



BENEFIT PLAN SELECTION (BPS) - ACA SMALL GROUP

Please complete & return this form in its entirety, including the required signatures

Section 1- Account Information:

A. Employer Name:		B. SIC Code	
C. Account #:		D. Effective Date:	
		E. Anniversary Date:	

- Only Individual cost shares are listed out for each plan.
- A group may select up to six health plan options.
- A group may select one dental plan or two dental plans if 10 or more are enrolled.
- For additional product detail, please utilize Summary of Benefits and Coverage (SBC) and Product Plan Grids

Billing Method Selection

Please select one of the following billing methods.

(For Existing Accounts: If no selection is made, your plans will default to their current billing method.)

- ☐ Composite Billing
- ☐ Age Billing

Section 2a- Renewing Groups Only: (*New Business update to Section 3)

Current Plan: Please list current plan(s) below	Retaining Plan:	Replacing Plan: Please list replacement plan in space below.
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2b- Renewing Groups Only: (*New Business update to Section 3)

Adding Plan (Medical and/or Dental):

Please list new plan(s) below

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Section 3 - New Business

Group Number:

Please select plan designs (Up to a maximum of 6 plans)

A. Blue Choice Preferred								
2022 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ¹	Urgent Care Copay	Non-Preferred Pharmacy**	
Platinum								
<input type="checkbox"/> P5E2BCE	\$250/\$500	\$30/\$60	80%/50%	\$1250/Unlimited	\$400	\$60	\$10/\$20/\$55/\$95/\$150/\$250	
<input type="checkbox"/> P5E1BCE	\$500/\$1000	\$20/\$40	90%/60%	\$1500/Unlimited	\$400	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
Gold								
<input type="checkbox"/> G532BCE	\$1500/\$3000	\$40/\$60	80%/50%	\$5500/Unlimited	\$400	\$75	\$15/\$25/\$70/\$120/\$250/\$350	
<input type="checkbox"/> G531BCE	\$2500/\$5000	\$20/\$60	80%/50%	\$5000/Unlimited	\$400	\$75	\$10/\$20/\$55/\$95/\$150/\$250	
<input type="checkbox"/> G530BCE	\$3750/\$7500	\$35/\$55	100%/100%	\$3750/\$7500	\$400	\$75	\$10/\$20/\$55/\$95/\$150/\$250	
Silver								
<input type="checkbox"/> S532BCE ²	\$3250/\$6500	\$50/\$70	60%/50%	\$8550/Unlimited	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
<input type="checkbox"/> S531BCE	\$4700/\$9400	\$45/\$65	80%/50%	\$8550/Unlimited	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
<input type="checkbox"/> S535BCE	\$7550/\$15100	\$30/\$50	100%/100%	\$7550/\$15100	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
Blue Choice Preferred HSA Plans								
2022 Plan ID	HSA Contr.	Deduct (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
<input type="checkbox"/> G533BCE ³	\$50-\$350	\$2900/\$5800	90%/90%	90%/60%	\$3600/Unlimited	DC/90%	DC/90%	80%/80%/70%/60%/60%/50%
<input type="checkbox"/> G535BCE	\$350-\$700	\$2900/\$5800	80%/80%	80%/50%	\$5250/Unlimited	DC/80%	DC/80%	80%/80%/70%/60%/60%/50%
Silver								
<input type="checkbox"/> S534BCE	\$0-\$115	\$4800/\$9600	100%/100%	100%/100%	\$4800/\$9600	NA	NA	100%
<input type="checkbox"/> S5J1BCE	\$150-\$400	\$6000/\$12000	100%/100%	100%/100%	\$6000/\$12000	NA	NA	100%
Bronze								
<input type="checkbox"/> B536BCE	\$0	\$6650/\$13300	80%/80%	80%/50%	\$6900/Unlimited	\$250	DC/80%	80%/80%/70%/60%/60%/50%
<input type="checkbox"/> B535BCE	\$0	\$6900/\$13800	100%/100%	100%/100%	\$6900/\$13800	\$250	NA	100%
All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts. Virtual Visits are available from a participating provider for certain non-emergency services **The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply. *1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance. *2 \$500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply. *3 Select HDHP-HSA preventive prescription drugs will be covered with no member cost share								

