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 4)

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**	
8.	☐ **Yes**	☐ **No**	

Section 2b- Renewing Groups Only: (*New Business update to Section 4)

Adding Plan (Medical and/or Dental)**:**
Please list new plan(s) below

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

Section 3- HSA

HSA Vendor: *** If HSA 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® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option B:** HSA Bank® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option C:** FlexHSA® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option D:** Other HSA Vendor / None (Select this option if using an HSA Vendor other than above or are not offering an employer sponsored HSA vendor.)

Section 4- New Business

Group Number:

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

A. Blue Choice Preferred							
2021 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%	$1250/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%	$5500/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	$3750/$7500	$35/$55	100%/100%	$3750/$7500	$400	$75	$10/$20/$55/$95/$150/$250
Silver							
☐S532BCE*2	$3250/$6500	$50/$70	60%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S501BCE	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	NA	$10/$20/$70/$120/$150/$250
☐S531BCE	$4700/$9400	$45/$65	80%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S535BCE	$7550/$15100	$30/$50	100%/100%	$7550/$15100	$500	$75	$10/$20/$70/$120/$150/$250

Blue Choice Preferred HSA Plans								
2021 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*3	$180-$280	$2800/$5600	90%/90%	90%/60%	$3500/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
☐G535BCE	$475-$625	$2800/$5600	80%/80%	80%/50%	$5000/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
Silver								
☐S534BCE	$0-$115	$4800/$9600	100%/100%	100%/100%	$4800/$9600	NA	NA	100%
☐S5J1BCE	$150-$400	$6000/$12000	100%/100%	100%/100%	$6000/$12000	NA	NA	100%
Bronze								
☐B536BCE	$0	$6650/$13300	80%/80%	80%/50%	$6900/Unlimited	$250	NA	80%/80%/70%/60%/60%/50%
☐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

B. Blue Precision HMO

2021 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	$2500	$55/$75	70%	$8550	$1000	$75	$10/$20/$50/$100/$250/$350
Silver							
☐S531PSN*6	$3000	$40/$60	80%	$8550	$1000	$60	$10/$20/$50/$100/$250/$350
☐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)

2021 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								
☐G506OPT	$750/ $1750/ $3500	$40/$60	$60/$100	80%/ 70%/ 50%	$5000/ $7000/ Unlimited	$600	$75	$20/$30/$70/$120/$250/$350
☐G508OPT	$1500/ $3250/ $6500	$30/$55	$45/$95	90%/ 70%/ 50%	$4100/ $6100/ Unlimited	$600	$75	$20/$30/$70/$120/$250/$350
☐G507OPT	$2000/ $3500/ $7000	$35/$60	$50/$100	90%/ 70% 50%	$3500/ $6500/ Unlimited	$400	$75	$10/$20/$55/$95/$150/$250
Silver								
☐S506OPT	$4850/ $5850/ $11700	$40/60	$60/$100	80%/ 60%/ 50%	$6850/ $8550/ Unlimited	$600	$75	$20/$30/$70/$120/$250/350

Blue Options HSA Plans

2020 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**
Silver									
☐S507OPT	$0-$50	$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.

D. PPO (Participating Provider Options)

2021 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%	$1250/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%	$6750/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐G532PPO	$1500/$3000	$40/$60	80%/50%	$5500/Unlimited	$400	$75	$15/$25/$70/$120/$250/$350
☐G536PPO	$2000/$4000	$45/$65	90%/60%	$5000/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	$2600/$5200	100%/100%	100%/100%	$2600/$5200	NA	NA	100%
☐G530PPO	$3750/$7500	$35/$55	100%/100%	$3750/$7500	$400	$75	$10/$20/$55/$95/$150/$250
Silver							
☐S532PPO*2	$3250/$6500	$50/$70	60%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S501PPO	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	NA	$10/$20/$70/$120/$150/$250
☐S531PPO	$4700/$9400	$45/$65	80%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S535PPO	$7550/$15100	$30/$50	100%/100%	$7550/$15100	$500	$75	$10/$20/$70/$120/$150/$250

PPO HSA Plans

2021 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*3	$180-$280	$2800/ $5600	90%/90%	90%/ 60%	$3500/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
☐G535PPO	$475-$625	$2800/ $5600	80%/80%	80%/ 50%	$5000/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
Sliver								
☐S534PPO	$0-$115	$4800/ $9600	100%/100%	100%/ 100%	$4800/$9600	NA	NA	100%
☐S5J1PPO	$150-$400	$6000/ $12000	100%/100%	100%/ 100%	$6000/$12000	NA	NA	100%
Bronze								
☐B536PPO	$0	$6650/ $13300	100%/100%	80%/ 50%	$6900/Unlimited	$250	NA	80%/80%/70%/60%/60%/50%
☐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 5- Ancillary Product Selection:

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**. **DILHM59** can be paired with **DILHR43**.	Any one voluntary high option can be paired with any voluntary low option. Voluntary plans and contributory plans may not be offered together. **DILHM42** can be paired with any contributory plan. **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								
☐ 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
☐ 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	NA	MAC	100%/80%/50%/NA	80%/60%/40%/NA	$1500/$1000	High
☐ DILHM46	Passive	$25/$75	NA	MAC	100%/80%*3/NA/NA	100%/80%*3/NA/NA	$750	High
☐ 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	NA	MAC	100%/80%/50%/NA	100%/50%/50%/NA	$750	Low
☐ DILHM59 *1	Passive	$50/$50	$1500	MAC	100%/100%/60%/50%	100%/50%/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. 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:	**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. 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 any other instruction or important information.

Section 7 - Signature

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