FAX FROM:

SCADA
South Carolina Automobile Dealers Association
526 Hampton Street, Columbia, S.C. 29201
803-252-0205 Fax 803-252-5965

To: All SCADA Dealer/Members

Subject: SCADA/BCBS Health Insurance Plan

I would like to let you know that the SCADA Health Insurance Program currently offers six plans with various deductibles and co-payments underwritten by Blue Cross & Blue Shield of S.C.. If you would like for me to obtain a quote for you, please complete the requested information to the best of your knowledge. Your employee census should include: name, date of birth, date of hire, and type of coverage (emp, emp/sp, emp/ch, family). The census should include all employees, even if they do not participate in your current plan. We will also need a copy of your current billing and a plan description. Please fax this information to me at 803-252-5965.
If you currently have coverage with BCBS of S.C. or Blue Choice we will not be able to obtain a quote for you.

If you have any questions please call me.

Current Plan Description

Deductible: _____ Max out of Pocket:_____

Co-Insurance: 80%/20% or 70%/30% or 60%/40% or 50%/50%

Doctor Visit Co-Pay:_____ Specialist Co-Pay:_____

Drug Plan:_____

BlueCross BlueShield of South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Associations Request for Proposal

Association Requesting Proposal SCADA

Producer Requesting Proposal Tom Cordan

Producer Contact #'s 803-252-0205 fax: 252-5965

Prospect Information:

Prospect Name _____

Type of Business _____

Contact & Title _____ (Name) _____ (Title)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (PO Box) _____ (City) _____ (State) _____ (Zip)

Contact #'s _____ (Phone) _____ (FAX)

Employer Premium Contribution _____ (Toward Single Cost) _____ (Toward Dependent (if Different))

Waiting Period for New Hires _____

Carrier Information:

Current Carrier Name _____

Renewal Date _____

Rates:	Current	Renewal
Single		
Employee & Child		
Employee & Spouse		
Family		

REQUIRED

Please provide a copy of the current schedule of benefits from the current carrier's benefit booklet. These are the 1 to 4 pages that show the deductible, copays, coinsurance, out-of-pocket limits, etc.

Total # of employees (full & part time) _____

Total # of full-time (30 hours/wk, 48 wks/yr) _____

Total # of part time employees _____

Total # of full-time employees covered by Medicare _____

Total # of employees in waiting period _____

Total # of employees refusing coverage _____

Total # of full-time employees not actively at work _____

Total # of employees currently enrolled in health plan _____

Please attach an employee listing showing: Date of birth, Sex, Currently enrolled type of coverage (i.e. – single, employee & child, employee & spouse or family)

For employers over 100 employees, please provide claims experience.

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Employer Supplemental Information

It is necessary for Blue Cross Blue Shield of South Carolina to obtain certain information in order to issue a proposal for group coverage. Please complete the following to the best of your knowledge.

		YES	NO
1.	Did any employee or dependent suffer a condition which resulted in a claim of $10,000 or more during the last 12 months?	___	___
2.	Are there any employees or dependents who have been or expect to be treated for a serious medical condition?	___	___
3.	Is any dependent child over age 19 incapable of self-support because of a physical or mental disability?	___	___
4.	How many employees and/or dependents are being covered under COBRA continuation? _____		
	To your knowledge, are there any serious medical problems on this group of COBRA continuation insureds?	___	___
	Is anyone presently covered under COBRA totally disabled?	___	___
5.	Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full-time?	___	___
6.	Are any employees or dependents presently disabled? *		
	* For an employee: he or she is absent from work due to injury or illness; * For a dependent: he or she is unable to perform the usual and customary activities of a person of like age and sex in good health.	___	___
7.	Carriers for the last five (5) years and length of time with each carrier:		

_____

_____

If any of the above questions were "YES", please explain below (write the question number and give details):

_____

_____

_____

Employer:_____ Date:_____

Signature of Applicant: _____ Title:_____

Signature of Agent or Record:_____

Rev. 2/05

South Carolina

SOUTH CAROLINA AUTOMOBILE DEALERS ASSOCIATION

Benefits Proposed for January 1, 2011

	Plan 1	Plan 1 Core Option	Plan 2	Plan 2 Core Option	Plan 3	Plan 3 Core Option
Deductible 2 per Family	$500	$1,500	$1,000	$2,000	$2,500	$3,500
Max Out of Pocket 2 per Family	$2,000	$3,000	$2,500	$4,000	$5,000	$7,000
Coinsurance	80% network/60% other	50% network/50% other	70% network/50% other	50% network/50% other	70% network/50% other	50% network/50% other
Copay Per Admission	$100 network/$200 other	$100 network/$200 other	$200 network/$300 other	$200 network/$300 other	$500 network/$750 other	$500 network/$750 other
Generalist Office Visit	$25 Copay	$25 Copay	$30 Copay	$30 Copay	$30 Copay	$30 Copay
Specialist Office Visit	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Preventive	$25 Copay then $200 Annual Max Benefit	$25 Copay then $200 Annual Max Benefit	$30 Copay then $200 Annual Max Benefit	$30 Copay then $200 Annual Max Benefit	$30 Copay then $200 Annual Max Benefit	$30 Copay then $200 Annual Max Benefit
Prescription Drugs Retail 31 Day Supply Mail-Order $20/$80/$140	$10 Generic $35 Name Brand $55 Non-Preferred	$10 Generic $35 Name Brand $55 Non-Preferred	$10 Generic $35 Name Brand $55 Non-Preferred	$10 Generic $35 Name Brand $55 Non-Preferred	$10 Generic $35 Name Brand $55 Non-Preferred	$10 Generic $35 Name Brand $55 Non-Preferred
Emergency Room	80% network/60% other	50% network/50% other	70% network/50% other	50% network/50% other	70% network/50% other	50% network/50% other
Emergency Room Copay	$75 + Ded & Max waived if admitted	$75 + Ded & Max waived if admitted	$75 + Ded & Max waived if admitted	$75 + Ded & Max waived if admitted	$75 + Ded & Max waived if admitted	$75 + Ded & Max waived if admitted

RATES:

Employee						
Family						
Employee/Child						
Employee/Spouse						

Note: rates include $10,000 life and ad&d insurance for each employee and $5000 life insurance for each dependent.