



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								
2025 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	\$350/\$700	\$35/\$70	80%/50%	\$1750/Unlimited	\$400	\$70	\$15/\$25/\$65/\$105/\$250/\$350	
☐ P5E1BCE	\$600/\$1200	\$25/\$50	90%/60%	\$1750/Unlimited	\$400	\$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	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G532BCE	\$1600/\$3200	\$45/\$70	80%/50%	\$6500/Unlimited	\$400	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G536BCE	\$2100/\$4200	\$50/\$75	90%/60%	\$6000/Unlimited	\$500	\$75	\$20/\$30/\$80/\$130/\$350/\$450	
☐ G531BCE	\$2600/\$5200	\$25/\$70	80%/50%	\$5250/Unlimited	\$400	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
☐ G5M2BCE	\$2500/\$5000	\$30/\$60	100%/80%	\$7500/\$15000	\$300	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G537BCE	\$3200/\$6400	100%/100%	100%/100%	\$3200/\$6400	DC/100%	DC/100%	100%	
☐ G530BCE	\$4000/\$8000	\$50/\$70	100%/100%	\$5500/\$11000	\$500	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
Silver								
☐ S532BCE ^{*2}	\$3700/\$7400	\$60/\$80	60%/50%	\$9200/Unlimited	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S531BCE	\$5100/\$10200	\$50/\$75	70%/50%	\$9200/Unlimited	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S535BCE	\$8000/\$16000	\$50/\$75	100%/100%	\$9200/\$18400	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
Blue Choice Preferred HSA Plans								
2025 Plan ID	HSA Contr.	Deduct (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ^{*1}	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
☐ G533BCE	\$50-\$350	\$3300/\$6600	90%/90%	90%/60%	\$3800/Unlimited	DC/90%	DC/90%	80%/80%/70%/60%/60%/50%
☐ G535BCE	\$350-\$700	\$3300/\$6600	80%/80%	80%/50%	\$5250/Unlimited	DC/80%	DC/80%	80%/80%/70%/60%/60%/50%
Silver								
☐ S534BCE	\$0-\$40	\$5350/\$10700	100%/100%	100%/100%	\$5350/\$10700	DC/100%	DC/100%	100%
☐ S5J1BCE	\$150-\$400	\$6350/\$12700	100%/100%	100%/100%	\$6350/\$12700	DC/100%	DC/100%	100%
Bronze								
☐ B536BCE	\$0	\$7050/\$14100	80%/80%	80%/50%	\$7400/Unlimited	\$250	DC/80%	80%/80%/70%/60%/60%/50%
☐ B535BCE	\$0	\$7300/\$14600	100%/100%	100%/100%	\$7300/\$14600	\$250	DC/100%	100%
☐ B5N1BCE	\$0	\$7350/\$14700	70%/70%	70%/50%	\$7600/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							
2025 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copoly ^{*1}	Urgent Care Copoly	Pharmacy
Platinum							
☐ P506PSN ^{*2}	\$0	\$15/\$45	100%	\$1750	\$300	\$45	\$5/\$15/\$60/\$110/\$250/\$350
☐ P5J1PSN ^{*3}	\$0	\$25/\$40	100%	\$2500	\$300	\$40	\$5/\$15/\$60/\$110/\$250/\$350
☐ P5E1PSN ^{*4}	\$1100	\$30/\$60	80%	\$3100	\$400	\$60	\$5/\$15/\$60/\$110/\$250/\$350
Gold							
☐ G5J2PSN ^{*5}	\$0	\$50/\$70	100%	\$5000	\$500	\$70	\$10/\$20/\$50/\$100/\$250/\$350
☐ G5N1PSN ^{*6}	\$0	\$45/\$65	80%	\$6500	\$300	\$65	\$10/\$20/\$50/\$100/\$250/\$350
☐ G532PSN ^{*4}	\$2850	\$60/\$85	70%	\$9200	\$1000	\$85	\$10/\$20/\$50/\$100/\$250/\$350
Silver							
☐ S531PSN ^{*7}	\$3350	\$35/\$70	70%	\$9200	\$500	\$70	\$10/\$20/\$50/\$100/\$250/\$350
☐ S530PSN ^{*8}	\$7100	\$60/\$85	70%	\$9200	\$700	\$85	\$5/\$15/\$60/\$110/\$250/\$350
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} - \$400 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} - \$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. ^{*8} - \$400 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply. \$125 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)								
2025 Plan ID	Deductible (BCO/ PPO/ OON)	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copoly ^{*1}	Urgent Care Copoly	Non-Preferred Pharmacy**
Platinum								
☐ P5N1OPT	\$350/ \$850/ \$1700	\$20/\$35	\$40/\$70	90%/ 70%/ 50%	\$2500/ \$7000/ Unlimited	\$200	\$75	\$25/\$35/\$80/\$130/\$350/\$450
Gold								
☐ G506OPT	\$850/ \$2100/ \$4200	\$45/\$65	\$70/\$110	80%/ 60%/ 50%	\$7000/ \$8750/ Unlimited	\$600	\$75	\$25/\$35/\$80/\$130/\$350/\$450
☐ G508OPT	\$1600/ \$3850/ \$7700	\$40/\$65	\$60/\$110	90%/ 70%/ 50%	\$6150/ \$8150/ Unlimited	\$600	\$75	\$25/\$35/\$80/\$130/\$350/\$450
☐ G507OPT	\$2100/ \$3600/ \$7200	\$40/\$65	\$60/\$110	90%/ 70%/ 50%	\$4600/ \$7600/ Unlimited	\$400	\$75	\$25/\$35/\$80/\$130/\$350/\$450
☐ G5M3OPT	\$3000/ \$5500/ \$11000	\$25/\$50	\$50/\$100	100%/ 80%/ 50%	\$7500/ \$9000/ Unlimited	\$300	\$75	\$25/\$35/\$80/\$130/\$350/\$450
Silver								
☐ S506OPT	\$5350/ \$6350/ \$12700	\$55/75	\$80/\$120	80%/ 60%/ 50%	\$8400/ \$9200/ Unlimited	\$600	\$75	\$25/\$35/\$80/\$130/\$350/\$450

