



of Tennessee

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

Renewal Alternate Request Form

- Confidential -

For Use With Groups 2-149 Enrolled

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

Renewal Alternate Request Form (Use Only for Group Size 2 - 149)

****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.

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

Deductible & Coinsurance Plans With & Without Office Visit Copays

Network Options: P S

Indiv Ded (\$100/250/500/\$750/1000) _____

Indiv OOP (\$1000/1500/2000/2500/4000) _____

Coins 90% / 70% 80% / 60%

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

Split OV Copay \$15/30 \$15/35 \$20/35 \$20/40 \$25/40 \$25/45 \$25/50 \$30/45 \$30/50
(Primary/Specialist)

OP Surgery Ded/Coins 100% / No Ded

ER Ded/Coins \$100 Copay

Wellcare Rider Same as OV Copay None \$20 Copay Preventive- (Avail with Ded/Coins OV Only)

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
- NONE - No Pharm Coverage - Preferred Pricing Only

RX Formulary:

- Standard
- Limited

Behavioral Health Riders (Mandatory for Groups > 25):

- 20 IP Days/25 OP Visits 30 IP Days/30 OP Visits None

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

Vision: Vision 1: Exam Only Vision 2: Exam & Hardware None

COBRA Administration (Available to Groups > 20):

- No Yes - With Initial Notification Letter Yes - Without Initial Notification Letter

Higher Deductible Plans - 80% Coinsurance Only (Not HSA Qualified)

Network Options: P S

Indiv Ded (\$1500/\$2000/\$2500/\$5000) _____

Indiv OOP (\$2000/\$3000/\$5000/\$6000/\$8000) _____

OV Copay Ded/Coins \$20 \$25 \$30 \$35

Split OV Copay \$20/35 \$20/40 \$25/40 \$25/45 \$25/50 \$30/45 \$30/50
(Primary/Specialist)

ER Ded/Coins \$100 Copay

Wellcare Rider (\$300 Limit) Same as OV Copay \$20 Copay Preventive None

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
- NONE - No Pharm Coverage - Preferred Pricing Only

RX Formulary:

- Standard
- Limited

Behavioral Health Riders (Mandatory for Groups > 25):

- 20 IP Days/25 OP Visits 30 IP Days/30 OP Visits None

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

Vision: Vision 1: Exam Only Vision 2: Exam & Hardware None

COBRA Administration (Available to Groups > 20):

- No Yes - With Initial Notification Letter Yes - Without Initial Notification Letter

HSA Qualified - High Deductible Health Plans (In Network)

Network Options: P S

Shared Deductible Plans

Plan (*11-01-07 Effective)	Plan Description	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 - 80%	\$1,200	\$2,400	\$2,500	\$5,000	80%
<input type="checkbox"/> HDHP - Plan 2	\$1,700 - 80%	\$1,700	\$3,400	\$3,500	\$7,000	80%
<input type="checkbox"/> HDHP - Plan 3	\$2,500 - 100%	\$2,500	\$5,000	\$2,500	\$5,000	100%
<input type="checkbox"/> HDHP - Plan 4	\$2,500 - 80%	\$2,500	\$5,000	\$4,000	\$8,000	80%
<input type="checkbox"/> HDHP - Plan 5	\$3,000 - 80%	\$3,000	\$6,000	\$5,000	\$10,000	80%
<input type="checkbox"/> HDHP - Plan 6*	\$3,000 - 100%	\$3,000	\$6,000	\$3,000	\$6,000	100%
<input type="checkbox"/> HDHP - Plan 7*	\$4,000 - 100%	\$4,000	\$8,000	\$4,000	\$8,000	100%
<input type="checkbox"/> HDHP - Plan 8*	\$5,000 - 100%	\$5,000	\$10,000	\$5,000	\$10,000	100%

Embedded Deductible Plans

Plan (*11-01-07 Effective)	Plan Description	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 - 100%	\$2,500	\$5,000	\$2,500	\$5,000	100%
<input type="checkbox"/> HDHP - Plan 4-ED*	\$2,500 - 80%	\$2,500	\$5,000	\$4,000	\$8,000	80%
<input type="checkbox"/> HDHP - Plan 5-ED*	\$3,000 - 80%	\$3,000	\$6,000	\$5,000	\$10,000	80%
<input type="checkbox"/> HDHP - Plan 6-ED*	\$3,000 - 100%	\$3,000	\$6,000	\$3,000	\$6,000	100%
<input type="checkbox"/> HDHP - Plan 7-ED*	\$4,000 - 100%	\$4,000	\$8,000	\$4,000	\$8,000	100%
<input type="checkbox"/> HDHP - Plan 8-ED*	\$5,000 - 100%	\$5,000	\$10,000	\$5,000	\$10,000	100%

