BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

Amendment of Application for Group Contract

GROUP NAME	GROUP NUMBER / DEPARTMENT

A. GROUP REQUESTED CHANGES

Change group name and/or address to:

Change probationary period for new hire enrollment eligibility to: days.

Medical changes: ______________________________

Dental changes: ______________________________

Family Deductible: ☐ Aggregate ☐ Embedded

Effective date of coverage changes: ______________________________

B. RATES AND EMPLOYER CONTRIBUTION

MONTHLY RATES	HEALTH	EMPLOYER CONTRIBUTION	DENTAL	EMPLOYER CONTRIBUTION
SINGLE:				
FAMILY:				
EMPLOYEE & SPOUSE:				
SINGLE PARENT (EMPLOYEE & CHILDREN):				
MEDICARE SUPPLEMENTAL:				

EFFECTIVE DATE OF RATES: ____________________. THESE RATES ARE GUARANTEED UNTIL ____________________ AS LONG AS COMPANY UNDERWRITING GUIDELINES ARE MET. If the number of employees increases or decreases 5% or more, the Company reserves the right to change the rates.

NOTE: Rates may be indicated on the attached quote.

C. RX NEBRASKA PRESCRIPTION DRUG PROGRAM:

RX NEBRASKA PRESCRIPTION DRUG CARD PROGRAM ☐ **No Changes** ☐ Rush Rx Set-Up

☐ **Standard Benefit Schedule –** Covered and noncovered services as stated in Master Group Contract. (If the designated Master Group Contract does not include RX Nebraska provision, use Endorsement 9856 to add standard RX Nebraska.)

☐ **Non-Standard Benefit Schedule -** Endorsement 99-841 and Form 4718A (please complete)

☐ **Rx Nebraska Prescription Drug Pass-Thru -** Endorsement 9-1313

☐ **Rx Nebraska Prescription Drug Benefits Integrated with Medical Benefits (IPS) -** Use applicable endorsement

☐ **BluePride / ChamberBlue Benefit Schedule**

☐ **BlueFreedom Benefit Schedule** - Health Option # with Rx Option # / Health Option # with Rx Option #

BENEFIT DESIGN OPTIONS (Standard and Non-Standard Benefits)

Mail Order Benefits: ☐ Yes ☐ No

Maximum Day Supply:

Retail: ☐ 90-Day Supply ☐ -Day Supply
Mail Order (if applicable): ☐ 90-Day Supply ☐ -Day Supply

Copayment Amounts:

		Copay $_	Coinsurance%	Minimum $/%	Maximum $/%
Retail:	☐Generic = Tier 1:	$ _____	/ _____	/ _____	/ _____
	☐Formulary Brand= Tier 2	$ _____	/ _____	/ _____	/ _____
	☐Non-Formulary Brand = Tier 3	$ _____	/ _____	/ _____	/ _____
	☐Specialty = Tier 4:	$ _____	/ _____	/ _____	/ _____
Mail Order:	☐Generic = Tier 1:	$ _____	/ _____	/ _____	/ _____
	☐Formulary Brand= Tier 2	$ _____	/ _____	/ _____	/ _____
	☐Non-Formulary Brand = Tier 3	$ _____	/ _____	/ _____	/ _____
	☐Specialty = Tier 4:	$ _____	/ _____	/ _____	/ _____

- Copayment is applicable per each -day supply (retail); per each -day supply (mail order)

Specialty Pharmacy Benefit ☐ Yes ☐ No Applies to drugs on the specialty pharmacy drug list. Place of dispensing overrides the formulary status for copayments for these drugs.
Specialty medications are not available through mail order.

Specialty Network: $________ or _____ % with max copay per RX $_____
Out-of-Network: $________ or _____ % with max copay per RX $_____

☐ **Mandatory Generic Penalty** ☐ **No Mandatory Generic Penalty**
Mandatory generic pricing: If the covered person requests a Name Brand Medication when a generic version is available, he or she is responsible for the difference in cost between the name brand and generic drug, plus the applicable copayment amount.

