



BlueCross BlueShield
of Illinois

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.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ 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								
2027 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**	
Platinum								
☐ P5E2BCE	\$350/\$700	\$35/\$70	80%/50%	\$2500/Unlimited	\$600	\$70	\$15/\$25/\$65/\$105/\$250/\$350	
☐ P5E1BCE	\$600/\$1200	\$25/\$60	90%/60%	\$2500/Unlimited	\$600	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ P5M1BCE	\$1500/\$3000	\$15/\$30	100%/80%	\$3000/\$6000	\$200	\$50	\$15/\$25/\$80/\$130/\$250/\$350	
Gold								
☐ G534BCE	\$1100/2200	\$50/\$75	80%/50%	\$8000/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G532BCE	\$1600/\$3200	\$45/\$70	80%/50%	\$6500/Unlimited	\$400*1	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G536BCE	\$2100/\$4200	\$50/\$75	90%/60%	\$6000/Unlimited	\$500*1	\$75	\$20/\$30/\$80/\$130/\$350/\$450	
☐ G531BCE	\$2600/\$5200	\$25/\$70	80%/50%	\$5500/Unlimited	\$400*1	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
☐ G5M2BCE	\$2500/\$5000	\$30/\$60	100%/80%	\$7750/\$15500	\$300*1	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G537BCE	\$3250/\$6500	DC/DC	100%/100%	\$3250/\$6500	DC	DC	100%	
☐ G530BCE	\$4000/\$8000	\$50/\$70	100%/100%	\$5500/\$11000	\$500*1	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
Silver								
☐ S532BCE*2	\$3700/\$7400	\$70/\$90	60%/50%	\$9750/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S531BCE	\$5100/\$10200	\$60/\$85	70%/50%	\$9950/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S535BCE	\$8000/\$16000	\$60/\$85	100%/100%	\$9950/\$19900	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
Blue Choice Preferred HSA Plans								
2027 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								
☐ G533BCE	\$50-\$350	\$3500/\$6600	DC/DC	90%/60%	\$4000/Unlimited	DC	DC	80%/80%/70%/60%/60%/50%
☐ G535BCE	\$350-\$700	\$3500/\$6600	DC/DC	80%/50%	\$5500/Unlimited	DC	DC	80%/80%/70%/60%/60%/50%
Silver								
☐ S534BCE	\$0-\$40	\$6000/\$12000	DC/DC	100%/100%	\$6000/\$12000	DC	DC	100%
☐ S5J1BCE	\$150-\$400	\$7100/\$14200	DC/DC	100%/100%	\$7100/\$14200	DC	DC	100%
Bronze								
☐ B536BCE	\$0	\$7050/\$14100	DC/DC	80%/50%	\$8150/Unlimited	\$250*1	DC	80%/80%/70%/60%/60%/50%
☐ B535BCE	\$0	\$8050/\$16100	DC/DC	100%/100%	\$8050/\$16100	\$250*1	DC	100%
☐ B5N1BCE	\$0	\$7350/\$14700	DC/DC	70%/50%	\$8100/Unlimited	\$1000*1	DC	80%/80%/70%/60%/60%/50%
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 The value shown is a Per Occurrence Deductible. Calendar Year Deductible and Coinsurance will apply after the Per Occurrence Deductible. *2 \$500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.								

B. Blue Precision HMO							
2027 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay	Urgent Care Copay	Pharmacy
Platinum							
☐ P506PSN ^{*2}	\$0	\$20/\$60	100%	\$2600	\$300	\$60	\$5/\$15/\$60/\$110/\$250/\$350
☐ P5J1PSN ^{*2}	\$0	\$25/\$40	100%	\$3000	\$300	\$40	\$5/\$15/\$60/\$110/\$250/\$350
☐ P5E1PSN ^{*2}	\$1400	\$30/\$70	80%	\$4000	\$400 ^{*1}	\$70	\$5/\$15/\$60/\$110/\$250/\$350
Gold							
☐ G5J2PSN ^{*2}	\$0	\$55/\$80	100%	\$5550	\$500	\$80	\$10/\$20/\$50/\$100/\$250/\$350
☐ G5N1PSN ^{*2}	\$0	\$45/\$65	80%	\$6500	\$300	\$65	\$10/\$20/\$50/\$100/\$250/\$350
☐ G532PSN ^{*2}	\$2850	\$65/\$90	70%	\$9500	\$1000 ^{*1}	\$90	\$10/\$20/\$50/\$100/\$250/\$350
Silver							
☐ S531PSN ^{*2}	\$3350	\$45/\$85	70%	\$9700	\$600 ^{*1}	\$85	\$10/\$20/\$50/\$100/\$250/\$350
☐ S530PSN ^{*2}	\$7100	\$65/\$95	70%	\$10000	\$700 ^{*1}	\$95	\$5/\$15/\$60/\$110/\$250/\$350
All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts. *1 The value shown is a Per Occurrence Deductible. Calendar Year Deductible and Coinsurance will apply after the Per Occurrence Deductible. *2 Plan applies copays on the following services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic imaging and Outpatient Surgery. See Summary of Benefits and Coverage for a full list of copay amounts.							

