Regence

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Group Name: Effective Date:
Agent:

**Employee Choice Benefit Selection Form Groups 1-50**

| Group number(s) | Group Name | Effective Date |
|---|---|---|
| | | |

**Instructions:** Select grouping number, network(s), and plans from quote number #_____.

**Employee Choice Grouping #_____**

**Select Network(s)** − choose up to three networks:

☐ 1. Preferred ValueCare ☐ 2. Preferred FocalPoint ☐ 3. Participating

**Select Plan(s):** – choose up to five plans:

| |
|---|
| ☐ A. **Platinum:** In Network − $25 Prim/$45 Spec Copay, $500 Ded, 80% Coins, $1,400 OOPM, Pharmacy: $5 / $30 / 50% / 50%, OOP Max Combined with Medical (All Tiers Ded waived) |
| ☐ B. **Gold 500:** In Network − $25 Prim/$45 Spec Copay, $500 Ded, 80% Coins, $5,000 OOPM, Pharmacy: $10 / $40 / 50% / 50%, OOP Max Combined with Medical (All Tiers Ded waived) |
| ☐ C. **Gold+:** In Network − $25 Prim/$45 Spec Copay, $1,000 Ded, 80% Coins, $3,500 OOPM, Pharmacy: $10 / $40 / 50% / 50%, OOP Max Combined with Medical (All Tiers Ded waived) |
| ☐ D. **Gold:** In Network − $25 Prim/$45 Spec Copay, $1,500 Ded, 80% Coins, $3,500 OOPM, Pharmacy:$10 / $40 / 50% / 50%, OOP Max Combined with Medical (All Tiers Ded waived) |
| ☐ E. **Gold Simple:** In Network − $0 Prim/$0 Spec Copay, $0 Ded, 75% Coins, $6,000 OOPM, Pharmacy:25% / 25% / 25% / 50%, OOP Max Combined with Medical (After Ded) |
| ☐ F. **Gold HSA:** In Network − $20 Prim/$30 Spec Copay after Ded, $1,400 Ind / $2,800 Family Ded, 80% Coins, $2,300 OOPM, Pharmacy: 10% / 20% / 50% / 50%, OOP Max Combined with Medical (After Ded) |
| ☐ G. **Silver+:** In Network − $30 Prim/$45 Spec Copay, $1,750 Ded, 70% Coins, $6350 OOPM, Pharmacy: $10 / $40 / 50% / 50%, OOP Max Combined with Medical (Tier 1, 2 & 3 Ded waived) |
| ☐ H. **Silver:** In Network − $30 Prim/$45 Spec Copay, $2,000 Ded, 70% Coins, $6,350 OOPM, Pharmacy: $10 / $40 / 50% / 50%, OOP Max Combined with Medical (Tier 1, 2 & 3 Ded waived) |
| ☐ I. **Silver Simple:** In Network − $0 Prim/$0 Spec Copay, $0 Ded, 50% Coins, $6,000 OOPM, Pharmacy: 50% / 50% / 50% / 50%, OOP Max Combined with Medical (After Ded) |
| ☐ J. **Silver HSA:** In Network − $20 Prim/$30 Spec Copay after Ded, $2,000 Ind / $4,000 Family Ded, 70% Coins, $4,400 OOPM, Pharmacy: 25% / 35% / 50% / 50%, OOP Max Combined with Medical (After Ded) |
| ☐ K. **Silver HSA 100%:** In Network − $0 Prim/$0 Spec Copay, $3,500 Ded, 100% Coins, $3,500 OOPM, Pharmacy: 100% / 100% / 100% / 100%, OOP Max Combined with Medical (After Ded) |
| ☐ L. **Bronze+:** In Network − $3,000 Ded, 50% Coins, $6,250 OOPM, Pharmacy: $15 / 50% / 50% / 50%, OOP Max Combined with Medical (Tier 1 Ded waived) |

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| |
|---|
| ☐ M. **Bronze HSA+:** In Network − $20 Prim/$30 Spec Copay after Ded, $2,750 Ind / $5,500 Family Ded, 50% Coins, $6,250 OOPM, Pharmacy: 50% / 50% / 50% / 50%, OOP Max Combined with Medical (After Ded) |
| ☐ N. **Bronze HSA:** In Network − $20 Prim/$30 Spec Copay after Ded, $5,000 Ind / $10,000 Family Ded, 80% Coins, $6,000 OOPM, Pharmacy: 25% / 35% / 50% / 50%, OOP Max Combined with Medical (After Ded) |

I acknowledge all selected benefit plans and networks have been indicated on this form. Each medical plan chosen will be offered with every selected network. Rates associated with these benefits are detailed on the rate sheets in quote #_____. I understand any options not specifically checked have not been selected and will not be included in the policy. I agree to the effective date of coverage as indicated in this document.

Group Authorized Signature: _____

Official Title: _____ Date: _____

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**Employee Choice Enrollment Form (Group 1-50)**

**Important note:**If a new employee is enrolling or an existing employee is making any change to enrollment such as adding a spouse/dependent, waiving an already enrolled spouse/dependent, or termination of coverage, this form cannot be used. An Application for Enrollment/Change form must be submitted.

| Employee's Name | Network Choice (1–3) | Plan Choice (A–N) | Employee's Name | Network Choice (1–3) | Plan Choice (A–N) |
|---|---|---|---|---|---|
| 1. | | | 26. | | |
| 2. | | | 27. | | |
| 3. | | | 28. | | |
| 4. | | | 29. | | |
| 5. | | | 30. | | |
| 6. | | | 31. | | |
| 7. | | | 32. | | |
| 8. | | | 33. | | |
| 9. | | | 34. | | |
| 10. | | | 35. | | |
| 11. | | | 36. | | |
| 12. | | | 37. | | |
| 13. | | | 38. | | |
| 14. | | | 39. | | |
| 15. | | | 40. | | |
| 16. | | | 41. | | |
| 17. | | | 42. | | |
| 18. | | | 43. | | |
| 19. | | | 44. | | |
| 20. | | | 45. | | |
| 21. | | | 46. | | |
| 22. | | | 47. | | |
| 23. | | | 48. | | |
| 24. | | | 49. | | |
| 25. | | | 50. | | |

**NOTICE TO GROUP:** By providing this form you acknowledge that you are accepting responsibility for making eligibility determinations. We will rely upon the information transmitted by you to Regence being accurate and in compliance with your Group contract. All applicable documentation (i.e. applications, certifications, marriage, divorce records, etc.) must be obtained and retained. These documents must be made available for our review and audit upon request. We reserve the right to audit at any time.

Group Authorized Signature: _____

Official Title: _____ Date: _____