Members are allowed two fills of a specialty medication at a retail network pharmacy, before being required to go through Triessent. ☐ Yes ☐ No

If the doctor indicates DAW Code 1 (dispense as written), and specifies a name brand drug be dispensed, copay is non-formulary brand. ASO groups may choose to apply this penalty. Per Nebraska law, insured groups may not apply Mandatory Generic penalty when DAW Code 1 is indicated.

Mail Order Maintenance List ☐ Yes ☐ No Limits the mail order benefit to chronically used medications, thereby Increasing the efficiency of mail order process. Available medications are listed on mail order maintenance list.

C. RX NEBRASKA PRESCRIPTION DRUG PROGRAM - continued:

Deductible: ☐ Yes ☐ No Amount: $
Family: ☐ Yes ☐ No
Individual: ☐ Yes ☐ No

Calendar Year Copayment Maximum: ☐ Yes ☐ No Amount: $____________
Once co-payment maximum is met for a year, benefits payable as follows: _______

Benefit Maximum Per Year: ☐ Yes ☐ No Amount: $_____________

Pharmacy Preauthorization Programs

COX-2 Inhibitor Preauthorization Program: ☐ Yes ☐ No.

Leukotriene Modifier Preauthorization Program: ☐ Yes ☐ No.

Proton Pump Inhibitor Therapy Preauthorization Program: ☐ Yes ☐ No.

Sedative Hypnotics (Insomnia) Preauthorization Program: ☐ Yes ☐ No.

Other Rx Nebraska Provisions: ______________________________

D. AUTHORIZED PLAN CONTACTS

The HIPAA Privacy Rules provide that the Group Health Plan is a separate legal entity from the Employer/Plan Sponsor. In compliance with the Rules, it is necessary to designate Authorized Plan Contacts for the Group Health Plan.

The Group Health Plan (GHP) Primary Contact is indicated on the Master Group Application. The GHP Primary Contact serves as BCBSNE's primary contact for the GHP, and may also designate additional Authorized Plan Contacts for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by noting changes/additions below.

We will automatically include your Group Health Plan's Agent of Record as one of your Authorized Plan Contacts. If you choose not to have the Group Health Plan's Agent of Record authorized to receive this information, please check here: ☐

In addition, the following individuals may be given access to Group Health Plan Information received from Blue Cross and Blue Shield of Nebraska in accordance with the requirements set forth within the HIPAA Privacy Rules.

Authorized Plan Contacts:

Reason for Change: New ☐ Delete ☐

Name: ____

Title: ____

Reason for Change: New ☐ Delete ☐

Name: ____

Title: ____

Reason for Change: New ☐ Delete ☐

Name: ____

Title: ____

BCBSNE will not release protected health information (PHI) to fully insured groups, except as specifically agreed in writing by BCBSNE, the Plan and Plan Sponsor. When there is a written agreement, all disclosure of PHI from BCBSNE shall be made to the Plan, or an Authorized Plan Contact.

E. ACCEPTANCE BY APPLICANT

I represent that I am authorized to obtain coverage on behalf of the Group.

Please check each applicable box:

☐ I hereby apply for the coverage changes specified in Part A. I acknowledge that this Amendment of Application is subject to Company approval.

☐ I accept the quoted rates and certify the accuracy of the employer contribution amounts.

It is understood that the changes on this form supersede any previous Application or Amendment of Application. Unless otherwise amended, the contract information in the original Application shall apply.

By signing this amendment, I represent that I am authorized to obtain coverage on behalf of the Group.

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF AGENT	TYPED NAME OF AGENT	DATE

F. ACCEPTANCE BY COMPANY

☐ This Amendment of Application is accepted.

☐ This Amendment of Application is accepted with the following changes: ______________________

SIGNATURE	TITLE	DATE

The noted changes in Part F are acceptable.

SIGNATURE OF APPLICANT	DATE

If the Applicant's signature is required on Part F, sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

FOR OFFICIAL USE ONLY

	CONTRACT NO.	PLAN CODE	PACKAGE NO.	ENDORSEMENTS			
HEALTH							
MED. SUPP.							
DENTAL							