



Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, 300 E Randolph, Chicago, IL 60601  
Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148

### BENEFIT PROGRAM APPLICATION (“BPA”)

#### Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (herein called “BCBSIL”)

(All items are applicable to 51-150 Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)  
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Group No.(s): \_\_\_\_\_ Section No.(s): \_\_\_\_\_

Account No. (Blue Star<sup>SM</sup>): \_\_\_\_\_

Employer’s Legal Name: \_\_\_\_\_  
(Specify the employer applying for coverage and list the names of any subsidiary or affiliated companies to be covered below.)

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer Identification Number (“EIN”): \_\_\_\_\_ Standard Industry Code (SIC): \_\_\_\_\_

Wholly Owned Subsidiaries to be covered (if additional space is needed, use the Additional Provisions section):  
\_\_\_\_\_

Affiliated Companies to be covered (if additional space is needed, use the Additional Provisions section):  
\_\_\_\_\_

(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)

Administrative Contact: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Blue Access for Employers<sup>SM</sup> (“BAE<sup>SM</sup>”) Contact: \_\_\_\_\_  
(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE)

Title: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy Effective Date (month/day/year): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Policy Anniversary Date (month/day/year): \_\_\_\_/\_\_\_\_/\_\_\_\_

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and church plans as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan\*:  Yes  No

If Yes, specify ERISA Plan Year\* (month/day/year): Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ERISA Plan Sponsor\*: \_\_\_\_\_

ERISA Plan Administrator\*: \_\_\_\_\_

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ERISA Plan Administrator's Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

ERISA Plan Administrator's Email: \_\_\_\_\_

Please provide your Non-ERISA Plan Month/Year: \_\_\_\_/\_\_\_\_

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption\*:

- Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- Non-Federal Governmental Plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
- Church Plan
- Other, please specify: \_\_\_\_\_

**For more information regarding ERISA, contact your Legal Advisor.**

\*All as defined by ERISA and/or other applicable law/regulations.

## ELIGIBILITY

The Employer is responsible for determining Eligible Employee/Subscribers and Eligible Family Members in accordance with applicable law. In some jurisdictions, coverage may be mandatory for certain members of the Group population. A selection of "No" in those categories below controls eligibility unless otherwise required by operation of law. For more details about the Employer's responsibilities with respect to identification of individuals eligible for coverage under the Employer's group health plan, see the Group Administration Document's General Provisions.

1. **Eligible Person.** Employer has decided that Eligible Person means: a Full-Time Employee of the Employer. Full-time Employee means an Employee of the Employer who is regularly scheduled to work a minimum of \_\_\_\_\_ hours per week.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. BCBSIL reserves the right to audit Employer's initial and ongoing eligibility determinations.

2. **Civil Union Partner Coverage:** A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. **(Optional) Domestic Partner Coverage:**  Yes  No

If Employer elects "Yes," a Domestic Partner, as defined in the Certificate Booklet, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

**Continuation coverage for Domestic Partners:** If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an Employee elects COBRA coverage. Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below:

- Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA.
- No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)
- Other: \_\_\_\_\_

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4. **Retiree Coverage:**  Yes  No If yes, complete the following, as applicable:

A. Retiree means those persons covered as retirees under the Employer's health care plan prior to the date the Employer initially purchased coverage from BCBSIL.  Yes  No

If yes, indicate the retiree name(s) below:

Name of Retiree	Name of Retiree

B. Retiree means those persons who retire on or after the effective date of this BPA: Yes  No

If yes: Such retirees must be at least \_\_\_\_ years of age on the date of retirement with \_\_\_\_ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former Employees who retired after the date the Employer initially purchased coverage from BCBSIL and prior to the initial effective date of the retiree coverage specified in item 4.B. above are not eligible. An Employer may only elect or change retiree coverage on the Policy Effective Date or Policy Anniversary Date. For Life Plans, retiree coverage is not available.

5. **Eligibility Date:** All current and new Employees must satisfy the substantive eligibility criteria and required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an Employee becomes eligible for coverage, unless otherwise permitted by applicable law.