C. Blue Options Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)									
2027 Plan ID	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**	
Platinum									
☐ P5N1OPT	\$600/ \$1200/ \$2400	\$20/\$35	\$40/\$85	90%/ 70%/ 50%	\$3000/ \$7500/ Unlimited	\$200*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
☐ P5BAOPT	\$1100/ \$2600/ \$5200	\$25/\$45	\$45/\$90	90%/ 70%/ 50%	\$4100/ \$7800/ Unlimited	\$200*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
Gold									
☐ G506OPT	\$850/ \$2100/ \$4200	\$45/\$65	\$70/\$110	80%/ 60%/ 50%	\$7000/ \$8750/ Unlimited	\$600*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
☐ G508OPT	\$1700/ \$3900/ \$7800	\$40/\$65	\$60/\$110	90%/ 70%/ 50%	\$6400/ \$8400/ Unlimited	\$600*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
☐ G507OPT	\$2200/ \$4000/ \$8000	\$50/\$75	\$70/\$110	90%/ 70%/ 50%	\$5100/ \$8100/ Unlimited	\$400*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
☐ G5M3OPT	\$3000/ \$5500/ \$11000	\$25/\$50	\$50/\$100	100%/ 80%/ 50%	\$7500/ \$9000/ Unlimited	\$300*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
Silver									
☐ S506OPT	\$5350/ \$6350/ \$12700	\$70/\$90	\$90/\$120	80%/ 60%/ 50%	\$9500/ \$11500/ Unlimited	\$600*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
☐ S5BBOPT	\$6000/ \$8000/ \$16000	\$70/\$90	\$90/\$120	80%/ 60%/ 50%	\$10000/ \$12000/ Unlimited	\$600*1	\$75	\$25/\$35/\$80/\$130/\$350/\$450	
Blue Options HSA Plans									
2027 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									
☐ G5K1OPT	\$50-\$325	\$3800/ \$5200/ \$10400	DC	DC	100%/ 80%/ 60%	\$3800/ \$7200/ Unlimited	DC	DC	100%
Silver									
☐ S507OPT	\$0	\$5900/ \$7500/ \$17000	DC	DC	100%/ 80%/ 50%	\$5900/ \$8500/ Unlimited	DC	DC	100%
☐ S5N1OPT	\$0	\$6000/ \$7000/ \$21000	DC	DC	100%/ 70%/ 50%	\$6000/ \$8000/ Unlimited	DC	DC	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 The value shown is a Per Occurrence Deductible. Calendar Year Deductible and Coinsurance will apply after the Per Occurrence Deductible.									

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GA-RSG 2026-BPS HCSC Rev. 07/23/2026

