

# **BENEFIT PLAN SELECTION (BPS)**

(To Be Used for Mid-Market Group Accounts)

Please co	omplete & return this form in it	s entirety, includ	ing the required signatures			
Section 1 - Account Information:						
Employer Name:						
Account #:	Effective Date:		Anniversary Date:			
Health Products / Mid-Market Medic	cal and/or Dental Plan Selectic	on:		•		
Section 2 - Renewing Groups Only	: (*If New Business, skip to Sect	ion 3)				
Please list current plan(s) below	Retaining Plan(s):		Replacing Plan(s): Please list replacement plan in space	e below.		
1.	☐ Yes	□ No	1.			
2.	☐ Yes	□ No	2.			
3.	☐ Yes	□ No	3.			
4.	☐ Yes	□ No	4.			
5.	☐ Yes	□ No	5.			
6.	☐ Yes	□ No	6.			
7.	☐ Yes	□ No	7.			
8.	☐ Yes	□ No	8.			
Section 2b - Renewing Groups		p to Section 3)		1		
Adding Plan (Medical and/or Der Please list new plan(s) below	ntal):					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
Section 3 – HSA / FSA Plans:						
HSA Vendor:		FSA Vendor:				
* If HSA is selected, a vendor will need	d to be selected.	* If FSA is sele	cted, a vendor will need to be selected.			
(If no selection is made, HSA Vendor wil	I default to Other / None.)	(If no selection i	is made, FSA Vendor will default to Other / I	None.)		
☐ Option A: BenefitWallet ®		☐ Option 1	: BenefitWallet®			
Account Maintenance Fee:   Emplo	oyer Paid 🗌 Employee Paid	Account Maint	enance Fee: 🛭 Employer Paid 🗀 Emp	oloyee Paid		
☐ Option B: HSA Bank®		☐ Option 2	: HSA Bank®			
Account Maintenance Fee:   Emplo	oyer Paid 🗌 Employee Paid	Account Maint	enance Fee: 🛭 Employer Paid 🗀 Emp	oloyee Paid		
☐ Option C: FlexHSA®		☐ Option 3: FlexHSA®				
Account Maintenance Fee:   Emplo	oyer Paid 🗌 Employee Paid	Account Maintenance Fee:   Employer Paid   Employee Paid				
☐ Option D: Other HSA Vendor			☐ Option 4: Other FSA Vendor / None			
(Select this option if using an HSA vendor other than a HSA vendor.)	above or are not offering an employer sponsored	(Select this option if u FSA vendor.)	(Select this option if using an FSA vendor other than above or are not offering an employer sponsored			

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#### Section 4 - New Business:

#### **GROUP NUMBER:**

- 1. Blue Directions (Private Exchange) Purchased? Yes ☐ No ☐
  - a. (If yes, the Blue Directions Addendum is attached and made a part of the policy.)
  - Please select plan designs (Up to a maximum of 6 plans)

A. Blue Advanta	A. Blue Advantage HMO <sup>®-1</sup>											
2021 Plan ID	Deductible In Network	Coins In-Network	OPX In-Network	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy					
□MIBAH2000	\$0	100%	\$1500	\$40/\$60	\$350	\$0/\$10/\$35/\$75/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250					
□MIBAH2010	\$0	100%	\$1500	\$30/\$50	\$250	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250					
□MIBAH2020	\$0	100%	\$1500	\$20/\$40	\$250	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250					

<sup>\*1</sup> Pharmacy benefits based on the Performance Drug List at HMO Network pharmacies.

B. Blue Advanta	B. Blue Advantage HMO <sup>®</sup> Value Choice <sup>11</sup>											
2021 Plan ID	Deductible In Network	Coins In Network	OPX In- Network	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy					
☐ MIBAV2110	\$0	100%	\$3,000	\$40/\$60	\$350	\$0/\$10/\$35/\$75/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250					
☐ MIBAV2120	\$0	100%	\$3,000	\$50/\$70	\$400	\$0/\$10/\$35/\$75/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250					
☐ MIBAV2130	\$1000	80%	\$3,000	\$50/\$70	\$250**	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250					
☐ MIBAV2140	\$1500	80%	\$4,500	\$50/\$70	\$400**	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250					

<sup>\*1</sup> Pharmacy benefits based on the Performance Drug List at HMO Network pharmacies.