If a person is added to the Policy and it is later determined that the Employer reported a Coverage Date earlier than what would apply to the Employee or dependent, based on the waiting period and eligibility conditions the Employer provided to BCBSIL, BCBSIL reserves the right to retroactively adjust the Coverage Date for such person.

A. **For Health, Dental PPO, and Life Coverage** (If purchasing Life, Disability, Critical Illness, Accident, Hospital Indemnity or Vision coverage, the account must have a first (1<sup>st</sup>) of the month effective date):

<input type="checkbox"/> The date of employment.	<input type="checkbox"/> The ____ day of employment. <b>Note:</b> This may not exceed ninety-one (91) calendar days	<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following the date of employment.
<input type="checkbox"/> The ____ day of the month following ____ month(s) of employment		
<input type="checkbox"/> The ____ day of the month following ____ days of employment (option of up to sixty (60) days)		
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.		

B. **For Dental HMO Coverage:**

<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following the date of employment.
<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following ____ month(s) of employment
<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following ____ day(s) of employment (option of up to sixty (60) days)
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.

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C. Waive the waiting period on initial group enrollment?  Yes  No If No is selected, complete Section D.

D. Number of Employees serving waiting period: \_\_\_\_\_

E. **Substantive eligibility criteria.** Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information. Check all that apply:

An Orientation Period that:

1. Does not exceed one (1) month (calculated by adding one (1) calendar month and subtracting one (1) calendar day from an Employee's start date); and
2. If used in conjunction with a waiting period, the waiting period begins on the first (1<sup>st</sup>) day after the orientation period.

A Cumulative hours of service requirement that does not exceed 1200 hours

An hours-of-service per period (or full-time status) requirement for which a measurement period is used to determine the status of variable-hour Employees, where the measurement period:

1. Starts between the Employee's date of hire and the first (1<sup>st</sup>) day of the following month;
2. Does not exceed twelve (12) months; and
3. Taken together with other eligibility conditions does not result in coverage becoming effective later than thirteen (13) months from the Employee's start date plus the number of days between a start date and the first (1<sup>st</sup>) day of the next calendar month (if start day is not the first (1<sup>st</sup>) day of the month).

Other substantive eligibility criteria not described above; please describe: \_\_\_\_\_

6. **Limiting Age for covered children:** Hereafter, Covered Children means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption,) a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. Health and dental coverage will terminate at the end of the month in which the covered child turns age twenty-six (26). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet. For Life Plans, coverage will terminate on the birthday. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

7. **Disabled Dependent:** Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Civil Union partner and/or Domestic Partner, if elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan and before the child attains the limiting age with no break in coverage. A disabled dependent is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled dependent is eligible to add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled dependent is provided.

Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

8. **Enrollment:**

**Special Enrollment:** An Eligible Person may apply for coverage, Family Coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage

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under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

**Annual Open Enrollment:** For Health and Dental Plans only, an Eligible Person, who did not enroll under Timely Enrollment, may apply for Individual coverage, Family coverage or add dependents during the Employer's Annual Open Enrollment Period. The Open Enrollment Period is to be held thirty (30) days prior to the Policy Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or dependent's Coverage Date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

**Late Enrollment:** For Life, Accidental Death and Dismemberment (AD&D) and Long and Short-Term Disability Plans only, an Eligible Person who did not apply under Timely Enrollment may apply for Individual coverage, Family coverage or add dependents during the Annual Open Enrollment. Late enrollees must furnish acceptable evidence of insurability.

9. **Extension of Benefits:** An Extension of Benefits will be provided for a period of thirty (30) days in the event of Temporary Layoff, Disability or Leave of Absence. However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and in accordance, with any applicable federal or state law.

For Life Plans, an extension of benefits will be provided as follows: Due to Disability - until the end of the twelfth (12<sup>th</sup>) month following the month in which the disability began; Due to Layoff and Leave of Absence - until the end of the month following the month during which the layoff or leave of absence began. The extension will apply, provided all premiums are paid when due.

