of Tennessee
plans for better health. plans for a better life.™

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Chattanooga, TN 37402

bcbst.com

Renewal Alternate Request Form

- **Confidential** -

For Use With Groups 2-149 Enrolled

Group Name	
Group No.	
Effective Date	
Account Manager	
Broker Name	
Fax No.	

All Multi Option Plans, Limits on the Number of Options, Riders and Price Differentials Apply

Traditional Plans

Indiv Ded	Indiv OOP
$100	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
$250	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
$500	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000
$750	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000
$1,000	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000
$1,500	☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000 ☐ $8,000
$2,000	☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000 ☐ $8,000
$2,500	☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000 ☐ $8,000
$3,000	☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000 ☐ $8,000
$4,000	☐ $4,000 ☐ $5,000 ☐ $6,000 ☐ $8,000
$5,000	☐ $5,000 ☐ $6,000 ☐ $8,000

Coins: ☐ 90% ☐ 80% ☐ 70%

($10 & $15 Copays Not Available with Deductibles > $1,000)

OV Copay: ☐ Ded/Coins ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35

($15/30 & $15/35 Copays Not Available with Deductibles > $1,000)

Split OV Copay: ☐ $15/30 ☐ $15/35 ☐ $20/35 ☐ $20/40 ☐ $25/40 ☐ $25/45 ☐ $25/50 ☐ $30/45 ☐ $30/50

$500 Special Accident*: ☐ Yes ☐ No ***(*Not Available with ER Copay)***

OP Surgery: ☐ Ded / Coins ☐ 100% / No Ded

ER: ☐ Ded/Coins ☐ $250 Copay

HSA Qualified – High Deductible Health Plans (In Network)

Shared Deductible Plans

Plan	Self-Only In Ded	Family In Ded	Self-Only In OOP	Family In OOP	In Co-Ins.
☐ HDHP Plan 1	$1,200	$2,400	$2,500	$5,000	80%
☐ HDHP Plan 2	$1,700	$3,400	$3,500	$7,000	80%
☐ HDHP Plan 3	$2,500	$5,000	$2,500	$5,000	100%
☐ HDHP Plan 4	$2,500	$5,000	$4,000	$8,000	80%
☐ HDHP Plan 5	$3,000	$6,000	$5,000	$10,000	80%
☐ HDHP Plan 6	$3,000	$6,000	$3,000	$6,000	100%
☐ HDHP Plan 7	$4,000	$8,000	$4,000	$8,000	100%
☐ HDHP Plan 8	$5,000	$10,000	$5,000	$10,000	100%

Embedded Deductible Plans

Plan	Self-Only In Ded	Family In Ded	Self-Only In OOP	Family In OOP	In Co-Ins.
☐ HDHP Plan 3-ED	$2,500	$5,000	$2,500	$5,000	100%
☐ HDHP Plan 4-ED	$2,500	$5,000	$4,000	$8,000	80%
☐ HDHP Plan 5-ED	$3,000	$6,000	$5,000	$10,000	80%
☐ HDHP Plan 6-ED	$3,000	$6,000	$3,000	$6,000	100%
☐ HDHP Plan 7-ED	$4,000	$8,000	$4,000	$8,000	100%

☐ HDHP Plan 8-ED	$5,000	$10,000	$5,000	$10,000	100%

Pharmacy Riders *(Standard RX Formulary Only):*

☐ Ded/Coins *☐ Ded/Coins w / Preventive Drug List Copay - $5 / $25 / $50

☐ No Pharmacy Coverage – Blue Perks Pharmacy Discount

Smart Consumer Plans *

	Individual Deductible	Individual Out-of-Pocket	Coinsurance
☐	$,500	$1,500	70%
☐	$750	$2,250	70%
☐	$1,000	$3,000	70%
☐	$1,500	$4,500	70%
☐	$2,000	$6,000	70%

Copay PPO Plans (In Network)

	Plan	Office Visit In Network	Inpatient Hospital	Individual OOP
☐	10/100/70	$10 OV	$100	$1,250
☐	10/200/60	$10 OV	$200	$1,500
☐	15/400/70	$15 OV	$400	$2,000
☐	20/500/60	$20 OV	$500	$2,000
☐	25/750/60	$25 OV	$750	$2,500
☐	30/1000/60	$30 OV	$1,000	$3,000
☐	35/1200/60	$35 OV	$1,200	$3,500

Network Options: ☐ P ☐ S ☐ K

Optional Coverages & Services

Pharmacy – (Complete if Quoting Traditional, Copay and/or Smart Consumer Plans –Other Plans Include Pharmacy)

****NOTE: The Limited RX Formulary differs from other drug formularies in that it may:**

1) exclude certain prescription drugs that have an over-the-counter alternative;
2) cover only generic equivalents or therapeutic alternatives for certain classes of prescription drugs; and
3) include Step Therapy procedures.