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B. Blue Precision HMO							
2022 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay ^{*1}	Urgent Care Copay	Pharmacy
Platinum							
<input type="checkbox"/> P506PSN ^{*2}	\$0	\$10/\$45	100%	\$1500	\$300	\$45	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> P5J1PSN ^{*3}	\$0	\$20/\$30	100%	\$2000	\$300	\$30	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> P5E1PSN ^{*4}	\$1000	\$25/\$50	80%	\$3000	\$400	\$50	\$0/\$10/\$50/\$100/\$150/\$250
Gold							
<input type="checkbox"/> G5J2PSN ^{*5}	\$0	\$50/\$70	100%	\$5000	\$500	\$70	\$10/\$20/\$50/\$100/\$250/\$350
<input type="checkbox"/> G532PSN ^{*4}	\$2500	\$55/\$75	70%	\$8550	\$1000	\$75	\$10/\$20/\$50/\$100/\$250/\$350
Silver							
<input type="checkbox"/> S531PSN ^{*6}	\$3000	\$40/\$60	80%	\$8550	\$1000	\$60	\$10/\$20/\$50/\$100/\$250/\$350
<input type="checkbox"/> S530PSN ^{*7}	\$7000	\$55/\$75	70%	\$7900	\$700	\$75	\$0/\$10/\$50/\$100/\$150/\$250
All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.							
*1 - ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.							
*2 - \$250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). \$45 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.							
*3 - \$250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). \$60 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.							
*4 - No deductible/coinsurance on capitated services: Imaging, Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.							
*5 - \$400 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). \$100 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.							
*6 - \$750 copay on Imaging (CT/PET/MRI) \$250 copay on other capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient surgery.							
*7 - \$400 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply. \$70 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery							

C. Blue Options Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)									
2022 Plan ID	Deductible (BCO/ PPO/ OON)	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay ¹	Urgent Care Copay	Non-Preferred Pharmacy**	
Gold									
<input type="checkbox"/> G506OPT	\$750/ \$1750/ \$3500	\$40/\$60	\$60/\$100	80%/ 70%/ 50%	\$6250/ \$8000/ Unlimited	\$600	\$75	\$20/\$30/\$70/\$120/\$250/\$350	
<input type="checkbox"/> G508OPT	\$1500/ \$3250/ \$6500	\$30/\$55	\$45/\$95	90%/ 70%/ 50%	\$5250/ \$7250/ Unlimited	\$600	\$75	\$20/\$30/\$70/\$120/\$250/\$350	
<input type="checkbox"/> G507OPT	\$2000/ \$3500/ \$7000	\$35/\$60	\$50/\$100	90%/ 70%/ 50%	\$3750/ \$6750/ Unlimited	\$400	\$75	\$20/\$30/\$70/\$120/\$250/\$350	
Silver									
<input type="checkbox"/> S506OPT	\$4850/ \$5850/ \$11700	\$40/60	\$60/\$100	80%/ 60%/ 50%	\$7350/ \$8700/ Unlimited	\$600	\$75	\$20/\$30/\$70/\$120/\$250/350	
Blue Options HSA Plans									
2022 Plan ID	HSA Cont.	Deductible (BCO/ PPO/ OON)	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**
Gold									
<input type="checkbox"/> G5K1OPT	\$50-\$325	\$2900/ \$4600/ \$9200	100%/80%	100%/80%	100%/ 80%/ 60%	\$2900/ \$6550/ Unlimited	NA	NA	100%
Silver									
<input type="checkbox"/> S507OPT	\$0	\$4000/ \$4750/ \$9500	100%/80%	100%/80%	100%/ 80%/ 50%	\$4000/ \$6900/ Unlimited	NA	NA	100%
All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts. Virtual Visits are available from a participating provider for certain non-emergency services. **The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply *1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.									