<sup>\*\*</sup>MIBAV2130 and MIBAV2140 have a Per Occurrence Deductible on ER, IP & OP Surg. Calendar Year Deductible and Coinsurance applies after POD.

C. BlueEdge SM	Select HSA*2						
2021 Plan ID	D21 Plan ID Deductible Coins In/Out In/Out		OPX In/Out OV/SPC		ER Coins.	Non-Preferred Pharmacy	Preferred Pharmacy
☐ MIESA2120	\$2500/\$5000	100%/100%	\$2500/\$5000	100%/100%	100%	100%	100%
☐ MIESA2110	\$2500/\$5000	80%/50%	\$5000/\$15000	80%/80%	80%	80%/80%/70%/60%/60%50%	90%/90%/80%/70%/60%50%
☐ MIESE1151	☐ MIESE1151 \$3500/\$7000 80%/50%		\$7000/\$21000 80%/80%		80%	80%/80%/70%/60%/60%50%	90%/90%/80%/70%/60%50%
☐ MIESE2181	\$6000/\$12000	100%/100%	\$6000/\$12000	100%/100%	100%	100%	100%

<sup>\*2</sup> Pharmacy benefits based on the Performance Drug List at Preferred Network pharmacies

Plans are HSA compatible. The 5th character in the Plan # indicates (A) for Aggregate or (E) for Embedded deductible and OPX.

D. Blue Choice S	Select PPO <sup>SM *2</sup>						
2021 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ MIBCS2010	\$250/\$500	80%/50%	\$1250/\$3750	\$20/\$20	\$200	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCS2020	\$500/\$1000	90%/60%	\$1500/4500	\$20/\$20	\$200	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBCS2030	\$500/\$1000	80%/50%	\$2500/7500	\$20/\$20	\$200	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBCS2040	\$1000/\$2000	90%/60%	\$2000/\$6000	\$20/\$20	\$200	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBCS2050	\$1000/\$2000	80%/50%	\$3000/\$9000	\$30/\$30	\$200	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCS2070	\$1500/\$3000	80%/50%	\$3500/\$10500	\$30/\$30	\$200	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCS2090	\$2000/\$4000	80%/50%	\$4000/\$12000	\$30/\$30	\$200	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCS2120	\$2500/\$5000	80%/50%	\$4500/\$13500	\$30/\$30	\$200	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBCS2160	\$4000/\$8000	80%/50%	\$5500/\$16500	\$30/\$30	\$200	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
*2 Pharmacy ben	efits based on the	Performance	Drug List at Prefe	rred Network	pharmacie	es.	

E. Blue Choice C	Options <sup>SM *2</sup> HS	A - Tiered Net	work (Blue Choi	ce OPT PPO	– BCO / PP	O - PPO / Out of Network - OON	
2021 NRMM Plan ID	Deductible (BCO/ PPO/ OON)	Coins (BCO/ PPO/ OON)	OPX (BCO/ PPO/ OON)	OV/SPC (BCO/ PPO)	ER Coins (BCO / PPO)	Non-Preferred Pharmacy	Preferred Pharmacy
□ MICOE2061	\$2900/ \$4600/ \$9200	100%/ 80%/ 60%	\$2900/ \$6550/ \$19650	100%/ 80%	100%	100%	100%
☐ MICOE1051	\$3500/ \$5000/ \$10000	80%/ 60%/ 50%	\$5500/ \$7000/ \$21000	80%/ 60%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MICOE1071	\$5000/ \$6000/ \$12000	80%/ 60%/ 50%	\$6000/ \$7000/ \$21000	80%/ 60%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

Plans are HSA compatible. The 5th character in the Plan # indicates (A) for Aggregate or (E) for Embedded deductible and OPX.

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<sup>\*2</sup> Pharmacy benefits based on the Performance Drug List at Preferred Network pharmacies.