D. PPO (Participating Provider Options)								
2027 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**	
Platinum								
☐ P503PPO	\$350/\$700	\$35/\$70	80%/50%	\$2500/Unlimited	\$600	\$70	\$15/\$25/\$65/\$105/\$250/\$350	
☐ P5E1PPO	\$600/\$1200	\$25/\$60	90%/60%	\$2500/Unlimited	\$600	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ P5M1PPO	\$1500/\$3000	\$15/\$30	100%/80%	\$3000/\$6000	\$200	\$50	\$15/\$25/\$80/\$130/\$250/\$350	
Gold								
☐ G534PPO	\$1100/\$2200	\$50/\$75	80%/50%	\$8000/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G532PPO	\$1600/\$3200	\$45/\$70	80%/50%	\$6500/Unlimited	\$400*1	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G536PPO	\$2100/\$4200	\$50/\$75	90%/60%	\$6000/Unlimited	\$500*1	\$75	\$20/\$30/\$80/\$130/\$350/\$450	
☐ G531PPO	\$2600/\$5200	\$25/\$70	80%/50%	\$5500/Unlimited	\$400*1	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
☐ G5M2PPO	\$2500/\$5000	\$30/\$60	100%/80%	\$7750/\$15500	\$300*1	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G537PPO	\$3250/\$6500	DC/DC	100%/100%	\$3250/\$6500	DC	DC	100%	
☐ G530PPO	\$4000/\$8000	\$50/\$70	100%/100%	\$5500/\$11000	\$500*1	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
Silver								
☐ S532PPO ²	\$3700/\$7400	\$70/\$90	60%/50%	\$9750/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S531PPO	\$5100/\$10200	\$60/\$85	70%/50%	\$9950/Unlimited	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S535PPO	\$8000/\$16000	\$60/\$85	100%/100%	\$9950/\$19900	\$500*1	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
PPO HSA Plans								
2027 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
☐ G533PPO	\$50-\$350	\$3500/\$6600	DC/DC	90%/60%	\$4000/Unlimited	DC	DC	80%/80%/70%/60%/60%/50%
☐ G535PPO	\$350-\$700	\$3500/\$6600	DC/DC	80%/50%	\$5500/Unlimited	DC	DC	80%/80%/70%/60%/60%/50%
Silver								
☐ S534PPO	\$0-\$40	\$6000/\$12000	DC/DC	100%/100%	\$6000/\$12000	DC	DC	100%
☐ S5J1PPO	\$150-\$400	\$7100/\$14200	DC/DC	100%/100%	\$7100/\$14200	DC	DC	100%
Bronze								
☐ B536PPO	\$0	\$7050/\$14100	DC/DC	80%/50%	\$8150/Unlimited	\$250*1	DC	80%/80%/70%/60%/60%/50%
☐ B535PPO	\$0	\$8050/\$16100	DC/DC	100%/100%	\$8050/\$16100	\$250*1	DC	100%
☐ B5N1PPO	\$0	\$7350/\$14700	DC/DC	70%/50%	\$8100/Unlimited	\$1000*1	DC	80%/80%/70%/60%/60%/50%
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 The value shown is a Per Occurrence Deductible. Calendar Year Deductible and Coinsurance will apply after the Per Occurrence Deductible. *2 \$500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.								

Section 4 – Consumer Directed Health Accounts

Blue Cross and Blue Shield of Illinois has preferred relationships with the vendors listed below. By selecting one of these vendors, employers agree to have the necessary data shared with the integrated vendor for purposes of plan administration. A vendor-specific employer set-up form is required to be submitted for first time vendor integration.

HSA Vendor: * If HSA is selected, you have the option of selecting an HSA vendor with enrollment, balance and transaction displayed on BAM and claims integration. Note: Integration features vary by vendor. (If no selection is made, HSA Vendor will default to Other / None.)	FSA Vendor: * Optional FSA vendor enrollment, balance and transaction displayed on BAM and claims integration is available. Clients who are renewing an FSA are required to re-submit employee elections with their renewal paperwork to continue the FSA plan. Note: Integration features vary by vendor. (If no selection is made, FSA Vendor will default to Other / None.)
☐ Flex [®] Account Maintenance Fee: ☐ Employer Paid ☐ Employee Paid	☐ Flex [®]
☐ HealthEquity [®] Account Maintenance Fee: ☐ Employer Paid ☐ Employee Paid	☐ HealthEquity [®]
☐ HSA Bank [®] Account Maintenance Fee: ☐ Employer Paid ☐ Employee Paid	☐ HSA Bank [®]
☐ Other HSA Vendor / None (Select this option if using an HSA vendor other than above or are not offering an employer sponsored HSA vendor.)	☐ Other FSA Vendor / None (Select this option if using an FSA vendor other than above or are not offering an employer sponsored FSA.)