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D. PPO (Participating Provider Options)								
2022 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ¹	Urgent Care Copay	Non-Preferred Pharmacy**	
Platinum								
<input type="checkbox"/> P503PPO	\$250/\$500	\$30/\$60	80%/50%	\$1250/Unlimited	\$400	\$60	\$10/\$20/\$55/\$95/\$150/\$250	
<input type="checkbox"/> P5E1PPO	\$500/\$1000	\$20/\$40	90%/60%	\$1500/Unlimited	\$400	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
Gold								
<input type="checkbox"/> G534PPO	\$1000/\$2000	\$50/\$70	80%/50%	\$6750/Unlimited	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
<input type="checkbox"/> G532PPO	\$1500/\$3000	\$40/\$60	80%/50%	\$5500/Unlimited	\$400	\$75	\$15/\$25/\$70/\$120/\$250/\$350	
<input type="checkbox"/> G536PPO	\$2000/\$4000	\$45/\$65	90%/60%	\$5000/Unlimited	\$500	\$75	\$15/\$25/\$70/\$120/\$250/\$350	
<input type="checkbox"/> G531PPO	\$2500/\$5000	\$20/\$60	80%/50%	\$5000/Unlimited	\$400	\$75	\$10/\$20/\$55/\$95/\$150/\$250	
<input type="checkbox"/> G537PPO	\$2600/\$5200	100%/100%	100%/100%	\$2600/\$5200	NA	NA	100%	
<input type="checkbox"/> G530PPO	\$3750/\$7500	\$35/\$55	100%/100%	\$3750/\$7500	\$400	\$75	\$10/\$20/\$55/\$95/\$150/\$250	
Silver								
<input type="checkbox"/> S532PPO ²	\$3250/\$6500	\$50/\$70	60%/50%	\$8550/Unlimited	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
<input type="checkbox"/> S531PPO	\$4700/\$9400	\$45/\$65	80%/50%	\$8550/Unlimited	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
<input type="checkbox"/> S535PPO	\$7550/\$15100	\$30/\$50	100%/100%	\$7550/\$15100	\$500	\$75	\$10/\$20/\$70/\$120/\$150/\$250	
PPO HSA Plans								
2022 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ¹	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
<input type="checkbox"/> G533PPO ³	\$50-\$350	\$2900/\$5800	90%/90%	90%/60%	\$3600/Unlimited	DC/90%	DC/90%	80%/80%/70%/60%/60%/50%
<input type="checkbox"/> G535PPO	\$350-\$700	\$2900/\$5800	80%/80%	80%/50%	\$5250/Unlimited	DC/80%	DC/80%	80%/80%/70%/60%/60%/50%
Silver								
<input type="checkbox"/> S534PPO	\$0-\$115	\$4800/\$9600	100%/100%	100%/100%	\$4800/\$9600	NA	NA	100%
<input type="checkbox"/> S5J1PPO	\$150-\$400	\$6000/\$12000	100%/100%	100%/100%	\$6000/\$12000	NA	NA	100%
Bronze								
<input type="checkbox"/> B536PPO	\$0	\$6650/\$13300	80%/80%	80%/50%	\$6900/Unlimited	\$250	DC/80%	80%/80%/70%/60%/60%/50%
<input type="checkbox"/> B535PPO	\$0	\$6900/\$13800	100%/100%	100%/100%	\$6900/\$13800	\$250	NA	100%
All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts. Virtual Visits are available from a participating provider for certain non-emergency services. **The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply *1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance. *2 \$500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply. *3 Select HDHP-HSA preventive prescription drugs will be covered with no member cost share								