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

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Blue Options HSA Plans									
2025 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	Urgent Care Copay	Non-Preferred Pharmacy**
Gold									
☐ G5K1OPT	\$50-\$325	\$3300/ \$4700/ \$9900	100%/80%	100%/80%	100%/ 80%/ 60%	\$3300/ \$6650/ Unlimited	DC/100%	DC/100%	100%
Silver									
☐ S507OPT	\$0	\$4900/ \$5600/ \$16500	100%/70%	100%/70%	100%/ 70%/ 50%	\$4900/ \$7350/ Unlimited	DC/100%	DC/100%	100%
☐ S5N1OPT	\$0	\$5350/ \$6350/ \$19050	100%/70%	100%/70%	100%/ 70%/ 50%	\$5350/ \$7600/ 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.									

D. PPO (Participating Provider Options)								
2025 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	\$350/\$700	\$35/\$70	80%/50%	\$1750/Unlimited	\$400	\$70	\$15/\$25/\$65/\$105/\$250/\$350	
☐ P5E1PPO	\$600/\$1200	\$25/\$50	90%/60%	\$1750/Unlimited	\$400	\$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	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G532PPO	\$1600/\$3200	\$45/\$70	80%/50%	\$6500/Unlimited	\$400	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G536PPO	\$2100/\$4200	\$50/\$75	90%/60%	\$6000/Unlimited	\$500	\$75	\$20/\$30/\$80/\$130/\$350/\$450	
☐ G531PPO	\$2600/\$5200	\$25/\$70	80%/50%	\$5250/Unlimited	\$400	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
☐ G5M2PPO	\$2500/\$5000	\$30/\$60	100%/80%	\$7500/\$15000	\$300	\$75	\$15/\$25/\$80/\$130/\$250/\$350	
☐ G537PPO	\$3200/\$6400	100%/100%	100%/100%	\$3200/\$6400	DC/100%	DC/100%	100%	
☐ G530PPO	\$4000/\$8000	\$50/\$70	100%/100%	\$5500/\$11000	\$500	\$75	\$15/\$25/\$65/\$105/\$250/\$350	
Silver								
☐ S532PPO ^{*2}	\$3700/\$7400	\$60/\$80	60%/50%	\$9200/Unlimited	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S531PPO	\$5100/\$10200	\$50/\$75	70%/50%	\$9200/Unlimited	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
☐ S535PPO	\$8000/\$16000	\$50/\$75	100%/100%	\$9200/\$18400	\$500	\$80	\$15/\$25/\$80/\$130/\$250/\$350	
PPO HSA Plans								
2025 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	\$3300/\$6600	90%/90%	90%/60%	\$3800/Unlimited	DC/90%	DC/90%	80%/80%/70%/60%/60%/50%
☐ G535PPO	\$350-\$700	\$3300/\$6600	80%/80%	80%/50%	\$5250/Unlimited	DC/80%	DC/80%	80%/80%/70%/60%/60%/50%
Silver								
☐ S534PPO	\$0-\$40	\$5350/\$10700	100%/100%	100%/100%	\$5350/\$10700	DC/100%	DC/100%	100%
☐ S5J1PPO	\$150-\$400	\$6350/\$12700	100%/100%	100%/100%	\$6350/\$12700	DC/100%	DC/100%	100%
Bronze								
☐ B536PPO	\$0	\$7050/\$14100	80%/80%	80%/50%	\$7400/Unlimited	\$250	DC/80%	80%/80%/70%/60%/60%/50%
☐ B535PPO	\$0	\$7300/\$14600	100%/100%	100%/100%	\$7300/\$14600	\$250	DC/100%	100%
☐ B5N1PPO	\$0	\$7350/\$14700	70%/70%	70%/50%	\$7600/Unlimited	\$1000	DC/70%	80%/80%/70%/60%/60%/50%
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GA-RSG 2025-BPS HCSC Rev. 09/30/2024

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 preferred 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, 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.)

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 DILHR33 . DILHM42 can be paired with any contributory plan.			Any one voluntary high option can be paired with any voluntary low option. Voluntary plans and contributory plans may not be offered together. DILHM59 can be paired with DILHR43 . DILHM46 can be paired with any voluntary plan.			>70% Participation >50% Employer contribution		>25% Participation Employers are not required to contribute to Voluntary Dental plans	
IL Plan ID	Plan Type	Deductible (In/Out) (3x Family Limit)	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Ortho Life Maximum	Allocation	
					In-Network (Class I/ II/ III/ IV)	Out-of-Network (Class I/ II/ III/ IV)			
Contributory Group ^{*2}									
☐ DILHR30 ^{*5}	Passive	\$25/\$25	\$5000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR31 ^{*5}	Passive	\$25/\$25	\$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR32 ^{*5}	Passive	\$50/\$50	\$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High	
☐ DILHR33 ^{*5}	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High	
☐ DILHR34 ^{*5}	Active	\$50/\$75	\$1500/\$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000	High	
☐ DILHR35 ^{*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	
☐ 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 ^{*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	
☐ DILHR61	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}									
☐ 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	
☐ 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	
☐ 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	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	
☐ 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 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, 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				

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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

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☐ 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

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