F. Blue Choice Op	otions <sup>SM</sup> - Tie	red Netwo	ork (Blue Ch	oice OPT PPO -	BCO/ PPO – PPO	/ Out of Network - OON)	
2021 Plan ID	Deductible (BCO/ PPO/ OON)	Coins (BCO/ PPO/ OON)	OPX (BCO/ PPO/ OON	OV/SPC (BCO//PPO)	ER Copay** (BCO/ PPO)	Non-Preferred Pharmacy	Preferred Pharmacy
☐ MIBCO2080*2	\$250/ \$1000/ \$2000	90%/ 70%/ 50%	\$750/ \$1250/ \$2500	\$20/\$40// \$40/\$80	\$400/\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/35/\$75/\$150/\$250
☐ MIBCO2010*2	\$500/ \$1500/ \$3000	100%/ 70%/ 50%	\$500/ \$3000/ \$9000	\$20/\$50// \$40/\$100	\$400/\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/35/\$75/\$150/\$250
☐ MIBCO2000*2	\$500/ \$1500/ \$3000	90%/ 70%/ 50%	\$4000/ \$5600/ \$16800	\$20/\$50// \$40/\$100	\$400/\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/35/\$75/\$150/\$250
☐ MIBCO0000*1	\$500/ \$1500/ \$3000	90%/ 70%/ 50%	\$4000/ \$5600/ \$16800	\$20/50// \$40/\$100	\$400/\$400	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
☐ MIBCO2030*2	\$1000/ \$2500/ \$5000	90%/ 70%/ 50%	\$2500/ \$5500/ \$16500	\$25/\$50// \$50/\$100	\$400/\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCO0030*1	\$1000/ \$2500/ \$5000	90%/ 70%/ 50%	\$2500/ \$5500/ \$16500	\$25/\$50// \$50/\$100	\$400/\$400	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
□ MIBCO2040 <sup>+2</sup>	\$1500/ \$3500/ \$7000	90%/ 70%/ 50%	\$3000/ \$5500/ \$16500	\$30/\$50// \$50/\$100	\$400/\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBCO1201*2	\$2500/ \$4000/ \$8000	80%/ 60%/ 50%	\$4500/ \$5500/ \$16500	80%/60%// 80%/60%	80%/80%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$55/\$100/\$150/\$250
☐ MIBCO2050 <sup>*2</sup>	\$4000/ \$5000/ \$10000	80%/ 60%/ 50%	\$5600/ \$5600/ \$16800	\$35/\$60// \$55/\$120	\$500/\$500	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250

<sup>\*1</sup> Pharmacy benefits based on the Enhanced Drug List at Advantage Network pharmacies.

<sup>\*2</sup> Pharmacy benefits based on the Performance Drug List at Preferred Network pharmacies.

\*\* Denotes Per Occurrence Deductible on service. Calendar Year Deductible and Coinsurance applies after POD.

G. Blue Edge SM	HSA*2						
2021 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Coins	Non-Preferred Pharmacy	Preferred Pharmacy
☐ MIEEA2000	\$1500/\$1500	100%/80%	\$3000/\$3000	100%/100%	100%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEA2010*3	\$1500/\$3000	80%/60%	\$3000/\$9000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEA2020*3	\$2500/\$2500	100%80%	\$5000/\$5000	100%/100%	100%	100%	100%
☐ MIEEA2030	\$2500/\$5000	80%/60%	\$5000/\$15000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEE2041	\$2900/\$5800	100%/100%	\$2900/\$5800	100%/100%	100%	100%	100%
☐ MIEEE2061	\$2900/\$5800	80%/60%	\$5800/\$17400	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEE1051	\$3500/\$7000	80%/60%	\$7000/\$21000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEA2070	\$3500/\$7000	80%/60%	\$5800/\$17400	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEE1071	\$5000/\$10000	80%/60%	\$7000/\$21000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ MIEEE2080	\$6000/\$12000	100%/100%	\$6000/\$12000	100%/100%	100%	100%	100%

Plans are HSA compatible. The 5th character in the Plan # indicates (A) for Aggregate or (E) for Embedded deductible and OPX.

<sup>\*2</sup> Pharmacy benefits based on the Performance Drug List at Preferred Network pharmacies.

<sup>\*3</sup> Select HDHP-HSA preventive prescription drugs will be covered with no member cost share.

