BlueCross BlueShield of Illinois

Dearborn National®
Underwritten by Dearborn National® Life Insurance Company

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. BlueSTAR 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.
- 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: (*If New Business, skip 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**	

Section 2b- Renewing Groups Only: (*If New Business, skip to section 3)

Adding Plan (Medical and/or Dental)**:**

Please list new plan(s) below

1.

2.

3.

4.

5.

6.

Section 3- HSA

HSA Vendor: * If an HSA plan is selected, a vendor will need to be selected. (If no HSA selection is made, HSA Vendor will default to Other / None.)	☐ **Option A:** BenefitWallet
	☐ **Option B:** HSA Bank
	☐ **Option C:** FlexHSA Plan
	☐ **Option D:** Other / None

Section 4- New Business

Group Number:

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

A. PPO (Participating Provider Options)

2018 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*1	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum									
☐P503PPO	N/A	$250/ $500	$25/$45	80%/ 50%	$1250/ $2500	$300	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Gold									
☐G530PPO	N/A	$3250/ $6500	$15/$35	100%/ 100%	$3250/ $6500	$400	100%/ 100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G531PPO	N/A	$1500/ $3000	$20/$60	80%/ 50%	$3500/ $7000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G532PPO	N/A	$1250/ $2500	$35/$60	80%/ 50%	$3500/ $7000	$400	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐G533PPO*3	$350-$575	$2700/ $5400	NA/NA	90%/ 60%	$3500/ $7000	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐G534PPO	N/A	$750/ $1500	$40/$60	80%/ 50%	$5500/ $11000	$400	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐G535PPO*3	$650-$900	$2700/ $5400	NA/NA	80%/ 50%	$5000/ $10000	NA	70% 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐G536PPO	N/A	$1800/ $3600	$20/$40	90%/ 60%	$4000/ $8000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G537PPO	N/A	$2000/ $4000	NA/NA	100%/ 100%	$2000/ $4000	NA	100%/ 100%	100%	100%
Silver									
☐S531PPO	N/A	$4000/ $8000	$30/$50	80%/ 50%	$7000/ $14000	$500	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S532PPO	N/A	$2400/ $4800	$50/$70	60%/ 50%	$7300/ $14600	$500	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S534PPO	$0-$300	$4800/ $9600	NA/NA	100%/ 100%	$4800/ $9600	NA	100%/ 100%	100%	100%
☐S535PPO	N/A	$7350/ $14700	$20/$40	100%/ 100%	$7350/ $14700	$500	100%/ 100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Bronze									
☐B535PPO	$0	$6400/ $12800	NA/NA	100%/ 100%	$6400/ $12800	NA	100%/ 100%	100%	100%
☐B536PPO	$0	$6150/ $12300	NA/NA	80%/ 50%	$6500/ $13000	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**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 Ped Dental Out coinsurance is subjected to INN ded/coins.
*3 These HSA plans require a mandatory employer contribution.

B. Blue Choice Preferred

2018 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*1	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold									
☐G530BCE	N/A	$3250/ $6500	$15/$35	100%/ 100%	$3250/ $6500	$400	100%/ 100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G531BCE	N/A	$1500/ $3000	$20/$60	80%/ 50%	$3500/ $7000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G532BCE	N/A	$1250/ $2500	$35/$60	80%/ 50%	$3500/ $7000	$400	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐G533BCE*3	$350-$575	$2700/ $5400	NA/NA	90%/ 60%	$3500/ $7000	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐G535BCE*3	$650-$900	$2700/ $5400	NA/NA	80%/ 50%	$5000/ $10000	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
Silver									
☐S531BCE	N/A	$4000/ $8000	$30/$50	80%/ 50%	$7000/ $14000	$500	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S532BCE	N/A	$2400/ $4800	$50/$70	60%/ 50%	$7300/ $14600	$500	70%/ 50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S534BCE	$0-$300	$4800/ $9600	NA/NA	100%/ 100%	$4800/ $9600	NA	100%/ 100%	100%	100%
☐S535BCE	N/A	$7350/ $14700	$20/$40	100%/ 100%	$7350/ $14700	$500	100%/ 100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Bronze									
☐B535BCE	$0	$6400/ $12800	NA/NA	100%/ 100%	$6400/ $12800	NA	100%/ 100%	100%	100%
☐B536BCE	$0	$6150/ $12300	NA/NA	80%/ 50%	$6500/ $13000	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**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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C. Blue Options

Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)

2018 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*1	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold										
☐G506OPT	N/A	$700/ $1500/ $3000	$20/ $50	$40/ $100	90%/ 70%/ 50%	$4200/ $6000/ $12000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G507OPT	N/A	$1000/ $2500/ $5000	$25/ $50	$50/ $100	90%/ 70%/ 50%	$2500/ $5500/ $11000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G508OPT	N/A	$1500/ $3000/ $6000	$15/ $40	$30/ $80	90%/ 70%/ 50%	$3000/ $5000/ $10000	$400	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Silver										
☐S506OPT	N/A	$4000/ $5000/ $10000	$25/ $50	$50/ $90	80%/ 60%/ 50%	$6000/ $6850/ $13700	$500	70%/ 50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐S507OPT	$0-$225	$4000/ $4750/ $9500	NA/ NA	NA/ NA	100%/ 80%/ 50%	$4000/ $6550/ $13100	NA	70%/ 50%	100%	100%

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**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply
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*2 Pediatric Dental Out coinsurance is subjected to INN ded/coins.

D. Blue Precision HMO

2018 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay*1	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
☐P506PSN	$0	$10/$45	100%	$1500	$300	100%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Gold								
☐G532PSN	$2500	$30/$50	70%	$6750	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐G533PSN	$4000	$30/$50	80%	$5500	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Silver								
☐S530PSN	$6250	$30/$50	70%	$7150	$500	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐S531PSN	$2000	$35/$55	80%	$6850	$1000	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**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.

E. BlueCare Direct HMO

2018 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay*1	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
☐P506BCH	$0	$10/$45	100%	$1500	$300	100%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Gold								
☐G532BCH	$2500	$30/$50	70%	$6750	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐G533BCH	$4000	$30/$50	80%	$5500	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Silver								
☐S530BCH	$6250	$30/$50	70%	$7150	$500	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐S532BCH	$2000	$35/$55	80%	$6850	$1000	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**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.

Section 5- Ancillary Product Selection:

A. Dental Products

1. Blue Care Dental

Plan Pairings (Groups 10+)				Participation Requirements	
Contributory Group		**Voluntary**		**Contributory Group**	**Voluntary**
High Option	**Low Option**	**High Option**	**Low Option**	>70% Participation >50% Employer contribution	>25% Participation Employers are not required to contribute to Voluntary Dental plans
DILHR01	DILLR06	DILHR13	DILLM25		
DILHR02	DILLR07	DILHR22	DILLM26		
DILHR03	DILLM21				
Any one contributory group high option can be paired with any one contributory group low option; DILHM12 can be freely paired with any contributory group.		Any one voluntary high option can be paired with any one voluntary low option. DILHM16 can be freely paired with any voluntary option			

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								
☐ DILHR01	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR02	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR03	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHR04	Active	$50/$75	$1500/$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	$1000	High
☐ DILHM08	Passive	$50/$50	$1000	MAC	100%/80/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHM10	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
☐ DILHM12	Passive	$25/$75	$750	MAC	100%/80*3/NA/NA	100%/80%*3/NA/NA	N/A	High
☐ DILHR20	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
☐ DILLR06	Passive	$50/$50	$1000	90th R&C	100%/80/50%/NA	100%/80%/50%/NA	N/A	Low
☐ DILLR07	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	N/A	Low
☐ DILLM11	Active	$75/$75	$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	N/A	Low
☐ DILLM21	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
Voluntary*2								
☐ DILHR13*1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHM14*1	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
☐ DILHM16	Passive	$25/$75	$750	MAC	100%/80%*3/NA/NA	100%/80%*3/NA/NA	N/A	High
☐ DILHR22*1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHR23*1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
☐ DILLR24*1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	Low
☐ DILLM25*1	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DILLM26*1	Active	$50/$100	$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	N/A	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, MAC: Maximum Allowable Charge
*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

B. Life Products

Group Number:

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:	**Choose a Reduction Method:**
☐ Flat Benefit of **$**_____ per Employee	(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
☐ _____ 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	☐ 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 by Dearborn National® Life Insurance Company. 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:	☐ Option1	$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

Section 6 - Additional Provisions:

Use this section to indicate if the account is retaining any plan(s) not shown above, or need to indicate any other instruction or important information.

Section 7 - Signature

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