Section 5- Ancillary Products

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 DILHR.33 . 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 DILHR.43 . 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									
☐ DILHR.30 ⁵	Passive	\$25/\$25	\$5000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR.31 ⁵	Passive	\$25/\$25	\$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR.32 ⁵	Passive	\$50/\$50	\$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR.33 ⁵	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High	
☐ DILHR.34 ⁵	Active	\$50/\$75	\$1500/\$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000	High	
☐ DILHR.35 ⁵	Active	\$0/\$0	\$2000	90th R&C	100%/90%/60%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILLR36	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
☐ DILHM38	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High	
☐ DILHM40	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High	
☐ DILLM41	Active	\$75/\$75	\$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	NA	Low	
☐ DILHM42	Passive	\$25/\$75	\$750	MAC	100%/80% ³ /NA/NA	100%/80% ³ /NA/NA	NA	High	
☐ DILHR.50	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High	
☐ DILLM51	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
☐ DILHM57 ⁵	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500	High	
☐ DILLR58 ⁴	Passive	\$50/\$50	\$1000	90 th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
☐ DILHR.61	Passive	\$50/\$50	\$2000	90 th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High	
☐ DILLR62	Passive	\$50/\$50	\$1500	90 th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
Voluntary ²									
☐ DILHR.43 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High	
☐ DILHM44 ¹	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High	
☐ DILHR.45 ¹	Active	\$25/\$75	\$2000	90th R&C	100%/90%/60%/50%	100%/80%50%/50%	\$2000	High	
☐ DILHM46	Passive	\$25/\$75	\$750	MAC	100%/80% ³ /NA/NA	100%/80% ³ /NA/NA	NA	High	
☐ DILLR47 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
☐ DILLR48 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
☐ DILLM49 ¹	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
☐ DILHR.53 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High	
☐ DILLR54 ¹	Passive	\$50/\$50	\$1000	90 th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low	
☐ DILLM55 ¹	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
☐ DILHM59 ¹	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500	High	
☐ DILLR60 ¹¹⁴	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low	
☐ DILLR63 ¹	Passive	\$50/\$50	\$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
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 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 Class IV Orthodontic 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. *5 Implants are covered at the same percentage as prosthodontics.									

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B. Standalone Vision, Critical Illness, Accident, and Hospital Indemnity Products

Standalone Vision	Yes ☐			No ☐			
Standalone Vision Plans							
Plan Name	Frequency Eye/Lens/Frame	Lens Copay	Allowance (Frame & Contacts)	Funded Fit and Follow up	Funded Standard Progressive	Funded Scratch Coating	Funded Kids Polycarb
Basic Standalone Vision							
☐ Plan 1	12/12/24	\$25	\$100	No	No	No	No
☐ Plan 2	12/12/24	\$10	\$130	No	No	Yes	No
☐ Plan 3	12/12/24	\$10	\$130	Yes	No	Yes	No
☐ Plan 4	12/12/12	\$10	\$130	No	No	Yes	No
☐ Plan 5	12/12/24	\$10	\$150	No	No	Yes	No
☐ Plan 6	12/12/12	\$10	\$150	No	No	Yes	No
☐ Plan 7	12/12/12	\$10	\$150	No	Yes	Yes	No
☐ Plan 8	12/12/24	\$25	\$130	No	No	Yes	No
☐ Plan 9	12/12/24	\$25	\$ 150	No	No	Yes	No
☐ Plan 10	12/12/12	\$25	\$150	No	No	Yes	No
☐ Plan 11	12/12/12	\$25	\$130	No	No	Yes	Yes
☐ Plan 12	12/12/12	\$10	\$200	No	No	Yes	Yes
☐ Plan 13	12/12/12	\$25	\$200	No	No	Yes	Yes
☐ Plan 14	12/12/24	\$25	\$200	No	No	Yes	Yes
Voluntary Standalone Vision							
☐ Plan 1	12/12/24	\$25	\$100	No	No	No	No
☐ Plan 2	12/12/24	\$10	\$130	No	No	Yes	No
☐ Plan 3	12/12/24	\$10	\$130	Yes	No	Yes	No
☐ Plan 4	12/12/12	\$10	\$130	No	No	Yes	No
☐ Plan 5	12/12/24	\$10	\$150	No	No	Yes	No
☐ Plan 6	12/12/12	\$10	\$150	No	No	Yes	No
☐ Plan 7	12/12/12	\$10	\$150	No	Yes	Yes	No
☐ Plan 8	12/12/24	\$25	\$130	No	No	Yes	No
☐ Plan 9	12/12/24	\$25	\$150	No	No	Yes	No
☐ Plan 10	12/12/12	\$25	\$150	No	No	Yes	No
☐ Plan 11	12/12/12	\$25	\$130	No	No	Yes	Yes
☐ Plan 12	12/12/12	\$10	\$200	No	No	Yes	Yes
☐ Plan 13	12/12/12	\$25	\$200	No	No	Yes	Yes
☐ Plan 14	12/12/24	\$25	\$200	No	No	Yes	Yes
Critical Illness	Yes ☐			No ☐			
Critical Illness Plans							
Plan Name	Plan Benefit			Benefit Maximum			
Basic Critical Illness							
☐ Plan 1	\$5,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
☐ Plan 2	\$10,000 Employee / \$5,000 Spouse / \$2,500 Child			Up to 3 times benefit amount			
☐ Plan 3	\$10,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
Voluntary Critical Illness							
☐ Plan 1	\$5,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
☐ Plan 2	Employee: \$10,000, \$20,000, or \$30,000 Spouse: 50% of the Employee's elected amount Child: 50% of the Employee's elected amount			Up to 3 times benefit amount			
Accident	Yes ☐			No ☐			
Accident Plans							
Plan Name	Benefit Description	24-hour coverage	Benefit Coverage		Wellness		
Basic Accident							
☐ Plan 1	Benefit for treatment and injuries due to an accident	No	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200		\$40		