Section 4 – Consumer Directed Health Accounts

HSA Vendor: * If HSA is selected, you have the option of selecting an HSA vendor with integration. (If no selection is made, HSA Vendor will default to Other / None.)	FSA Vendor: * Optional FSA vendor integration is available. (If no selection is made, FSA Vendor will default to Other / None.)
<input type="checkbox"/> BenefitWallet [®] Account Maintenance Fee: <input type="checkbox"/> Employer Paid <input type="checkbox"/> Employee Paid	<input type="checkbox"/> BenefitWallet [®]
<input type="checkbox"/> Flex [®] Account Maintenance Fee: <input type="checkbox"/> Employer Paid <input type="checkbox"/> Employee Paid	<input type="checkbox"/> Flex [®]
<input type="checkbox"/> Further [®] Account Maintenance Fee: <input type="checkbox"/> Employer Paid <input type="checkbox"/> Employee Paid	<input type="checkbox"/> Further [®]
<input type="checkbox"/> HealthEquity [®] Account Maintenance Fee: <input type="checkbox"/> Employer Paid <input type="checkbox"/> Employee Paid	<input type="checkbox"/> HealthEquity [®]
<input type="checkbox"/> HSA Bank [®] Account Maintenance Fee: <input type="checkbox"/> Employer Paid <input type="checkbox"/> Employee Paid	<input type="checkbox"/> HSA Bank [®]
<input type="checkbox"/> Other HSA Vendor / None (Select this option if using an HSA vendor other than above or are not offering an employer sponsored HSA vendor.)	<input type="checkbox"/> Other FSA Vendor / None (Select this option if using an FSA vendor other than above or are not offering an employer sponsored FSA.)

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Section 5- Ancillary Product

A. Dental Products

Blue Care Dental									
Plan Pairings (Groups 10+ enrolled)					Participation Requirements				
Contributory Group			Voluntary		Contributory Group		Voluntary		
Any one contributory high option can be paired with any one contributory low option. Exceptions: DILHM57 can be paired with DILHR33 . DILHM42 can be paired with any contributory plan.			Any one voluntary high option can be paired with any voluntary low option. Voluntary plans and contributory plans may not be offered together. DILHM59 can be paired with DILHR43 . DILHM46 can be paired with any voluntary plan.		>70% Participation >50% Employer contribution		>25% Participation Employers are not required to contribute to Voluntary Dental plans		
IL Plan ID	Plan Type	Deductible (In/Out) (3x Family Limit)	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Ortho Life Maximum	Allocation	
					In-Network (Class I/ II/ III/ IV)	Out-of-Network (Class I/ II/ III/ IV)			
Contributory Group ^{*2}									
<input type="checkbox"/> DILHR31	Passive	\$25/\$25	\$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
<input type="checkbox"/> DILHR32	Passive	\$50/\$50	\$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
<input type="checkbox"/> DILHR33	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High	
<input type="checkbox"/> DILHR34	Active	\$50/\$75	\$1500/\$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000	High	
<input type="checkbox"/> DILLR36	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
<input type="checkbox"/> DILLR37	Passive	\$75/\$75	\$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	NA	Low	
<input type="checkbox"/> DILHM38	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High	
<input type="checkbox"/> DILHM40	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High	
<input type="checkbox"/> DILLM41	Active	\$75/\$75	\$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	NA	Low	
<input type="checkbox"/> DILHM42	Passive	\$25/\$75	\$750	MAC	100%/80% ^{*3} /NA/NA	100%/80% ^{*3} /NA/NA	NA	High	
<input type="checkbox"/> DILHR50	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High	
<input type="checkbox"/> DILLM51	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
<input type="checkbox"/> DILHM57	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500	High	
<input type="checkbox"/> DILLR58 ^{*4}	Passive	\$50/\$50	\$1000	90 th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
Voluntary ^{*2}									
<input type="checkbox"/> DILHR43 ^{*1}	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High	
<input type="checkbox"/> DILHM44 ^{*1}	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High	
<input type="checkbox"/> DILHM46	Passive	\$25/\$75	\$750	MAC	100%/80% ^{*3} /NA/NA	100%/80% ^{*3} /NA/NA	NA	High	
<input type="checkbox"/> DILHR52 ^{*1}	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High	
<input type="checkbox"/> DILHR53 ^{*1}	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High	
<input type="checkbox"/> DILLR54 ^{*1}	Passive	\$50/\$50	\$1000	90 th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
<input type="checkbox"/> DILLM55 ^{*1}	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
<input type="checkbox"/> DILLM56 ^{*1}	Active	\$50/\$100	\$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	NA	Low	
<input type="checkbox"/> DILHM59 ^{*1}	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500	High	
<input type="checkbox"/> DILLR60 ^{*1*4}	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
Coinsurance Type - I: Exams/Cleanings/X-Rays (both High & Low Coverage). Coinsurance Type - II: Fillings/Non-Surgical Perio/Non-Surgical Extractions (both High & Low), Endo/Perio/Oral Surgery (High). Coinsurance Type - III: Inlays/Onlays/Crowns/Dentures (both High & Low), Endo/Perio/Oral Surgery (Low). Coinsurance Type - IV: Ortho (both High & Low Coverage). R&C: Reasonable & Customary - Out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSIL to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses MAC: Out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSIL to accept he maximum Allowable amount paid to Contracting Dentist as payment in full for Eligible Dental Expenses. Passive: Plans have the same benefits In and Out of Network Active: Plans have a richer In Network Benefit ^{*1} Waiting Period 12 month applicable for Surgical Perio/Major Restorative/Prosthodontics/Misc Rest & Prosth Services. ^{*2} Waived Deductible applies to all Class I services and plans include 3x Family Deductible Limit. ^{*3} Only Basic Restorative Services are covered. ^{*4} Preventive/Diagnostic services do not count toward annual max.									