10. **Current Eligibility Information**

**Total number of Employees (Please indicate the total number of actual Employees, not enrollees):**

- A. On payroll \_\_\_\_\_
- B. On COBRA continuation coverage \_\_\_\_\_
- C. Continuing coverage as a retiree (if applicable) \_\_\_\_\_
- D. Who work part-time \_\_\_\_\_
- E. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) \_\_\_\_\_
- F. Declining coverage (not covered elsewhere) \_\_\_\_\_

11. **Premium Period:** The Premium Period must be consistent with the Policy Effective Date and/or Policy Anniversary Date.

<input type="checkbox"/> First (1 <sup>st</sup> ) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare Dental HMO <sup>SM</sup> coverage.)
<input type="checkbox"/> Fifteenth (15 <sup>th</sup> ) day of each calendar month through the fourteenth (14 <sup>th</sup> ) day of the following calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)
Note: Groups with life and/or disability coverage and having less than one hundred dollars (\$100.00) monthly combined life and disability premium will be billed on a quarterly basis.

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**12. Employer Contribution.** The following elections apply to both Grandfathered and Non-Grandfathered Groups unless otherwise indicated.

**A. Health and Dental Plans:**

<input type="checkbox"/> ____% for Employee Coverage	<input type="checkbox"/> ____% for Employee plus Spouse Coverage
<input type="checkbox"/> ____% for Employee plus Child(ren) Coverage	<input type="checkbox"/> ____% for Family Coverage
<input type="checkbox"/> One hundred percent (100%) of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	
<input type="checkbox"/> Other (specify): ____	

**B.** BCBSIL reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered. A substantial change will be deemed to have occurred when the number of Subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty-five percent (25%) or more over a ninety (90) day period.

**C. The following applies to Grandfathered Groups:** The required minimum Employer contribution is twenty-five percent (25%). No policy will be issued or renewed unless at least seventy percent (70%) of Eligible Employees have enrolled for coverage. This applies to health and dental business separately. This does not include those Eligible Employees waiving coverage under BCBSIL due to other group coverage. In no event, however, shall the policy be issued or renewed unless at least two (2) Eligible Employees have enrolled for coverage.

**D. The following applies to Non-Grandfathered Groups.** BCBSIL reserves the right to take any or all of the following actions:

1. Initial rates will be finalized for the effective date of the policy based on the enrolled participation and Employer contribution levels;
2. After the policy effective date, the group will be required to maintain a minimum Employer contribution of twenty-five percent (25%), and at least a seventy percent (70%) participation of Eligible Employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or
3. Non-renew or discontinue coverage unless the twenty-five percent (25%) minimum Employer contribution is met and at least seventy percent (70%) of Eligible Employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSIL of any change in participation and Employer contribution.

**E. For Life, Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability, Long-Term Disability, Critical Illness, Accident, Hospital Indemnity, and Vision Plans:**

____% for Group Life, AD&D	____% for Dependent Life	____% Supplemental Life Insurance, AD&D
____% for Short-Term Disability	____% Long-Term Disability	____% for Critical Illness
____% for Accident Insurance	____% for Vision	____% for Hospital Indemnity

If the Employer contributes one hundred percent (100%) toward the cost of coverage, no policy will be issued or renewed unless at least one hundred percent (100%) of Eligible Employees have enrolled for that coverage. If both the employer and employee contribute toward the cost of coverage, no policy will be issued or renewed unless at least seventy-five percent (75%) of Eligible Employees have enrolled for that coverage.