Pharmacy Riders (Standard RX Formulary Only):

Ded/Coins NONE - No Pharmacy Coverage - Preferred Pricing Only

COBRA Administration (Available to Groups > 20):

No Yes - With Initial Notification Letter Yes - Without Initial Notification Letter

HRA Compatible Plans (In Network) (Available for Groups 26+ Employees)

Network Options: P S

Plan	Ind. Ded	Ind. OOP	Co-Ins.	Office Visits
<input type="checkbox"/> HRA Plan 1	\$1,500	\$3,000	80%	\$35
<input type="checkbox"/> HRA Plan 2	\$2,000	\$4,000	80%	\$35
<input type="checkbox"/> HRA Plan 3	\$2,500	\$5,000	80%	\$35
<input type="checkbox"/> HRA Plan 4	\$1,500	\$3,000	80%	OV @ Ded/Coins
<input type="checkbox"/> HRA Plan 5	\$2,500	\$5,000	80%	OV @ Ded/Coins
<input type="checkbox"/> HRA Plan 6	\$5,000	\$6,000	80%	OV @ Ded/Coins

Pharmacy & Vision Riders (Plans 1 - 6 ONLY) (Standard RX Formulary Only):

- Pharm Ded/Coins
- Pharm \$10/35/50 with \$200 Brand-Only Ded
- Pharm 20% Copay / \$1,000 Annual Pharm OOP Max
- NONE - No Pharm Coverage - Preferred Pricing Only
- Vision 2

Plan	Self-Only Deductible	Self-Only OOP	Family Deductible	Family OOP	% After Deductible
<input type="checkbox"/> HRA Plan 7	\$1,700	\$3,500	\$3,400	\$7,000	80%
<input type="checkbox"/> HRA Plan 8	\$2,500	\$2,500	\$5,000	\$5,000	100%
<input type="checkbox"/> HRA Plan 9	\$2,500	\$4,000	\$5,000	\$8,000	80%
<input type="checkbox"/> HRA Plan 10	\$3,000	\$5,000	\$6,000	\$10,000	80%

Pharmacy Riders (Plans 7 - 10 ONLY) (Standard RX Formulary Only):

Pharm Ded/Coins NONE - No Pharm Coverage - Preferred Pricing Only

Copay PPO (In Network)

Network Options: P S

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

Well Care Rider (\$300 Limit): Yes No

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
- NONE - No Pharm Coverage - Preferred Pricing Only

RX Formulary:

- Standard
- Limited

Behavioral Health Riders (Mandatory for Groups > 25):

- 20 IP Days/25 OP Visits 30 IP Days/30 OP Visits None

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

Vision: Vision 1: Exam Only Vision 2: Exam & Hardware None

COBRA Administration (Available to Groups > 20):

- No Yes - With Initial Notification Letter Yes - Without Initial Notification Letter

ValuePak (In Network)

Network Options: P S

***Standard RX Formulary Only**

Plan	Deductible	OOP	Coinsurance	Office Visits	Pharmacy*
<input type="checkbox"/> ValuePak 1	\$5,000	\$5,000	100% after Ded.	2 per member/per yr.	None-Pref Pricing Only
<input type="checkbox"/> ValuePak 2	\$750	\$2,500	80% after Ded.	2 per member/per yr.	\$10/50% - MAC A
<input type="checkbox"/> ValuePak 3	\$1,000	\$4,000	70% after Ded.	2 per member/per yr.	50% Copay - MAC A
<input type="checkbox"/> ValuePak 4	\$0	\$10,000	50% - No Ded.	50% Coinsurance	50% Copay - MAC A
<input type="checkbox"/> ValuePak 5	\$750	\$2,500	80% after Ded.	2 per member/per yr.	\$10/35/50 - MAC A

Dental Blue

Stand alone dental requires a minimum enrollment of 5

Traditional Group 2-9 Enrolled:

Standard Plan

100/80/50 - \$50 Ded - \$1,000 Max Benefit
 Child Orthodontics: Yes No
 Reimbursement Option: Choice Preferred

