



An Independent Licensee of the Blue Cross Blue Shield Association

### Group Enrollment & Coverage Agreement, Benefit Change - Part C

Federal Tax Id

\_\_\_\_ - \_\_\_\_\_

**Check One:**  Group Wide Change  Transfer  Maintenance

Total Eligible: \_\_\_\_\_

Order IDs?  Yes  No

Group Name (Full Legal Name)	Group Number	Suffix Number	Requested Effective Date
_____	_____	_____	____ / ____ / ____

#### Hospital/Medical/Surgical Plans

<b>Managed Traditional</b>	<input type="checkbox"/> First Dollar Plan	<input type="checkbox"/> AP2 <input type="checkbox"/> PSA <input type="checkbox"/> Master Medical Option 1 <input type="checkbox"/> MMC-PC
<b>Managed Traditional Comprehensive Major Medical:</b>	<input type="checkbox"/> Plan 2 - CMM250 <input type="checkbox"/> CMM-PPO <input type="checkbox"/> Plan 3 - CMM500	<input type="checkbox"/> ML <input type="checkbox"/> XVA <input type="checkbox"/> Master Medical Option 5 (MMC5/MMC-CR50/MMC-LCP 1500, MMC-PD)
<b>Community Blue PPO, CB-PCM \$500</b>	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 10 <input type="checkbox"/> Plan 14 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 12 <input type="checkbox"/> Plan 15	<input type="checkbox"/> AP2 <input type="checkbox"/> CMM-SAB <input type="checkbox"/> CB-OV\$20 <input type="checkbox"/> CBC-MT <input type="checkbox"/> CB-OV\$30* <input type="checkbox"/> CH-CB Cheboygan *(Included in plans 12,14,15) <input type="checkbox"/> CB CSR (Upper Peninsula Only) <input type="checkbox"/> XVA
<b>Healthy Blue PPO</b>	<input type="checkbox"/> Healthy Blue 80 PPO <input type="checkbox"/> Healthy Blue 70 PPO	<input type="checkbox"/> OCSM24 <input type="checkbox"/> XVA
<b>Blue Value Options</b>	<input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 6	<input type="checkbox"/> BVO-OV <input type="checkbox"/> XVA
<b>Blue Choice Point of Service</b>	<input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 7	<input type="checkbox"/> POS-OV\$20 <input type="checkbox"/> POS-OV\$30 <input type="checkbox"/> XVA

<b>Flexible Blue - 0%/20%</b>	<b>For other than 0% Copay, Check one Copay AND one Copay Maximum Rider</b>		<b>Prescription Drug</b>	<b>Options</b>
<b>Deductibles</b> <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <small>(Dollar Amounts indexed to inflation &amp; regulated minimums/maximums)</small>	<b>Co Pay</b> <input type="checkbox"/> FB C20%/P/40%NP <input type="checkbox"/> FB C30P/50%NP	<b>Co Pay Maximum</b> <input type="checkbox"/> FB CM1000/2000P; 2000/4000NP <input type="checkbox"/> FB CM2000/4000P; 4000/8000NP <b>If \$10/\$60 RX option selected, Copay Maximum required</b>	<input type="checkbox"/> RX after Deductible (FB RX) <input type="checkbox"/> Blue Advantage (No optional riders) <input type="checkbox"/> \$10/\$60, PRX-MM* (FB RX-PD-GB\$10/60) <small>*Requires selection of Copay Maximum</small>	<input type="checkbox"/> FB CSR (Upper Peninsula Only) <input type="checkbox"/> FB OCSM-24 (Manipulative Therapy) <input type="checkbox"/> FB PC\$500M, RM100(Preventive & RM) <input type="checkbox"/> XVA (Exclude Abortion) <input type="checkbox"/> PCD2, PD-CM,CI (Contraceptives) <input type="checkbox"/> PD-XED (Exclude Lifestyle Drugs)

#### Additional Programs\*: All Freestanding requires prior Underwriting Approval

<b>Prescription Drug Preferred RX Plan, MOPD2X</b>	<input type="checkbox"/> MOPD(Maintain)	<b>Optional Preferred RX Only Riders</b>	<b>Vision</b>	<b>Traditional Plus Dental</b>	<b>Dental Community Dental</b>	<b>Exclusive Dental</b>
<input type="checkbox"/> PD\$10/\$20 <input type="checkbox"/> PD\$10/\$40 <input type="checkbox"/> PD\$10/\$40, PD-RXP <input type="checkbox"/> PD\$10/\$60, PRX-MM <input type="checkbox"/> PD\$10/\$60, PRX-MM, PD-RXP <input type="checkbox"/> PD\$15/\$30 <input type="checkbox"/> PD\$15/\$50, PRX-MM <small>(PRX-MM=Mandatory Mac,PD-RXP=PreAuth including Step Therapy)</small>	<input type="checkbox"/> PD50%/\$10/\$100 <input type="checkbox"/> PD-TTC, \$15/\$30/\$60, CMAC <input type="checkbox"/> PD-TTC, \$15/\$30/\$60 PD-RXP, CMAC <input type="checkbox"/> Blue Advantage RX <small>(Optional riders not available)</small>	<input type="checkbox"/> PCD, PD-CM, CI <small>(Contraceptives)</small> <input type="checkbox"/> PD-XED <small>(Exclude Lifestyle)</small>	<input type="checkbox"/> Blue Vision 12-12-12 <input type="checkbox"/> Blue Vision 24-24-24 <input type="checkbox"/> Freestanding Vision*	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> CD Plan 2 <input type="checkbox"/> ED Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> CD Plan 3 <input type="checkbox"/> ED Plan 3 <input type="checkbox"/> Plan 4 <small>(Preventive)</small> <input type="checkbox"/> Plan 5	<input type="checkbox"/> CD Plan 2 <input type="checkbox"/> ED Plan 2 <input type="checkbox"/> CD Plan 3 <input type="checkbox"/> ED Plan 3 <input type="checkbox"/> Freestanding Dental*	
<input type="checkbox"/> \$250/\$500 Deductible (Available with plans listed above)						

Spending Accounts	<input type="checkbox"/> HSA (Health Savings Account - for Flexible Blue Products ONLY) <input type="checkbox"/> HRA (Health Reimbursement Account - for any hospital/medical/surgical plan)	<input type="checkbox"/> Add <input type="checkbox"/> Maintain <input type="checkbox"/> Cancel - attach group letter	Funded Account Program: <input type="checkbox"/> Maintain <input type="checkbox"/> Cancel - attach group letter	Coordination of Benefits: COB1 100+: <input type="checkbox"/> Other - COB form must be attached
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The Group agrees with all terms as stipulated in this Agreement and in specified Blue Cross and Blue Shield of Michigan Health Care Certificate(s) and Rider(s). Do not sign this agreement unless a benefit description is enclosed.

Group Health Plan Name: \_\_\_\_\_

Signature of Group Executive on behalf of the Group and the Group Health Plan: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of BCBSM Rep: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Underwriter/Group Administration AdAdministration: \_\_\_\_\_ Date: \_\_\_\_\_