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GA-RSG 2026-BPS HCSC Rev. 07/23/2026

☐ Plan 2	Benefit for treatment and injuries due to an accident	No	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50		
☐ Plan 1 – 24 Hr.	Benefit for treatment and injuries due to an accident	Yes	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40		
☐ Plan 2 – 24 Hr.	Benefit for treatment and injuries due to an accident	Yes	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50		
☐ Smart Plan 1	Benefits for treatment due to an accident	No	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 2	Benefits for treatment due to an accident	No	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 1 – 24 Hr.	Benefits for treatment due to an accident	Yes	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 2 – 24 Hr.	Benefits for treatment due to an accident	Yes	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0		
Voluntary Accident						
☐ Plan 1	Benefit for treatment and injuries due to an accident	No	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40		
☐ Plan 2	Benefit for treatment and injuries due to an accident	No	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50		
☐ Plan 1 – 24 Hr.	Benefit for treatment and injuries due to an accident	Yes	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40		
☐ Plan 2 – 24 Hr.	Benefit for treatment and injuries due to an accident	Yes	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50		
☐ Smart Plan 1	Benefits for treatment due to an accident	No	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 2	Benefits for treatment due to an accident	No	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 1 – 24 Hr.	Benefits for treatment due to an accident	Yes	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0		
☐ Smart Plan 2 – 24 Hr.	Benefits for treatment due to an accident	Yes	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0		
Hospital Indemnity		Yes ☐		No ☐		
Hospital Indemnity Plans						
Plan Name	Hospital Admission Once per calendar year	Daily Hospital Confinement Up to 30 days per calendar year	Intensive Care Unit Admission-once per calendar year	Daily ICU Confinement-up to 10 days per calendar year	Newborn Confinement – (Routine Nursery care)	Wellness – Once per calendar year
Basic Hospital Indemnity						
☐ Plan 1	\$500	\$100/day	\$500	\$100/day	\$50/day	\$50/day
☐ Plan 2	\$1,000	\$100/day	\$1,000	\$100/day	\$50/day	\$50/day
☐ Plan 3	\$2,000	\$200/day	\$2,000	\$200/day	\$50/day	\$50/day
Voluntary Hospital Indemnity						
☐ Plan 1	\$500	\$100/day	\$500	\$100/day	\$50/day	\$50/day
☐ Plan 2	\$1,000	\$100/day	\$1,000	\$100/day	\$50/day	\$50/day
☐ Plan 3	\$2,000	\$200/day	\$2,000	\$200/day	\$50/day	\$50/day

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GA-RSG 2026-BPS HCSC Rev. 07/23/2026

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