Blue Cross Blue Shield of Rhode Island

2022 Request for Amendment to Sales Agreement Small Group

COMPLETE AND RETURN THIS FORM ONLY IF YOU ARE MAKING PLAN CHANGES.

Group Name: _____(hereinafter referred to as "Group")

Group Policy Number: _____ (9-digit # on Group's Renewal Notice)

Affiliate Number(s): _____ (8-digit #)

Sub-Group Number(s): _____ (4-digit #)

As an authorized representative of the above named Group, I request that the Sales Agreement Small Group in effect between BCBSRI and Group be amended with the following changes:

Rates are effective: (mm/dd/yyyy) ____ / ____ / _____ through (mm/dd/yyyy) ____ / ____ / _____

MEDICAL AND PEDIATRIC PRODUCTS:

Please check the appropriate letter(s): A=ADD PLAN, **D**=DELETE PLAN

A	D		A	D		A	D	
☐	☐	VantageBlue 100/80 500	☐	☐	VantageBlue 70/50 2000	☐	☐	BlueSolutions 100/60 1500
☐	☐	VantageBlue 100/80 750	☐	☐	Network Blue NE Options 100/NC 0/2000	☐	☐	BlueSolutions 100/60 1500 w/copay
☐	☐	VantageBlue 100/80 1000	☐	☐	Network Blue NE Options 100/NC 0/5000	☐	☐	BlueSolutions 100/60 1900
☐	☐	VantageBlue 100/60 1500	☐	☐	Network Blue New England 100/NC 500	☐	☐	BlueSolutions 100/60 2500
☐	☐	VantageBlue 100/80 2000	☐	☐	Network Blue New England 100/NC 1000	☐	☐	BlueSolutions 100/60 3400
☐	☐	VantageBlue 100/80 2500	☐	☐	Network Blue New England 100/NC 2000	☐	☐	BlueSolutions 100/60 4000
☐	☐	VantageBlue 100/80 3000	☐	☐	Network Blue New England 100/NC 3000	☐	☐	BlueSolutions 100/60 5000
☐	☐	VantageBlue 100/80 4000	☐	☐	Network Blue New England 100/NC 4000	☐	☐	BlueSolutions 100/60 6000
☐	☐	VantageBlue 100/80 5000	☐	☐	Blue Choice New England 100/80 500	☐	☐	BlueSolutions 100/60 7000
☐	☐	VantageBlue 100/80 8550	☐	☐	Blue Choice New England 100/80 1000	☐	☐	Access Blue New England 100/NC 1900
☐	☐	VantageBlue 80/60 1000	☐	☐	Blue Choice New England 100/80 2000	☐	☐	Access Blue New England 100/NC 3400
☐	☐	VantageBlue 80/60 2000	☐	☐	Blue Choice New England 100/80 3000	☐	☐	Access Blue New England 100/NC 7000
☐	☐	VantageBlue 80/60 3000	☐	☐	Blue Choice New England 100/80 4000			

MUST BE COMPLETED:

Please check one of the boxes below:

☐ Group attests that it has purchased a qualified dental plan separately.
Group **DOES NOT REQUIRE** Pediatric Dental benefits to be included in medical plan(s).

☐ Group attests that it has not purchased a qualified dental plan separately.
Group **REQUIRES** Pediatric Dental benefits to be included in all medical plan(s).

continued ➤

DENTAL, PLAN 65, AND/OR VISION PRODUCTS:

Please check the appropriate letter(s) and complete table below:
A=ADD PLAN, **D**=DELETE PLAN, and/or **M**=MODIFY RATE

A D M		Plan Name	Monthly Premium			
☐ ☐ ☐	**Dental**		$	$	$	$
☐ ☐ ☐	**Dental**		$	$	$	$
☐ ☐ ☐	**Vision***		$	$	$	$
☐ ☐ ☐	**Vision***		$	$	$	$
☐ ☐ ☐	**Plan 65**		$	$	$	$

*If Contributory Vision is purchased by Group, Group is required to make a minimum 50% contribution to Monthly Premium for its vision coverage. If Group does not contribute at least 50%, BCBSRI may change the Monthly Premium rate for vision coverage upon written notice to Group.

GROUP requests that BCBSRI accept the terms and conditions of this Request for Amendment ("Amendment"). Group understands that this Amendment will not become effective unless it is approved by BCBSRI. If the Amendment is approved, BCBSRI shall sign the Amendment and deliver it to Group, along with the Alternative Plan Benefits (Medical)/ Small Group Rate Table for Group, which shall then both be made part of the Sales Agreement Small Group without further acceptance required by Group. The Parties agree that this Amendment may be signed electronically, and that the electronic signatures appearing on this Amendment are the same as handwritten signatures for the purposes of validity, enforceability and admissibility. This Amendment may be executed and delivered by fax or e-mail, and such fax or e-mail delivery shall constitute the final agreement of the Parties and conclusive proof of this Amendment.

IN WITNESS WHEREOF, BCBSRI AND GROUP HAVE EXECUTED THIS AMENDMENT:

Group

SIGN HERE ☞

By: _____

Authorized Signature *Date*

Print Name: _____

Title: _____

Blue Cross & Blue Shield of Rhode Island

SIGN HERE ☞

By: _____

Authorized Signature on behalf of Melissa B. Cummings, SVP, Chief Customer Officer *Date*

Print Name: _____

Title: _____

continued ➤

IF YOU DO NOT HAVE ACCESS TO DOCUSIGN, PLEASE CONTACT YOUR DEDICATED SALES REPRESENTATIVE.

The following information must be provided for each change in order for the Amendment to be processed.
This page is for informational purposes only and not deemed to be part of the Amendment Form.
If you need assistance, please contact your broker or Small Business Sales Representative.

GROUP POLICY NUMBER	Insert the group policy number (the nine (9) digit number) on your Renewal Notice.
AFFILIATES OR SUBGROUPS (if applicable)	If plan changes apply to main Group, and all affiliates and subgroups, submit one (1) Amendment requesting changes for all. If plan changes apply only to an affiliate or subgroup, please complete an Amendment for each respective affiliate and subgroup.
RATES ARE EFFECTIVE	Insert the requested effective dates. These should be the effective dates of your plan year through the last day prior to GROUP's renewal. (e.g., 2/1/2022 through 1/31/2023)
KEY CODES	Circle the appropriate code. Please use: • "A" to Add a new product. • "D" to Delete a current product. Dental only, use: • "M" to modify the Monthly Premium. In this case, Group has requested that BCBSRI review the Group's demographics and this review has resulted in a change to the Monthly Premium amount provided to Group in the renewal packet. This Monthly Premium rate change can only be effective on the Group's renewal date.
PRODUCT NAME/ DESCRIPTION	Insert the product name and description (e.g. Group Plan 65, Plan G, Dental Flex-Choice 308N, etc.) affected by this change. Please refer to your Renewal Packet.
MONTHLY PREMIUM	Insert the applicable rates for dental, vision, and/or Plan 65. Please refer to your Renewal Packet.
QUALIFIED DENTAL PLAN CHECK BOX	Under the Patient Protection and Affordable Care Act (ACA), groups are responsible for offering their employees plans that cover certain pediatric dental services. Please check the corresponding box to indicate whether you require Pediatric Dental under your medical plan. If Group selects a medical benefit plan that does not cover the required pediatric dental services, it must attest to BCBSRI that it has separately purchased a qualified dental plan.

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com
500 Exchange Street • Providence, RI 02903-2699
Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.
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