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## OTHER PROVISIONS

1. **Reimbursement:** It is understood and agreed that in the event BCBSIL makes a recovery on a third-party liability claim, BCBSIL will retain twenty-five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.
2. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement/Subrogation Services):** BCBSIL engages with third-party recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.
3. **HCA purchased:**  Yes  No (If yes, complete and attach a separate HCA Benefit Program Application)
4. **Blue Directions for Large Business<sup>SM</sup> purchased:**  Yes  No (if yes, the Blue Directions<sup>SM</sup> Addendum is attached and made a part of the Policy.)
5. **Massachusetts Health Care Reform Act:** If elected below, BCBSIL will provide required written statements of Minimum Creditable Coverage ("MCC") to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSIL by Employer and coverage under the Plan(s) during the term of the Policy. By electing to have BCBSIL transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that BCBSIL is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.  
 Employer consents to BCBSIL transmitting MCC reports on its behalf. Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.  
 Employer will transmit MCC reports, and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.
6. **Wellbeing Management (WBM) (included)**
7.  **Medical and Ancillary Package Pricing:** The rates shown in this Policy reflect a volume-based discount in an amount up to three percent (3%) of the medical premium for the twelve (12) month period beginning on the Policy Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSIL reserves the right to remove the volume-based discount attributable to the lapsed product on medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will be adjusted to reflect the removal of the discount attributable to the lapsed product.

## EMPLOYER STATEMENTS:

1. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.
2. The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the proposal document submitted to the Employer by the Sales Representative. It is understood and agreed that the actual terms and conditions are those contained in the Policy. It is further understood and agreed that the terms of the BPA may be subject to change. The final terms may be specified in a benefit program and premium notification letter or the applicable rate summary(ies) for the plan number(s) selected

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which may be attached hereto and made a part of the BPA. Payment of the first (1<sup>st</sup>) premium due under the Policy constitutes acceptance of such terms. No coverage will begin until receipt of the first (1<sup>st</sup>) premium by BCBSIL.

3. This BPA is subject to acceptance by BCBSIL as to coverage it underwrites. We certify that all the information and all attestations provided to BCBSIL is correct and complete. Upon acceptance of this BPA, BCBSIL shall issue a Policy to the Employer and this BPA and the benefit program and premium notification letter or the applicable rate summary(ies) for the plan number(s) selected shall be incorporated and made a part of the Policy. Upon acceptance of this BPA by BCBSIL and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the proposal document and the Policy, the provisions of the Policy shall prevail.
4. The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL may pay the Employer's producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid to the producer by BCBSIL in connection with the issuance of a Policy, the Employer should contact its producer.
5. The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund, or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident, or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities there under. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer is effective with respect to or accepted by BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.
6. **With respect to Life, Disability, Critical Illness, Accident, Hospital Indemnity or Vision coverage applied for:** We agree to comply with and participate in all provisions of the Group Policy providing the coverage applied for. We understand that BCBSIL intends to rely on this information in determining whether the enrolling Employees may become insured.

#### ADDITIONAL PROVISIONS:

- A. **Grandfathered Health Plans:** Employer shall provide BCBSIL with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and made part of the BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSIL with any requested grandfathered health plan information, BCBSIL may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

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- B.** Employer shall indemnify and hold harmless BCBSIL and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against BCBSIL in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Employer, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.
- C.** Medicare Secondary Payer (MSP): Policyholders are required to provide accurate employee counts annually during the data collection period through Blue Access for Employers<sup>SM</sup> or through a stand-alone MSP form emailed to data\_collection@bcbsil.com. This is required even when there has been no change to the information from the previous year. In the absence of an annual certification of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Therefore, the failure to timely provide this information and to submit annual employee count reports will result in the group health plan being primary to Medicare and could impact the coverage and benefits your Medicare-enrolled plan enrollees experience. To the extent CMS imposes civil money penalties on the Plan as a result of the Policyholder's inaccurate or untimely reporting of employee counts, the Policyholder agrees that it is responsible for such civil money penalties and is required to reimburse the Plan.

The provisions of paragraphs A-C (directly above) shall be in addition to (and does not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSIL reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSIL to pay, submit or forward, on its own behalf or on the Employer's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

**Renewals Only:** If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Employer's first renewal date on or after September 23, 2010, the provisions of paragraphs A-B (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the certificate booklet.