Preventive Plan

100/50/0 - \$25 Ded - \$500 Max Benefit
 Child Orthodontics: N/A
 Reimbursement Option: Choice Preferred

Traditional Group 10+ Enrolled:

**Deluxe Plan
100/100/80**

Dental Services:

Major Endodontics:

B C

Major Periodontics:

B C

Major Oral Surgery:

B C

Deductible:

\$25 \$50

Family Deductible:

3 x's Max

Unlimited

Maximum Benefit:

\$1,000 \$1,500

Orthodontics:

Yes No

Orthodontics Max:

\$1,000 \$1,500

Orthodontics Age:

Child

No Age Limit

(Avail only to groups 26+)

12-Month Waiting Period:

***(Ortho Only)**

Yes No

Reimbursement Option:

Choice

Preferred

**Standard Plan
100/80/50**

Dental Services:

Major Endodontics:

B C

Major Periodontics:

B C

Major Oral Surgery:

B C

Deductible:

\$25 \$50

Family Deductible:

3 x's Max

Unlimited

Maximum Benefit:

\$1,000 \$1,500

Orthodontics:

Yes No

Orthodontics Max:

\$1,000 \$1,500

Orthodontics Age:

Child

No Age Limit

(Avail only to groups 26+)

12-Month Waiting Period:

***(Ortho Only)**

Yes No

Reimbursement Option:

Choice

Preferred

**Basic Plan
80/80/50**

Dental Services:

Major Endodontics:

B C

Major Periodontics:

B C

Major Oral Surgery:

B C

Deductible:

\$25 \$50

Family Deductible:

3 x's Max

Unlimited

Maximum Benefit:

\$1,000 \$1,500

Orthodontics:

Yes No

Orthodontics Max:

\$1,000 \$1,500

Orthodontics Age:

Child

No Age Limit

(Avail only to groups 26+)

12-Month Waiting Period:

***(Ortho Only)**

Yes No

Reimbursement Option:

Choice

Preferred

**Preventive Plan
100/50/0**

Dental Services:

Major Endodontics:

B No Coverage

Major Periodontics:

B No Coverage

Major Oral Surgery:

B No Coverage

Deductible:

\$0 \$25

Family Deductible:

3 x's Max

Unlimited

Maximum Benefit:

\$500 \$1,000

Reimbursement Option:

Choice

Preferred

***If Ortho Waiting Period is requested a waiver is allowed at initial takeover for members covered under the prior plan. The prior billing and benefits is required with initial group paperwork to receive member waivers.**

Dental Blue Select 51+ Total Eligible:

Standard Plan
100/80/50

Deductible:
 \$25 \$50

Family Deductible:
 3 x's Max
 Unlimited

Maximum Benefit:
 \$1,000 \$1,500

Orthodontics:
 Yes No

Orthodontics Max:
 \$1,000 \$1,500

Orthodontics Age:
 Child
 No Age Limit
(Avail only to groups 26+)

**Reimbursement Option
- Preferred**

***Waiting Periods Apply to Major Services and Ortho**

**Waiver of waiting period is allowed at initial takeover for members covered under the prior plan.
The prior billing and benefits is required with initial group paperwork to receive member waivers.*

Basic Plan
80/80/50

Deductible:
 \$25 \$50

Family Deductible:
 3 x's Max
 Unlimited

Maximum Benefit:
 \$1,000 \$1,500

Orthodontics:
 Yes No

Orthodontics Max:
 \$1,000 \$1,500

Orthodontics Age:
 Child
 No Age Limit
(Avail only to groups 26+)

**Reimbursement Option
- Preferred**

***Waiting Periods Apply to Major Services and Ortho**

**Waiver of waiting period is allowed at initial takeover for members covered under the prior plan.
The prior billing and benefits is required with initial group paperwork to receive member waivers.*

Preventive Plan
100/50/0

Deductible:
 \$0 \$25

Family Deductible:
 3 x's Max
 Unlimited

Maximum Benefit:
 \$500 \$1,000

**Reimbursement Option
- Preferred**

***Waiting Periods Apply to Major Services and Ortho**

**Waiver of waiting period is allowed at initial takeover for members covered under the prior plan.
The prior billing and benefits is required with initial group paperwork to receive member waivers.*

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:

1X Salary _____ 2X Salary _____ Other _____

(Salary must be provided for this option)

Group Dependent Life: Employer Contribution: _____%

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