



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

1 Cameron Hill Circle
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.
<input type="checkbox"/> HDHP Plan 1	\$1,200	\$2,400	\$2,500	\$5,000	80%
<input type="checkbox"/> HDHP Plan 2	\$1,700	\$3,400	\$3,500	\$7,000	80%
<input type="checkbox"/> HDHP Plan 3	\$2,500	\$5,000	\$2,500	\$5,000	100%
<input type="checkbox"/> HDHP Plan 4	\$2,500	\$5,000	\$4,000	\$8,000	80%
<input type="checkbox"/> HDHP Plan 5	\$3,000	\$6,000	\$5,000	\$10,000	80%
<input type="checkbox"/> HDHP Plan 6	\$3,000	\$6,000	\$3,000	\$6,000	100%
<input type="checkbox"/> HDHP Plan 7	\$4,000	\$8,000	\$4,000	\$8,000	100%
<input type="checkbox"/> 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.
<input type="checkbox"/> HDHP Plan 3-ED	\$2,500	\$5,000	\$2,500	\$5,000	100%
<input type="checkbox"/> HDHP Plan 4-ED	\$2,500	\$5,000	\$4,000	\$8,000	80%
<input type="checkbox"/> HDHP Plan 5-ED	\$3,000	\$6,000	\$5,000	\$10,000	80%
<input type="checkbox"/> HDHP Plan 6-ED	\$3,000	\$6,000	\$3,000	\$6,000	100%
<input type="checkbox"/> HDHP Plan 7-ED	\$4,000	\$8,000	\$4,000	\$8,000	100%

<input type="checkbox"/> HDHP Plan 8-ED	\$5,000	\$10,000	\$5,000	\$10,000	100%
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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
<input type="checkbox"/>	\$,500	\$1,500	70%
<input type="checkbox"/>	\$750	\$2,250	70%
<input type="checkbox"/>	\$1,000	\$3,000	70%
<input type="checkbox"/>	\$1,500	\$4,500	70%
<input type="checkbox"/>	\$2,000	\$6,000	70%

Copay PPO Plans (In Network)

	Plan	Office Visit In Network	Inpatient Hospital	Individual OOP
<input type="checkbox"/>	10/100/70	\$10 OV	\$100	\$1,250
<input type="checkbox"/>	10/200/60	\$10 OV	\$200	\$1,500
<input type="checkbox"/>	15/400/70	\$15 OV	\$400	\$2,000
<input type="checkbox"/>	20/500/60	\$20 OV	\$500	\$2,000
<input type="checkbox"/>	25/750/60	\$25 OV	\$750	\$2,500
<input type="checkbox"/>	30/1000/60	\$30 OV	\$1,000	\$3,000
<input type="checkbox"/>	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:

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

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: _____%
<input type="checkbox"/> \$10,000 Spouse	\$ 5,000 Child	\$100 - 15 Days to 6 Months
<input type="checkbox"/> \$ 7,500 Spouse	\$ 5,000 Child	\$100 - 15 Days to 6 Months
<input type="checkbox"/> \$ 5,000 Spouse	\$ 2,500 Child	\$100 - 15 Days to 6 Months
<input type="checkbox"/> \$ 2,000 Spouse	\$ 1,000 Child	\$100 - 15 Days to 6 Months

Group Short-term Disability:	Employer Contribution: _____%
Plan Options:	
<input type="checkbox"/> 1-8-13 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 8-8-13 <input type="checkbox"/> 8-8-26	
Benefit Amount:	
<input type="checkbox"/> Flat Amount \$ _____ / Week <i>(Provide salary for amount greater than \$150 weekly)</i>	
<input type="checkbox"/> % of Salary _____% <i>(Please provide salary)</i>	

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:
<input type="checkbox"/> With Portability <input type="checkbox"/> Without Portability <i>(Standard is with Portability)</i>

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: <input type="checkbox"/> 90-Day <input type="checkbox"/> 180-Day
Benefit Period: <input type="checkbox"/> 5-Year <input type="checkbox"/> 2-Year <input type="checkbox"/> 5-Year <input type="checkbox"/> 5-Year <input type="checkbox"/> 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