Pharmacy Riders:

☐ Ded/Coins ☐ $10/35 ☐ $10/20/40 ☐ $10/35/50 ☐ $8/40/60 ☐ $8/35/70

☐ $10/35/50 after $200 Brand-Only Ded

☐ $10/50% with $4000 OOP Max ☐ 50% with $4000 OOP Max

☐ No Pharmacy Coverage – Blue Perks Pharmacy Discount

RX Formulary **:

☐ Standard

☐ Limited

Behavioral Health Riders-*(Complete if Quoting Traditional, Copay and/or Smart Consumer Plans–Other Plans Include Behavioral Health)*
(Mandatory for Groups 25 +)

☐ 20 IP Days / 25 OP Visits

☐ 30 IP Days / 30 OP Visits

☐ None

☐ Parity *(Mandatory if group>50. Includes all FT, PT & avg. seasonal regardless if covered under this policy.)*

Well Care Rider - *(Complete if Quoting Traditional or CopayPlans - Other Plans Include Well Care)*

☐ Same as OV Copay

☐ None

☐ $20 Copay Preventive (Avail with Ded/Coins OV Only)

4th Qtr Ded Carryover - *(Complete if Quoting Traditional, Copay and/or Smart Consumer Plans) (Not Available with HRA Plans)*

☐ Included ☐ Excluded

Vision

☐ Vision 1: Exam Only

☐ Vision 2: Exam & Hardware

☐ None

COBRA Administration

☐ No ☐ Yes – With Initial Notification Letter ☐ Yes – Without Initial Notification Letter

☐ No ☐ Yes–*Administer Other Carrier Products in the Group?*

If "Yes," # of Other Carriers? __________

☐ **HRA**

The monthly HRA administrative fee is $3.00 per subscriber (or $4.00 with Debit Card)
(HRA fee not included in the total premium rate).

☐ **FSA Quote Request**

Request will be sent separately, not as part of your medical options requested. The monthly FSA administrative fee is $4.00 per subscriber (or $5.00 with Debit Card). (FSA fee not included in the total premium rate).

Additional Notes Regarding Plans Requested – Explain Below:

DentalBlue

1. **If a group has current dental coverage, it is preferred you submit a copy of the current and renewal rates and benefits. We will provide a quote(s) with benefits and reimbursement arrangements as close to current as our plans allow.**

   ☐ Current benefits included

2. **Deductible**: Individual: ☐ $0 ☐ $25 ☐ $50

   Family: ☐ 3 per family ☐ Per Covered Member

3. **Annual Maximum:** ☐ $500 ☐ $1,000 ☐ $1,250 ☐ $1,500

4. **Exclude Class A from Annual Maximum:** ☐ Yes ☐ No

5. **In-Network Coinsurance:**

   Coverage A: ☐ 100% ☐ 80%

   Coverage B: ☐ 100% ☐ 90% ☐ 80% ☐ 50%

   Coverage C: ☐ 80% ☐ 60% ☐ 50% ☐ 10% ☐ 0%

6. **Major Endodontics, Major Periodontics, Major Oral Surgery – To Be Covered Under Coverage:**

   Major Endodontics: ☐ B ☐ C *(available for 10+ enrolled only)*

   Major Periodontics: ☐ B ☐ C *(available for 10+ enrolled only)*

   Major Oral Surgery: ☐ B ☐ C *(available for 10+ enrolled only)*

7. **Orthodontics:** ☐ Yes ☐ No

   Lifetime Max: ☐ $1,000 ☐ $1,500

   Age Limit: ☐ Child ☐ No Age Limit *(available for 26+ enrolled)*

   Waiting Period: ☐ Yes ☐ No *(available for 10+ enrolled only)*

8. **Reimbursement Options:**

   ☐ **Preferred** - The plan design the same in and out of network; penalties of large balance billing when out-of-network providers are used.

