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| BCBSIL - Black Left 2007 | | |  | | | |
| **BENEFIT PLAN SELECTION (BPS) - ACA SMALL GROUP** | | | | | | |
| **Please complete & return this form in its entirety, including the required signatures** | | | | | | |
| **Section 1- Account Information:** | | | | | | |
| 1. Employer Name: |  | | | | 1. SIC Code |  |
| 1. Account #: |  | 1. Effective Date: | |  | 1. 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. | | |  | **Yes**   **No** |  | | |  | **Yes**  **No** |  | | |  | **Yes**   **No** |  | | |  | **Yes**   **No** |  | | |  | **Yes**  **No** |  | | |  | **Yes**   **No** |  | | |  | **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 | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | |   **Section 3 - New Business Group Number:**  Please select plan designs (Up to a maximum of 6 plans) | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **A. Blue Choice Preferred** | | | | | | | | | | | | | | **2024 Plan ID** | | **Deductible (In/Out)** | | **Office Visit/**  **Specialist** | | **Coins**  **(In/Out)** | | **OPX**  **(In/Out)** | **ER**  **Copay\*1** | **Urgent Care**  **Copay** | **Non-Preferred Pharmacy\*\*** | | | **Platinum** | | | | | | | | | | | | | | P5E2BCE | | $250/$500 | | $30/$60 | | 80%/50% | | $1500/Unlimited | $400 | $60 | $10/$20/$55/$95/$150/$250 | | | P5E1BCE | | $500/$1000 | | $20/$40 | | 90%/60% | | $1500/Unlimited | $400 | $75 | $10/$20/$70/$120/$150/$250 | | | **Gold** | | | | | | | | | | | | | | G532BCE | | $1500/$3000 | | $40/$60 | | 80%/50% | | $6250/Unlimited | $400 | $75 | $15/$25/$70/$120/$250/$350 | | | G531BCE | | $2500/$5000 | | $20/$60 | | 80%/50% | | $5000/Unlimited | $400 | $75 | $10/$20/$55/$95/$150/$250 | | | G530BCE | | $4000/$8000 | | $50/$70 | | 100%/100% | | $5500/$11000 | $500 | $75 | $10/$20/$55/$95/$150/$250 | | | **Silver** | | | | | | | | | | | | | | S532BCE\*2 | | $3600/$7200 | | $60/$80 | | 60%/50% | | $9100/Unlimited | $500 | $80 | $10/$20/$70/$120/$150/$250 | | | S531BCE | | $5000/$10000 | | $45/$65 | | 70%/50% | | $9100/Unlimited | $500 | $75 | $10/$20/$70/$120/$150/$250 | | | S535BCE | | $7900/$15800 | | $45/$65 | | 100%/100% | | $9000/$18000 | $500 | $75 | $10/$20/$70/$120/$150/$250 | | | **Blue Choice Preferred HSA Plans** | | | | | | | | | | | | | | **2024 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 | | $3200/  $6400 | | 90%/90% | | 90%/  60% | $3700/Unlimited | DC/90% | DC/90% | | 80%/80%/70%/60%/60%/50% | | G535BCE | $350-$700 | | $3200/  $6400 | | 80%/80% | | 80%/  50% | $5250/Unlimited | DC/80% | DC/80% | | 80%/80%/70%/60%/60%/50% | | **Silver** | | | | | | | | | | | | | | S534BCE | $0-$40 | | $5250/  $10500 | | 100%/100% | | 100%/  100% | $5250/$10500 | DC/100% | DC/100% | | 100% | | S5J1BCE | $150-  $400 | | $6250/  $12500 | | 100%/100% | | 100%/  100% | $6250/$12500 | DC/100% | DC/100% | | 100% | | **Bronze** | | | | | | | | | | | | | | B536BCE | $0 | | $6950/  $13900 | | 80%/80% | | 80%/  50% | $7300/Unlimited | $250 | DC/80% | | 80%/80%/70%/60%/60%/50% | | B535BCE | $0 | | $7200/  $14400 | | 100%/100% | | 100%/  100% | $7200/$14400 | $250 | DC/100% | | 100% | | B5N1BCE | $0 | | $7250/  $14500 | | 70%/70% | | 70%/  50% | $7500/Unlimited | $1000 | DC/70% | | 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 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. | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | **B. Blue Precision HMO** | | | | | | | | | **2024 Plan ID** | **Deductible (In)** | **Office Visit/**  **Specialist** | **Coins**  **(In)** | **OPX**  **(In)** | **ER**  **Copay\*1** | **Urgent Care Copay** | **Pharmacy** | | **Platinum** | | | | | | | | | P506PSN\*2 | $0 | $10/$45 | 100% | $1500 | $300 | $45 | $0/$10/$50/$100/$150/$250 | | P5J1PSN\*3 | $0 | $20/$30 | 100% | $2000 | $300 | $30 | $0/$10/$50/$100/$150/$250 | | P5E1PSN\*4 | $1000 | $25/$50 | 80% | $3000 | $400 | $50 | $0/$10/$50/$100/$150/$250 | | **Gold** | | | | | | | | | G5J2PSN\*5 | $0 | $50/$70 | 100% | $5000 | $500 | $70 | $10/$20/$50/$100/$250/$350 | | G532PSN\*4 | $2750 | $55/$75 | 70% | $9100 | $1000 | $75 | $10/$20/$50/$100/$250/$350 | | G5N1PSN\*6 | $0 | $50/$75 | 80% | $6500 | $500 | $75 | $10/$20/$50/$100/$250/$350 | | **Silver** | | | | | | | | | S531PSN\*6 | $3250 | $30/$60 | 70% | $9100 | $500 | $60 | $10/$20/$50/$100/$250/$350 | | S530PSN\*7 | $7000 | $55/$75 | 70% | $9100 | $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 | | | | | | | | |  | | | | | | | | | | | | | | |