H. Blue Print® PPC							
2021 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ MIBPP2000*2	\$0/\$0	90%/70%	\$1000/\$3000	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2010*2	\$250/\$500	80%/60%	\$1250/\$3750	\$20/\$40	\$150	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBPP2020*2	\$500/\$1000	90%/70%	\$1500/\$4500	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP0020*1	\$500/\$1000	90%/70%	\$1500/\$4500	\$20/\$40	\$150	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
☐ MIBPP2030*2	\$500/\$1000	80%/60%	\$2500/\$7500	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP1031*2	\$500/\$1000	80%/60%	\$6000/\$18000	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2040*2	\$1000/\$2000	90%/70%	\$2000/\$6000	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2050*2	\$1000/\$2000	80%/60%	\$3000/\$9000	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2180*2	\$1000/\$2000	80%/60%	\$3000/\$9000	80%/80%	80%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP0050*1	\$1000/\$2000	80%/60%	\$3000/\$9000	\$30/\$50	\$150	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
☐ MIBPP2060*2	\$1000/\$2000	80%/60%	\$4000/\$12000	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2070*2	\$1500/\$3000	80%/60%	\$3500/\$10500	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP0070*1	\$1500/\$3000	80%/60%	\$3500/\$10500	\$30/\$50	\$150	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
☐ MIBPP2190*2	\$1500/\$3000	80%/60%	\$3500/\$10500	80%/80%	80%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2080*2	\$1500/\$3000	80%/60%	\$4500/\$13500	\$30/\$50	\$150	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBPP2090*2	\$2000/\$4000	80%/60%	\$4000/\$12000	\$30/\$50	\$150	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBPP1091*2	\$2000/\$4000	80%/60%	\$6000/\$18000	\$30/\$50	\$150	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBPP2110*2	\$2500/\$5000	90%/70%	\$3500/\$10500	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2120*2	\$2500/\$5000	80%/60%	\$4500/\$13500	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP0120*1	\$2500/\$5000	80%/60%	\$4500/\$13500	\$30/\$50	\$150	\$0/\$15/\$30/\$50/\$150	\$0/\$15/\$30/\$50/\$150
☐ MIBPP2200*2	\$2500/\$5000	80%/60%	\$4500/\$13500	80%/80%	80%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2130*2	\$2500/\$5000	80%/60%	\$5500/\$16500	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP1121*2	\$3000/\$6000	80%/60%	\$6000/\$18000	\$30/\$50	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2140*2	\$3500/\$7000	80%/60%	\$5500/\$16500	\$20\$/40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP2160*2	\$4000/\$8000	80%/60%	\$5500/\$16500	\$30/\$50	\$150	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
☐ MIBPP2170*2	\$5000/\$10000	80%/60%	\$5600/\$16800	\$40/\$60	\$250	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
☐ MIBPP1171*2	\$5000/\$10000	80%/60%	\$8550/\$25650	\$40/\$60	\$250	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250

<sup>\*1</sup> Pharmacy benefits based on the Enhanced Drug List at Advantage Network pharmacies.
\*2 Pharmacy benefits based on the Performance Drug List at Preferred Network pharmacies.

## **Dental Products**

## **DENTAL PPO GROUP NUMBER:**

Blue Care Dental P	PO					
	Contributory DPPO	Voluntary DPPO				
	Plan Pairings (Groups 10+)	Plan Pairings (Groups 10+)				
High Allocation	Low Allocation	High Allocation Low Allocation				
DINHR31	DINLR36	DINHR43 DINLR54				
DINHR32	DINLR37	DINHM44 DINLM55				
DINHR33	DINLM41	DINHM46 DINLM56				
DINHR34	DINLM51	DINHR52 DINLR60				
DINHM38	DINLR58	DINHR53				
DINHM40		DINHM59				
DINHM42						
DINHR50						
DINHM57						
Any one of the abov	e Contributory High Allocation DPPO plans can be paired	Any one of the above Voluntary High Allocation DPPO plans can be paired with				
	Contributory Low Allocation DPPO plans.	any one of the Voluntary Low Allocation DPPO plans.				
,	,					
Two High Contribute	ory plans that can be paired are DINHM57 and DINHR33.	Two High Voluntary plans that can be paired are DINHM59 and DINHR43.				
DINHM42 can be fre	eely paired with any Contributory High or Low Allocation	DINHM46 can be freely paired with any Voluntary High or Low Allocation Plan.				
Plan.						
	_					
Participation Requ	irements	Participation Requirements				
>70% Participation		>25% Participation				
>50% Employer con		<50% Employer contribution				
	Contributory DHMO	Voluntary DHMO				
Any one Contributor	y DHMO plan can be paired with any one Contributory	Any one Voluntary DHMO plan can be paired with any one Voluntary DPPO				
DPPO Allocation Pla		Allocation Plan.				
Participation Requ	irements	Participation Requirements				
>70% Participation		>25% Participation				
>50% Employer con	tribution					
1	Camtulland	ory*2 DBBO				