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\_\_\_\_\_  
 Producer Agency Representative

\_\_\_\_\_  
 Signature of Producer Agency Representative

\_\_\_\_\_  
 Producer Agency Name

\_\_\_\_\_  
 Producer Address

\_\_\_\_\_  
 Producer Phone No.

\_\_\_\_\_  
 Producer Number

\_\_\_\_\_  
 Contracted Producer Tax ID No.

\_\_\_\_\_  
 BCBSIL Sales Representative                  District / Cluster

\_\_\_\_\_  
 Signature of Employer/Authorized Purchaser

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness

Other Information: \_\_\_\_\_

<b>UNDERWRITING AUTHORIZATION</b>	
<b>INTERNAL USE ONLY</b>	Benefit program and premium notification letter included: <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Letter: _____

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## PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof, with full power of substitution, and such persons as the Board of Directors may designate by resolution as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

HCSC pays indemnification or advances expenses to its directors, officers, employees, or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s): \_\_\_\_\_ By: \_\_\_\_\_  
Print Signer's Name Here

➔ \_\_\_\_\_  
Signature and Title

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_,  
Month Year

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**BENEFIT PLAN SELECTION (BPS)**  
(To Be Used for Mid-Market Group Accounts)

**Please complete & return this form in its entirety, including the required signatures**

**Section 1 - Account Information:**

<b>Employer Name:</b>			
<b>Account #:</b>		<b>Effective Date:</b>	
		<b>Anniversary Date:</b>	

**Health Products / Mid-Market Medical and/or Dental Plan Selection:**

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

Please list current plan(s) below	Retaining Plan(s):		Replacing Plan(s): Please list replacement plan in space below.
1.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	1.
2.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	2.
3.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	3.
4.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	4.
5.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	5.
6.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	6.
7.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	7.
8.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8.

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

<b>Adding Plan (Medical and/or Dental):</b> Please list new plan(s) below
1.
2.
3.
4.
5.
6.
7.
8.

**Section 3 – New Business:**

**GROUP NUMBER:**

- Blue Directions (Private Exchange) Purchased? Yes  No   
(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 Advantage HMO®							
2026 Plan ID	Deductible In Network	Coins In-Network	OPX In-Network	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIBAH2000	\$0	100%	\$1500	\$40/\$60	\$350	\$0/\$10/\$35/\$75/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250
<input type="checkbox"/> MIBAH2016	\$0	100%	\$1500	\$40/\$70	\$350	\$5/\$15/\$60/\$110/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBAH2026	\$0	100%	\$1500	\$30/\$60	\$350	\$5/\$15/\$60/\$110/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350

Pharmacy benefits based on the Performance Annual Drug List at HMO Network pharmacies.

B. Blue Advantage HMO® Value Choice							
2026 Plan ID	Deductible In Network	Coins In Network	OPX In-Network	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIBAV2116	\$0	100%	\$3000	\$50/\$80	\$450	\$5/\$15/\$45/\$85/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBAV2126	\$0	100%	\$3000	\$60/\$90	\$500	\$5/\$15/\$45/\$85/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBAV4016	\$0	80%	\$6500	\$30/\$60	\$500**	\$5/\$15/\$60/\$110/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBAV2136	\$1250	80%	\$3500	\$60/\$90	\$350**	\$5/\$15/\$60/\$110/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBAV2146	\$1750	80%	\$5000	\$60/\$90	\$500**	\$5/\$15/\$60/\$110/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBAV2152	\$3000	80%	\$8700	\$20/\$40	\$400**	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250

Pharmacy benefits based on the Performance Annual Drug List at HMO Network pharmacies.

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

C. BlueEdge SM Select HSA							
2026 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Coins.	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIESA2122	\$2500/\$5000	100%/100%	\$2500/\$5000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIESA3113	\$2500/\$5000	80%/50%	\$5000/\$15000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIESE3153	\$3500/\$7000	80%/50%	\$7000/\$21000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIESE2052	\$4000/\$8000	100%/80%	\$4000/\$24000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIESE4014	\$5000/\$10000	100%/100%	\$5000/\$10000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIESE3076	\$5000/\$10000	80%/50%	\$7500/\$22500	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIESE3183	\$6000/\$12000	100%/100%	\$6000/\$12000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIESE4024	\$7500/\$15000	100%/100%	\$7500/\$15000	100%/100%	100%	100%	100%

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

Coinsurance applies after the medical deductible is met, as applicable.