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| **C.     Blue Options**  **Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)** | | | | | | | | | | | |
| **2024 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\*\*** |
| **Platinum** | | | | | | | | | | | |
| P5N1OPT | $250/  $750/  $1500 | | $15/$30 | | $30/$60 | 90%/  70%/  50% | $2250/  $6750/  Unlimited | $200 | $75 | | $20/$30/$70/$120/$250/$350 |
| **Gold** | | | | | | | | | | | |
|  | |  | |  |  |  |  |  |  |  | |
| G506OPT | | $750/  $2000/  $4000 | | $40/$60 | $60/$100 | 80%/  60%/  50% | $6750/  $8500/  Unlimited | $600 | $75 | $20/$30/$70/$120/$250/$350 | |
| G508OPT | | $1500/  $3750/  $7500 | | $35/$60 | $50/$100 | 90%/  70%/  50% | $5850/  $7850/  Unlimited | $600 | $75 | $20/$30/$70/$120/$250/$350 | |
| G507OPT | | $2000/  $3500/  $7000 | | $35/$60 | $50/$100 | 90%/  70%  50% | $4350/  $7350/  Unlimited | $400 | $75 | $20/$30/$70/$120/$250/$350 | |
| **Silver** | | | | | | | | | | | |
| S506OPT | | $5250/  $6250/  $12500 | | $50/70 | $70/$110 | 80%/  60%/  50% | $8150/  $9100/  Unlimited | $600 | $75 | $20/$30/$70/$120/$250/350 | |

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| **Blue Options HSA Plans** | | | | | | | | | |
| **2024 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 | $3200/  $4700/  $9400 | 100%/80% | 100%/80% | 100%/  80%/  60% | $3200/  $6650/  Unlimited | DC/100% | DC/100% | 100% |
| **Silver** | | | | | | | | | |
| S507OPT | $0 | $4800/  $5500/  $16500 | 100%/70% | 100%/70% | 100%/  70%/  50% | $4800/  $7250/  Unlimited | DC/100% | DC/100% | 100% |
| S5N1OPT | $0 | $5250/  $6250/  $18750 | 100%/70% | 100%/70% | 100%/  70%/  50% | $5250/  $7500/  Unlimited | DC/100% | DC/100% | 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)** |