contribution				*0		
			Contribute	ory <sup>2</sup> DPPO		
	Deductible	Annual	Out-of-	Coins	urance	Ortho Life
Plan Type	In/Out (3x) Family Limit	Benefit Max	Network Reimb.	In-Network (Class I/II/III/IV)	Out-Of-Network (Class I/II/III/IV)	Maximum
Passive	\$25/\$25	\$3000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000
Passive	\$50/\$50	\$2000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000
Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500
Active	\$50/\$75	\$1500/\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000
Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A
Passive	\$25/\$75	\$750	MAC	100%/80% <sup>*3</sup> /NA/NA	100%/80% <sup>*3</sup> /NA/NA	N/A
Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500
Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
Passive	\$75/\$75	\$1000	90 <sup>th</sup> R&C	90%/70%/50%/NA	90%/70%50%/NA	N/A
Active	\$75/\$75	\$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	N/A
Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
	Plan Type  Passive Passive Active Passive Active Passive Passive Passive Passive Passive Passive Passive Passive Passive	Plan Type         Deductible In/Out (3x) Family Limit           Passive         \$25/\$25           Passive         \$50/\$50           Passive         \$50/\$50           Active         \$50/\$75           Passive         \$50/\$50           Active         \$50/\$50           Passive         \$25/\$75           Passive         \$50/\$50           Passive         \$50/\$50           Passive         \$50/\$50           Passive         \$75/\$75           Active         \$75/\$75           Passive         \$50/\$50	Plan Type         Deductible In/Out (3x) Family Limit         Annual Benefit Max           Passive         \$25/\$25         \$3000           Passive         \$50/\$50         \$2000           Passive         \$50/\$50         \$1500           Active         \$50/\$75         \$1500/\$1000           Passive         \$50/\$50         \$1500/\$1000           Active         \$50/\$50         \$1500/\$1000           Passive         \$25/\$75         \$750           Passive         \$50/\$50         \$1500           Passive         \$50/\$50         \$1500           Passive         \$50/\$50         \$1000           Passive         \$50/\$55         \$1000           Passive         \$75/\$75         \$1000           Passive         \$50/\$50         \$1000	Plan Type         Deductible In/Out (3x) Family Limit         Annual Benefit Max         Out-of-Network Reimb.           Passive         \$25/\$25         \$3000         90th R&C           Passive         \$50/\$50         \$2000         90th R&C           Passive         \$50/\$50         \$1500         90th R&C           Passive         \$50/\$50         \$1500/\$1000         90th R&C           Passive         \$50/\$50         \$1500/\$1000         MAC           Active         \$50/\$50         \$1500/\$1000         MAC           Passive         \$25/\$75         \$750         MAC           Passive         \$50/\$50         \$1500         90th R&C           Passive         \$50/\$50         \$1500         90th R&C           Passive         \$50/\$50         \$1500         MAC           Passive         \$50/\$50         \$1000         90th R&C           Passive         \$50/\$50         \$1000         MAC	Plan Type	Plan Type

Coinsurance Type - I: Exams/Cleanings/X-Rays (both High & Low Coverage).

Coinsurance Type - II: Fillings/Non-Surgical Periodontal/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).

High Allocation refers to the placement of the miscellaneous preventive, Endodontic, Periodontic and Oral Surgery service categories. High allocation means that these services are covered in Type II.

Low Allocation refers to the placement of the miscellaneous preventive, Endodontic, Periodontic and Oral Surgery service categories. Low allocation means that these services are covered in Type III.

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 under Class II.

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<sup>\*4</sup> Preventive & Diagnostic Services do not count toward the Annual Benefit Max.

