	\$2,500/\$5,000	N/A	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-00-00 HGRI/HGSF	\$1,500/\$3,000	\$2,500/\$5,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-30-45 HHFI/HHGF	\$1,500/\$3,000	\$3,000/\$6,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-30-45 HHHI/HHIF	\$2,000/\$4,000	\$4,000/\$8,000	\$15/\$25/\$40
<input type="checkbox"/> POS-0A-30-45 HHJI/HHKF	\$2,500/\$5,000	\$5,000/\$10,000	\$15/\$25/\$40
<input type="checkbox"/> FlexPOS-HSA 2000/HSA 4000	\$2,000/\$4,000	\$4,000/\$8,000	100%/50% (00N)

ConnectiCare Dental Plans: CT Domiciled Only (For groups with 5 or more employees)	
NETWORK	
<input type="checkbox"/> Value <input type="checkbox"/> Plus <input type="checkbox"/> Premium	
PLAN	
<input type="checkbox"/> \$1,000 benefit maximum <input type="checkbox"/> \$1,500 benefit maximum (10+ ees only.)	
<input type="checkbox"/> Basic Plan (10+ ees only.) <input type="checkbox"/> 5-9 employee plan	
<input type="checkbox"/> with orthodontia (10+ ees only.) Not applicable to Basic Plan.	
DOMESTIC PARTNER (Dental only)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Note: Affidavit must be received with paperwork.	