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies

All HSA compatible HDHP plans include select preventive categories of prescription drugs covered with no member cost share.

D. Blue Edge SM HSA							
2026 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Coins	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIEEA3005	\$1800/\$1800	100%/80%	\$3600/\$3600	100%/100%	100%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEA3015	\$1800/\$3600	80%/60%	\$3600/\$10800	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEA2020	\$2500/\$2500	100%/80%	\$5000/\$5000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIEEA3033	\$2500/\$5000	80%/60%	\$5000/\$15000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEE4045	\$3500/\$7000	100%/100%	\$3500/\$7000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIEEA3096	\$3500/\$7000	80%/60%	\$6300/\$18900	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEE3053	\$3500/\$7000	80%/60%	\$7000/\$21000	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEE2052	\$4000/\$8000	100%/80%	\$4000/\$24000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIEEE4014	\$5000/\$10000	100%/100%	\$5000/\$10000	100%/100%	100%	100%	100%
<input type="checkbox"/> MIEEE3076	\$5000/\$10000	80%/60%	\$7500/\$22500	80%/80%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MIEEE3083	\$6000/\$12000	100%/100%	\$6000/\$12000	100%/100%	100%	100%	100%

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<input type="checkbox"/> MIEEE4024	\$7500/\$15000	100%/100%	\$7500/\$15000	100%/100%	100%	100%	100%
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Plans are HSA compatible. The 5th character in the Plan ID indicates (A) for Aggregate or (E) for Embedded deductible and OPX.

Coinsurance applies after the medical deductible is met, as applicable.

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies

All HSA compatible HDHP plans include select preventive categories of prescription drugs covered with no member cost share.

E. Blue Choice Select PPO <sup>SM</sup>							
2026 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SPC	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIBCS5006	\$250/\$500	80%/50%	\$1250/\$3750	\$30/\$30	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2016	\$500/\$1000	80%/50%	\$1750/\$5250	\$30/\$30	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2026	\$750/\$1500	90%/60%	\$2000/\$6000	\$30/\$30	\$400	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCS2036	\$750/\$1500	80%/50%	\$3000/\$9000	\$30/\$30	\$400	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCS2046	\$1000/\$2000	90%/60%	\$2500/\$7500	\$30/\$30	\$400	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCS2056	\$1250/\$2500	80%/50%	\$3500/\$10500	\$40/\$40	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2076	\$1500/\$3000	80%/50%	\$4000/\$12000	\$40/\$40	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2086	\$2000/\$4000	80%/50%	\$5000/\$15000	\$40/\$40	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2096	\$2250/\$4500	80%/50%	\$4500/\$13500	\$40/\$40	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2126	\$2500/\$5000	80%/50%	\$5000/\$15000	\$40/\$40	\$400	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCS1126	\$3000/\$6000	80%/50%	\$6500/\$19500	\$40/\$40	\$400	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCS2146	\$3500/\$7000	80%/50%	\$6000/\$18000	\$30/\$30	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2166	\$4250/\$8500	80%/50%	\$6000/\$18000	\$40/\$40	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS2176	\$5000/\$10000	80%/50%	\$6100/\$18300	\$50/\$50	\$400	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCS1176	\$5000/\$10000	80%/50%	\$8550/\$25650	\$50/\$50	\$400	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies.