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B. Life Products

If Life is a desired benefit, the Group Term Life product must be selected to also select Dependent Life and Short-Term Disability.

1. Group Term Life / Accidental Death & Dismemberment (AD&D)

☐ **Yes** ☐ **No** Complete Item 4 below if Term Life benefits vary by class

Choose a Benefit:

☐ Flat Benefit of \$_____ per Employee

☐ _____ times Basic Annual Salary (rounded to the next higher multiple of \$1,000, if not already a multiple), up to a Maximum benefit of \$_____ per Employee

Choose a Reduction Method:

(Only available to groups with 10 or more enrolled lives)

☐ 35% of the original amount at age 65 / 50% of the original amount at age 70

☐ 50% of the original amount at age 70

(Only applicable to groups with 2 - 9 enrolled lives)

☐ 35% of the original amount at age 65, 50% of the original amount at age 70, 75% of the original amount at age 75, 85% of the original amount at age 80.

Excess Amounts of Life Insurance:

Evidence of Insurability will be required for individual life insurance amounts in excess of \$_____. Such excess insurance amounts shall become effective on the date Evidence of Insurability is approved. Waiver of Premium, in the event of total disability, will terminate at age 65 or when no longer disabled, whichever is earlier. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day coverage would otherwise be effective, the effective date of coverage will be the date of return to Active Work. If an employee does not return to Active Work, he/she will not be covered

2. Dependent Life

☐ **Yes** ☐ **No**

Spouse

Children – age birth to 14 days

Children – age 14 days to 6 months

Children – age 6 months to 26 years / students 26

Choose a Plan:

☐ Option 1

\$10,000

\$100

\$100

\$5,000

☐ Option 2

\$5,000

\$100

\$100

\$5,000

☐ Option 3

\$5,000

\$100

\$100

\$2,000

3. Short Term Disability (STD)

☐ **Yes** ☐ **No**

Complete Item 4 below if Short Term Disability benefits vary by class (3 Max 2 – 9 lives) (6 Max 10+ lives) Benefit will not exceed 66 2/3% of Basic Weekly Salary and is payable for non-occupational disabilities only

Choose a Benefit:

☐ Flat \$_____ weekly (not to exceed \$250)

☐ Salary Based (select one) -

☐ 50%

☐ 60%

☐ 66 2/3% of Basic Weekly Salary up to a maximum of \$_____

Choose a Plan: Accident/Sickness/Duration

☐ 1 / 8 / 13 weeks ☐ 8 / 8 / 13 weeks ☐ 15 / 15 / 13 weeks

* ☐ 31 / 31 / 13 weeks *Only available to groups with 10 or more lives enrolled

☐ 1 / 8 / 26 weeks ☐ 8 / 8 / 26 weeks ☐ 15 / 15 / 26 weeks

* ☐ 31 / 31 / 26 weeks

4. Classes

Please complete this chart if Term Life or Short Term Disability benefits vary by class

Class Description	Term Life / AD&D	Short Term Disability

Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Section 6 - Additional Provisions:

Use this section to indicate any other instruction or important information.

Section 7 - Signature

Signatures	
Employer / Authorized Purchaser: Title:	Date
Underwriter: Title:	Date

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