BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

REP NUMBER:

# GROUP APPLICATION FOR CHANGE TO EXISTING GROUP CONTRACT

It is intended that this application be completed by the Group's Producer of Record or Account Consultant and be verified by an officer of the Company. Except as amended below, the Group Contract and Group Application remain unchanged.

| GROUP NUMBER | GROUP NAME | EFFECTIVE DATE OF CHANGE |
|---|---|---|
| | | |

| MAILING ADDRESS | CITY | STATE |
|---|---|---|
| | | |

| ZIP CODE | PHONE NO. | GROUP LEADER | PRODUCER NUMBER |
|---|---|---|---|
| | | | |

**BENEFIT OPTION(S)TO BE ADDED OR CHANGED:**

☐ BLUECHOICE (**OVC** ☐None ☐$10 ☐$20**)** ☐ BLUEPREFERRED (**OVC** ☐$10 ☐$20**)**

☐ BLUETRADITIONAL ☐ BLUEOPTIONS (**OVC** ☐$20 ☐$30 ☐$35**)** ☐ HSA BLUE

**BENEFIT OPTION(S) TO BE CANCELED:**

☐BLUECHOICE ☐BLUEPREFERRED ☐BLUETRADITIONAL ☐BLUEOPTIONS ☐CHAMBER CHOICE ☐HSA BLUE

**DEDUCTIBLE:**

☐ $200 ☐ $750 ☐ $2,000

☐ $300 ☐ $1000 ☐ $2,500

☐ $500 ☐ $1,500 ☐ $5,000

**STOP-LOSS LIMIT:**

☐ $5000 / $10,000

☐ $10,000 / $20,000

☐ $10,000 BlueOptions

**PRESCRIPTION CARD:**

☐ 4 Tier ☐ 50/50

☐ $300 Deductible 4 Tier

☐ $300 Deductible 50/50

**HSA BLUE DEDUCTIBLE:**

Single Family

☐ $1,500 / $3,000 Option 1

☐ $1,500 / $3,000 Option 2

☐ $2,000 / $4,000 Option 3

☐ $2,500 / $5,000 Option 4

☐ $3,000 / $6,000 Option 5

☐ $5,000 / $10,000 Option 6

**DENTAL:**

☐ DentalPlus PPO ☐ DentalPlus Traditional ☐ Basic Dental

☐ $0 Deductible ☐ $50 Deductible ☐ $100 Deductible ☐ Orthodontia

☐ Remove Dental Coverage ☐ Remove Orthodontia ONLY

**WAITING PERIOD:**

ELIGIBILITY DATE (Days / Months following the date of employment.)

☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 6 Months

EFFECTIVE DATE:

☐ Date of Employment ☐ Date of Eligibility ☐ First Billing Coinciding With Or Next Following The Date Of Eligibility

As a Company Officer or Owner of the above group, I am requesting these changes be made to our existing Group Contract. By signing this form I am agreeing that the requested changes will be made, subject to approval by Blue Cross and Blue Shield of Oklahoma. If this application is accepted, the contract and any endorsements thereto will contain all of the terms and conditions. I have reviewed the changes we are requesting with my Producer of Record or assigned Account Consultant and understand the changes we are requesting.

| SIGNATURE DATE | COMPANY OFFICER OR OWNER | SIGNATURE DATE | ACCOUNT CONSULTANT OR PRODUCER |
|---|---|---|---|
| | | | |

*For Office Use Only.*

| # EMP | # ELIG | COBRA FLAG | MED COB | WP | WP CODE | BILL CYCLE | SM B PKG. | BILL TYPE | RATE SEGMENT |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

| RATE NOTICE | RENEWAL DATE | RATE CALL | PRIOR TIER CODE | TIER CODE | PL/PN | OVC $ | COV OPT |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| EFFECTIVE DATE | LOB | TERM DATE | ID CARD CODE | ELIG CERT | TOB | RATE CLASS | MKT. SEG | BENEFIT TABLE NO. | ADS | PRC | MHP DEF. | DPF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

| DATE RECEIVED | STOP DATE | REASON |
|---|---|---|
| DATE RELEASED | RESTART DATE | |

☐ ENS. ☐ BILL. ☐ I.A. ☐ M.I. ☐ M.S.E. ☐ M.S.W. ☐ ENS. RPT.

***Changes made with this document may result in a new contract being issued to your group. Please review the summary information on the back of this form.***

This is only a summary of available Group Benefits; this is not a contract. If this application is accepted, the details of the terms and conditions will be listed in the Group Contract.

BluePreferred Benefit Deductibles carry an out-of-network penalty based on the following schedule:

- $200 BluePreferred Provider Services Deductible/$300 Out-of-Network Provider Services Deductible
- $300 BluePreferred Provider Services Deductible/$500 Out-of-Network Provider Services Deductible
- $500 BluePreferred Provider Services Deductible/$800 Out-of-Network Provider Services Deductible
- $1,000 BluePreferred Provider Services Deductible/$1,500 Out-of-Network Provider Services Deductible
- $1,500 BluePreferred Provider Services Deductible/$2,500 Out-of-Network Provider Services Deductible
- $2,000 BluePreferred Provider Services Deductible/$3,500 Out-of-Network Provider Services Deductible
- $2,500 BluePreferred Provider Services Deductible/$4,000 Out-of-Network Provider Services Deductible
- $5,000 BluePreferred Provider Services Deductible/$7,500 Out-of-Network Provider Services Deductible

BlueOptions Benefits are subject to the following provisions:

- A Hospital Admission Deductible equal to $500 or 50% of Benefit Period Deductible amount, whichever is less (Applies to each admission to a hospital).
- An Outpatient Surgery Deductible of $200 (applies to each visit to an Outpatient facility for Surgery).
- An Emergency Room Deductible of $100 (applies to each visit to a Hospital emergency room).
- A Benefit Coinsuance Percentage Amount of 80% for BluePreferred Provider Services/70% for BlueChoice Provider Services/60% for BlueTraditional Provider Services/50% for Out-of-Network Provider Services.

DentalPlus Benefits:

- Deductible applies to Primary, Prosthetic and Complex Restorative Services. Diagnostic and Preventative Services are not subject to a Deductible.
- Diagnostic and Preventative Services are paid at 100% of Allowable Charges.
- Primary Services are paid at 80% of Allowable Charges.
- Prosthetic and Complex Restorative Services are paid at 50% of Allowable Charges.

HSA Blue Benefits:

- Options 1, 3 & 4
  - Single Coverage is subject to a $3,000 Out-of-Pocket limit.
  - Family Coverage is subject to a $6,000 Out-of-Pocket limit.
- Options 2, 5 & 6
  - Single Coverage is subject to a $5,000 Out-of-Pocket limit.
  - Family Coverage is subject to a $10,000 Out-of-Pocket limit.

**WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**