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| **2024 Plan ID** | **Deductible**  **(In/Out)** | | **Office Visit/**  **Specialist** | | **Coins**  **(In/Out)** | | **OPX**  **(In/Out)** | | **ER**  **Copay\*1** | | **Urgent Care**  **Copay** | | **Non-Preferred Pharmacy\*\*** | |
| **Platinum** | | | | | | | | | | | | | | |
| P503PPO | $250/$500 | | $30/$60 | | 80%/50% | | $1500/Unlimited | | $400 | | $60 | | $10/$20/$55/$95/$150/$250 | |
| P5E1PPO | $500/$1000 | | $20/$40 | | 90%/60% | | $1500/Unlimited | | $400 | | $75 | | $10/$20/$70/$120/$150/$250 | |
| **Gold** | | | | | | | | | | | | | | |
| G534PPO | $1000/$2000 | | $50/$70 | | 80%/50% | | $7750/Unlimited | | $500 | | $75 | | $10/$20/$70/$120/$150/$250 | |
| G532PPO | $1500/$3000 | | $40/$60 | | 80%/50% | | $6250/Unlimited | | $400 | | $75 | | $15/$25/$70/$120/$250/$350 | |
| G536PPO | $2000/$4000 | | $45/$65 | | 90%/60% | | $5750/Unlimited | | $500 | | $75 | | $15/$25/$70/$120/$250/$350 | |
| G531PPO | $2500/$5000 | | $20/$60 | | 80%/50% | | $5000/Unlimited | | $400 | | $75 | | $10/$20/$55/$95/$150/$250 | |
| G537PPO | $2800/$5600 | | 100%/100% | | 100%/100% | | $2800/$5600 | | DC/100% | | DC/100% | | 100% | |
| G530PPO | $4000/$8000 | | $50/$70 | | 100%/100% | | $5500/$11000 | | $500 | | $75 | | $10/$20/$55/$95/$150/$250 | |
| **Silver** | | | | | | | | | | | | | | |
| S532PPO\*2 | $3600/$7200 | | $60/$80 | | 60%/50% | | $9100/Unlimited | | $500 | | $80 | | $10/$20/$70/$120/$150/$250 | |
| S531PPO | $5000/$10000 | | $45/$65 | | 70%/50% | | $9100/Unlimited | | $500 | | $75 | | $10/$20/$70/$120/$150/$250 | |
| S535PPO | $7900/$15800 | | $45/$65 | | 100%/100% | | $9000/$18000 | | $500 | | $75 | | $10/$20/$70/$120/$150/$250 | |
| **PPO HSA Plans** | | | | | | | | | | | | | | |
| **2024 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** | | | | | | | | | | | | | | |
| G533PPO | $50-$350 | $3200/  $6400 | | 90%/90% | | 90%/  60% | | $3700/Unlimited | | DC/90% | | DC/90% | | 80%/80%/70%/60%/60%/50% |
| G535PPO | $350-$700 | $3200/  $6400 | | 80%/80% | | 80%/  50% | | $5250/Unlimited | | DC/80% | | DC/80% | | 80%/80%/70%/60%/60%/50% |
| **Sliver** | | | | | | | | | | | | | | |
| S534PPO | $0-$40 | $5250/  $10500 | | 100%/100% | | 100%/  100% | | $5250/$10500 | | DC/100% | | DC/100% | | 100% |
| S5J1PPO | $150-$400 | $6250/  $12500 | | 100%/100% | | 100%/  100% | | $6250/$12500 | | DC/100% | | DC/100% | | 100% |
| **Bronze** | | | | | | | | | | | | | | |
| B536PPO | $0 | $6950/  $13900 | | 80%/80% | | 80%/  50% | | $7300/Unlimited | | $250 | | DC/80% | | 80%/80%/70%/60%/60%/50% |
| B535PPO | $0 | $7200/  $14400 | | 100%/100% | | 100%/  100% | | $7200/$14400 | | $250 | | DC/100% | | 100% |
| B5N1PPO | $0 | $7250/  $14500 | | 70%/70% | | 70%/  50% | | $7500/Unlimited | | $1000 | | DC/70% | | 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 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. | | | | | | | | | | | | | | |

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**Section 4 – Consumer Directed Health Accounts**

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

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| **HSA Vendor:**    **\* If HSA is selected, you have the option of selecting an HSA vendor with enrollment, BAM-SSO and claims integration.**  (If no selection is made, HSA Vendor will default to Other / None.) | **FSA Vendor:**  **\* Optional FSA vendor enrollment, BAM-SSO 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 for Flex FSA.**  (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.) |

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| **Section 5- Ancillary Products** |