# **Section 5 - Ancillary Product Selection:**

# **Dental Products**

#### **DENTAL GROUP NUMBER:**

				Volunta	ry DPPO						
II Dian Cada	Plan	Deductible In/Out	Annual	Out-of-	Coins	surance	Ortho Life				
IL Plan Code	Туре	(3x) Family Limit	Benefit Max	Network Reimb.	In-Network (Class I/II/III/IV)	Out-Of-Network (Class I/II/III/IV)	Maximum				
High Allocation											
☐ DINHR43*1	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500				
☐ DINHM44*1	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A				
☐ DINHM46	Passive	\$25/\$75	\$750	MAC	100%/80% <sup>*3</sup> /NA/NA	100%/80%*3/NA/NA	N/A				
☐ DINHR52*1	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000				
☐ DINHR53*1	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A				
☐ DINHM59*1	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500				
Low Allocation											
☐ DINLR54*1	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A				
☐ DINLM55 *1	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000				
☐ DINLM56*1	Active	\$50/\$100	\$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	N/A				
☐ DINLR60*1*4	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000				
Contributory DF	IMO										
☐ DNCAP710	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A				
☐ DNCAP730	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A				
Voluntary DHM0	)				<u>.</u>						
☐ DNCAP810	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A				
☐ DNCAP830	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A				

Coinsurance Type - I: Exams/Cleanings/X-Rays (both High & Low Coverage).

Coinsurance Type - II: Fillings/Non-Surgical Periodontal/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).

High Allocation refers to the placement of the miscellaneous preventive, Endodontic, Periodontic and Oral Surgery service categories. High allocation means that these services are covered in Type II.

Low Allocation refers to the placement of the miscellaneous preventive, Endodontic, Periodontic and Oral Surgery service categories. Low allocation means that these services are covered in Type III.

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 under Class II.
- \*4 Preventive & Diagnostic Services do not count toward the Annual Benefit Max.

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C.	 e	D.,		 cts
	 ГО	ur	$\mathbf{a}$	 CTC

## **GROUP NUMBER:**

If Life is a desired benefit, the Group Term Life product must be selected in order to also select Dependent Life and Short-Term Disability.

1. Group Term Life / Accidental Death & Dismemberment (AD&D)								
☐ Yes ☐ No				Complete Ite	Complete Item 4 below if Term Life benefits vary by class			
	Cho	oose a Benefit:			Choose a Reduction Method:			
☐ Flat Benefit of \$ per Employee			(Or	(Only available to groups with 10 or more enrolled lives)				
			☐ 35% of th	☐ 35% of the original amount at age 65 / 50% of the original amount at age 70				
				☐ 50% of th	☐ 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 E	Employee			D 050/ -(1)	(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 80			
Fycass Amou	ınts of Life Insu			1370 OI ti	13% of the original amount at age 75, 65% of the original amount at age 60			
			insurance amour	nts in excess of	\$ Such excess insurance	e amounts shall become effective		
on the date Ev	ridence of Insura	ability is approved. Waiver	of Premium, in th	e event of total	disability, will terminate at age 65	or when no longer disabled,		
					e is not Actively at Work on the da ployee does not return to Active V			
2. Depend		Jordago IIII Do III o dato	91.01411110			1011, 110, 0110 1111 1101 50 00101011		
□ Yes □	No	Spouse	Children – ag	e birth to 14	Children – age 14 days to	Children – age 6 months to		
		<b>^</b> 40.000	day		6 months	26 years / student 26		
Choose a		\$10,000	\$100		\$100	\$5,000		
Plan:	☐ Option 2	\$5,000	\$10		\$100	\$5,000		
	☐ Option 3	\$5,000	\$10	00	100	\$2,000		
3. Short Te	erm Disabilit							
□ Yes □	NO '	lete Item 4 below if Short in the street in	•		lass yable for non-occupational disabi	lities only		
	Denon	t will flot exceed do 2/070		hoose a Benefi	•	nuos omy		
☐ Flat \$	weekly (not to	exceed \$250)						
☐ Salary Bas	sed (select one)	-	□ 50%	□ 60%	☐ 66 2/3% of Basic Weekly Sala	ry up to a maximum of \$		
			Choose a Plan:	: Accident/Sick	ness/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 w	reeks □ 8 /	/ 8 / 26 weeks ☐ 1	5 / 15 / 26 weeks	* 🗆 31 / 31	/ 26 weeks			
4. Classes								
Please complete this chart if Term Life or Short-Term Disability benefits vary by class (3 Max 2 – 9 lives) (6 Max 10+ lives)								
Class Description			To	erm Life / AD&D	Short Term Disability			

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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.							
Use this section to indicate if the account is retain	ling any plan(s) not shown above	e or need to indicate any other instruction	n or important information.				
Section 6 – Signatures:							
Signatures							
Employer / Authorized Purchaser	Title	Date					

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