   ☐ **Choice** - The plan design the same in and out of network; allowable charges for out-of-network subject to reasonable and customary; minimal balance billing.

   ☐ **Choice Plus** - This option includes a 10 percent coinsurance differential for coverage class B and C; minimal balance billing.

9. **High Deductible Dental Plan:** 100/70/70 **Individual Deductible:** $250 **Annual Max:** $2,500 ☐

   Family Deductible: ☐ 2 x Individual ☐ 3 x Individual

   Preventive Copay: ☐ $0 ☐ $10 ☐ $25

   Orthodontics: ☐ Yes ☐ No *(age limit to 18 and $1,000 LTM)*

   Orthodontics Waiting Period: ☐ Yes ☐ No

   Reimbursement Options:

   ☐ Preferred

   ☐ Choice

   ☐ Choice Plus

VisionBlue

1. **Total Participating in Vision:** _____
2. **Employer Contribution:** _____%
3. **Exam Copay:** ☐ **$10** ☐ **$20** ☐ **Exam Only Option**
4. **Materials Copay:** ☐ **$10** ☐ **$25**
5. **Materials Allowance:** ☐ **Low** ☐ **Standard** ☐ **Premium**
6. **Frame Frequency:** ☐ **Every 12 months** ☐ **Every 24 months**

Group Life Products

Group Life Quote: **Employer Contribution: _____%**

(Life amounts of up to $150,000 may be quoted according to job classification, a multiple of salary, or a flat amount)

All Guarantee Issue Guidelines Apply

☐ **Flat Amount**

☐ $25,000 ☐ $35,000 ☐ Other: $ _____

☐ **Job Classification:**

Class I _____ Class II _____ Class III _____ Class IV _____

☐ **Multiple of Salary:** *(Salary must be provided for this option)*

1X Salary _____ 2X Salary _____ Other _____

Group Dependent Life: **Employer Contribution:** _____%

☐ $10,000 Spouse	$ 5,000 Child	$100 - 15 Days to 6 Months
☐ $ 7,500 Spouse	$ 5,000 Child	$100 - 15 Days to 6 Months
☐ $ 5,000 Spouse	$ 2,500 Child	$100 - 15 Days to 6 Months
☐ $ 2,000 Spouse	$ 1,000 Child	$100 - 15 Days to 6 Months

Group Short-term Disability: **Employer Contribution:** _____%

Plan Options:

☐ **1-8-13** ☐ **1-8-26** ☐ **8-8-13** ☐ **8-8-26**

Benefit Amount:

☐ **Flat Amount $** _____ / Week (***Provide salary for amount greater than $150 weekly)***

☐ **% of Salary** _____% ***(Please provide salary)***

Group Long-term Disability: ☐ **Yes** ***(If "Yes," your Account Sales Executive will contact you.)***

☐ **Flexible Spending (Section 125)** ☐ **Employee Assistance Program (EAP)**

Voluntary Products *(Employer contribution not required if 10% of employees live outside of Tennessee. Please provide zip codes if possible).*

Dental:

☐ **(Prime Plan with and without Ortho and Choice plan will be quoted)**

Life:

☐ With Portability ☐ Without Portability *(Standard is with Portability)*

Short-term Disability:

☐ **1-8-13** ☐ **1-8-26** ☐ **1-8-52** ☐ **15-15-13** ☐ **15-15-26** ☐ **15-15-52**

Continuity rates requested? ☐ **Yes** ☐ **No**

Long-term Disability:

Elimination Period: ☐ 90-Day ☐ 180-Day

Benefit Period: ☐ 5-Year 2-Year ☐ 5-Year 5-Year ☐ To Age 65

Specialty Products:

☐ Cancer Care ☐ Accident Guard ☐ Cardiac Care ☐ Intensive Care ☐ Critical Illness ☐ Mini-Med

☐ Vision ☐ Long-term Care

Rate Selection for Payroll Deduction: ☐ **Weekly** ☐ **Monthly** ☐ **24-Pays** ☐ **26-Pays**