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| **A.      Dental Products** | | | |  |  |  |  | |  | |  |
| **Blue Care Dental** | | | | | | | | | | | |
| **Plan Pairings (Groups 10+ enrolled)** | | | | | | | **Participation Requirements** | | | | |
| **Contributory Group**  Any one contributory high option can be paired with any one contributory low option. Exceptions:  **DILHM57** can bepaired with **DILHR33**.  **DILHM42** can be paired with any contributory plan. | | | **Voluntary**  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. | | | | **Contributory Group**  >70% Participation  >50% Employer contribution | | | **Voluntary**  >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** | | | | | | | | | | | |
| DILHR30 | Passive | $25/$25 | $5000 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $2000 | High |
| DILHR31 | Passive | $25/$25 | $3000 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $2000 | High |
| DILHR32 | Passive | $50/$50 | $2000 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $2000 | High |
| DILHR33 | Passive | $50/$50 | $1500 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $1500 | High |
| DILHR34 | Active | $50/$75 | $1500/$1000 | | 90th R&C | 100%/80%/50%/50% | | 80%/60%/50%/50% | | $1000 | High |
| DILHR35 | 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 |
| DILLR37 | Passive | $75/$75 | $1000 | | 90th R&C | 90%/70%/50%/NA | | 90%/70%/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 |
| DILHR50 | 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 | Passive | $50/$50 | $1500 | | MAC | 100%/100%/60%/50% | | 100%/100%/60%/50% | | $1500 | High |
| DILLR58\*4 | Passive | $50/$50 | $1000 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $1000 | Low |
| **Voluntary\*2** | | | | | | | | | | | |
| DILHR43\*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 |
| DILHR45\*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 |
| DILLM49\*1 | Passive | $50/$50 | $1000 | | MAC | 100%/80%/50%/NA | | 100%/80%/50%/NA | | NA | Low |
| DILHR52\*1 | Passive | $50/$50 | $1000 | | 90th R&C | 100%/80%/50%/50% | | 100%/80%/50%/50% | | $1000 | High |
| DILHR53\*1 | Passive | $50/$50 | $1500 | | 90th R&C | 100%/80%/50%/NA | | 100%/80%/50%/NA | | NA | High |
| DILLR54\*1 | Passive | $50/$50 | $1000 | | 90th 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 |
| DILLM56\*1 | Active | $50/$100 | $750 | | MAC | 100%/80%/50%/NA | | 100%/50%/50%/NA | | NA | Low |
| DILHM59\*1 | Passive | $50/$50 | $1500 | | MAC | 100%/100%/60%/50% | | 100%/100%/60%/50% | | $1500 | High |
| 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. | | | | | | | | | | | |

**B.    Standalone Vision, Life, Disability, Accident, and Critical Illness 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 | | |
| 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 | | |
| If Life is a desired benefit, the Group Term Life product must be selected to also select Dependent Life and Supplemental Life. | | | | | | | | | | | | | | | |
| **Group Term Life / Accidental Death & Dismemberment (AD&D)** | **Yes** | | | | | | | **No** | | | | | | | |
| **Group Term Life / Accidental Death & Dismemberment (AD&D) Plans** | | | | | | | | | | | | | | | |
| Plan Name | Plan Benefit | | | | | | | Benefit Maximum | Age Reduction | | | | | | |
| Plan 1 | $15,000 | | | | | | | N/A | 35% at 65 / 50% at 70 | | | | | | |
| Plan 2 | $25,000 | | | | | | | N/A | 35% at 65 / 50% at 70 | | | | | | |
| Plan 3 | $50,000 | | | | | | | N/A | 35% at 65 / 50% at 70 | | | | | | |
| Plan 4 | $100,000 | | | | | | | N/A | 35% at 65 / 50% at 70 | | | | | | |
| Plan 5 | 1 x Salary | | | | | | | $150,000 | 35% at 65 / 50% at 70 | | | | | | |
| Plan 6 | 2 x Salary | | | | | | | $200,000 | 35% at 65 / 50% at 70 | | | | | | |
| **Dependent Basic Life Plans** | | | | | | | | | | | | | | | |
| Plan Name | Plan Benefit | | | | | | | Benefit Maximum | | | | | | | |
| Plan 1 | $10,000 Spouse / $5,000 Child | | | | | | | $10,000 Spouse / $5,000 Child | | | | | | | |
|  |  | | | | | | |  | | | | | | | |
| **Supplemental Life Plans** | | | | | | | | | | | | | | | |
| Plan Name | Plan Benefit | | | | | | | Benefit Maximum | | | | | | | |
| Plan 1 | Employee / Spouse / Child | | | | | | | $500,000 Employee / $150,000 Spouse / $10,000 Child | | | | | | | |
| **Short-Term Disability** | **Yes** | | | | | | | **No** | | | | | | | |
| **Short-Term Disability Plans** | | | | | | | | | | | | | | | |
| Plan Name | Plan Benefit | | | | | | | Elimination Period (Days)  Injury / Sickness | Maximum Benefit Duration (Weeks) | | | | | | |
| Basic Short-Term Disability | | | | | | | | | | | | | | | |
| Plan 1 | 60% salary weekly max $750 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 2 | 60% salary weekly max $750 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 3 | 60% salary weekly max $750 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 4 | 60% salary weekly max $750 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 5 | 60% salary weekly max $750 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 6 | 60% salary weekly max $750 | | | | | | | 14/14 | 26 | | | | | | |
| Plan 7 | 60% salary weekly max $1,000 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 8 | 60% salary weekly max $1,000 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 9 | 60% salary weekly max $1,000 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 10 | 60% salary weekly max $1,000 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 11 | 60% salary weekly max $1,000 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 12 | 60% salary weekly max $1,000 | | | | | | | 14/14 | 26 | | | | | | |
| Plan 13 | 60% salary weekly max $1,500 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 14 | 60% salary weekly max $1,500 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 15 | 60% salary weekly max $1,500 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 16 | 60% salary weekly max $1,500 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 17 | 60% salary weekly max $1,500 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 18 | 60% salary weekly max $1,500 | | | | | | | 14/14 | 26 | | | | | | |
| \* Only available for 10-50 lives | | | | | | | | | | | | | | | |
| Voluntary Short-Term Disability | | | | | | | | | | | | | | | |
| Plan 1 | 60% salary weekly max $750 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 2 | 60% salary weekly max $750 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 3 | 60% salary weekly max $750 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 4 | 60% salary weekly max $750 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 5 | 60% salary weekly max $750 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 6 | 60% salary weekly max $750 | | | | | | | 14/14 | 26 | | | | | | |
| Plan 7 | 60% salary weekly max $1,000 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 8 | 60% salary weekly max $1,000 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 9 | 60% salary weekly max $1,000 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 10 | 60% salary weekly max $1,000 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 11 | 60% salary weekly max $1,000 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 12 | 60% salary weekly max $1,000 | | | | | | | 14/14 | 26 | | | | | | |
| Plan 13\* | 60% salary weekly max $1,500 | | | | | | | 0/7 | 13 | | | | | | |
| Plan 14\* | 60% salary weekly max $1,500 | | | | | | | 0/7 | 26 | | | | | | |
| Plan 15\* | 60% salary weekly max $1,500 | | | | | | | 7/7 | 13 | | | | | | |
| Plan 16\* | 60% salary weekly max $1,500 | | | | | | | 7/7 | 26 | | | | | | |
| Plan 17\* | 60% salary weekly max $1,500 | | | | | | | 14/14 | 13 | | | | | | |
| Plan 18\* | 60% salary weekly max $1,500 | | | | | | | 14/14 | 26 | | | | | | |
|  |  | | | | | | |  |  | | | | | | |
| **Long-Term Disability** | **Yes** | | | | | | | **No** | | | | | | | |
| **Long-Term Disability Plans** | | | | | | | | | | | | | | | |
| Plan Name | Plan Benefit | | | | | | | Elimination Period (Days) | Maximum Benefit Duration | | | | | | |
| Basic Long-Term Disability | | | | | | | | | | | | | | | |
| Plan 1 | 60% salary monthly max $3,500 | | | | | | | 90 | SSNRA | | | | | | |
| Plan 2 | 60% salary monthly max $3,500 | | | | | | | 90 | 5 Years | | | | | | |
| Plan 3 | 60% salary monthly max $3,500 | | | | | | | 180 | SSNRA | | | | | | |
| Plan 4 | 60% salary monthly max $3,500 | | | | | | | 180 | 5 Years | | | | | | |
| Plan 5 | 60% salary monthly max $6,000 | | | | | | | 90 | SSNRA | | | | | | |
| Plan 6 | 60% salary monthly max $6,000 | | | | | | | 90 | 5 Years | | | | | | |
| Plan 7 | 60% salary monthly max $6,000 | | | | | | | 180 | SSNRA | | | | | | |
| Plan 8 | 60% salary monthly max $6,000 | | | | | | | 180 | 5 Years | | | | | | |
| Voluntary Long-Term Disability | | | | | | | | | | | | | | | |
| Plan 1 | 60% salary monthly max $6,000 | | | | | | | 90 | SSNRA | | | | | | |
| Plan 2 | 60% salary monthly max $6,000 | | | | | | | 90 | 5 Years | | | | | | |
| Plan 3 | 60% salary monthly max $6,000 | | | | | | | 180 | SSNRA | | | | | | |
| Plan 4 | 60% salary monthly max $6,000 | | | | | | | 180 | 5 Years | | | | | | |
| **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 | $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 | | | | | | | |
| **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 | |
| 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 |
| **Classes** | | | | | | | | | | | | | | | |
| Please complete this chart if Group Term Life, Short-Term Disability, or Long-Term Disability benefits vary by class | | | | | | | | | | | | | | | |
| Class Description | | Group Term Life / AD&D | | | | | Short-Term Disability | | | | Long-Term Disability | | | | |
|  | |  | | | | |  | | | |  | | | | |
|  | |  | | | | |  | | | |  | | | | |

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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 |