F. Blue Choice Options <sup>SM</sup> HSA - Tiered Network (Blue Choice OPT PPO – BCO / PPO – PPO / Out of Network - OON)							
2026 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
<input type="checkbox"/> MICOE4066	\$3500/ \$4600/ \$10500	100%/ 80%/ 60%	\$3500/ \$6800/ \$20400	100%/ 80%	100%	100%	100%
<input type="checkbox"/> MICOE3026	\$4000/ \$5700/ \$12000	100%/ 80%/ 60%	\$4000/ \$7750/ \$23250	100%/ 80%	100%	100%	100%
<input type="checkbox"/> MICOE3056	\$3500/ \$5000/ \$10000	80%/ 60%/ 50%	\$5500/ \$7250/ \$21750	80%/ 60%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MICOE3076	\$5000/ \$6000/ \$12000	80%/ 60%/ 50%	\$6000/ \$7250/ \$21750	80%/ 60%	80%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> MICOE3016	\$6000/ \$7000/ \$14000	80%/ 60%/ 50%	\$7000/ \$7750/ \$23250	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 ID indicates (A) for Aggregate or (E) for Embedded deductible and OPX.

Coinsurance applies after the medical deductible is met, as applicable.

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies

All HSA compatible HDHP plans include select preventive categories of prescription drugs covered with no member cost share.

G. Blue Choice Options <sup>SM</sup> - Tiered Network (Blue Choice OPT PPO – BCO/ PPO – PPO / Out of Network - OON)							
2026 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
<input type="checkbox"/> MIBCO2086	\$500/ \$1250/ \$2500	90%/ 70%/ 50%	\$1250/ \$1500/ \$4500	\$30/\$50// \$60/\$90	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO2006	\$750/ \$1750/ \$3500	90%/ 70%/ 50%	\$4500/ \$6100/ \$18300	\$30/\$60// \$60/\$110	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO2016	\$750/ \$1750/ \$3500	100%/ 70%/ 50%	\$750/ \$3500/ \$10500	\$30/\$60// \$60/\$110	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO2036	\$1000/ \$2500/ \$5000	90%/ 70%/ 50%	\$3000/ \$6000/ \$18000	\$35/\$60// \$70/\$110	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO2046	\$1500/ \$3750/ \$7500	90%/ 70%/ 50%	\$3500/ \$6000/ \$18000	\$40/\$60// \$70/\$110	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO5006	\$2000/ \$4000/ \$8000	90%/ 70%/ 50%	\$4500/ \$6500/ \$13000	\$40/\$60// \$70/\$110	\$500**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO1205	\$2500/ \$4000/ \$8000	80%/ 60%/ 50%	\$5000/ \$6000/ \$18000	80%/60%// 80%/60%	80%/60%	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBCO5016	\$3000/ \$4500/ \$9000	80%/ 60%/ 50%	\$5500/ \$6500/ \$13000	\$45/\$70// \$75/\$130	\$600**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO2056	\$4250/ \$5250/ \$10000	80%/ 60%/ 50%	\$6100/ \$6100/ \$18300	\$45/\$70// \$75/\$130	\$600**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBCO4076	\$5250/ \$6250/ \$18750	80%/ 60%/ 50%	\$7100/ \$8100/ \$24300	\$50/\$75// \$80/\$130	\$600**	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies.

Coinsurance applies after the medical deductible is met, as applicable.

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

H. BluePrint <sup>®</sup> PPO							
2026 Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	OV/SP C	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
<input type="checkbox"/> MIBPP2000	\$0/\$0	90%/70%	\$1000/\$3000	\$20/\$40	\$150	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> MIBPP5006	\$250/\$500	80%/60%	\$1250/\$3750	\$30/\$60	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBPP2016	\$500/\$1000	80%/60%	\$1750/\$5250	\$30/\$60	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBPP2026	\$750/\$1500	90%/70%	\$2000/\$6000	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2036	\$750/\$1500	80%/60%	\$3000/\$9000	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP1036	\$750/\$1500	80%/60%	\$6500/\$19500	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2046	\$1000/\$2000	90%/70%	\$2500/\$7500	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2056	\$1250/\$2500	80%/60%	\$3500/\$10500	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2066	\$1250/\$2500	80%/60%	\$4500/\$13500	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2076	\$1500/\$3000	80%/60%	\$4000/\$12000	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2086	\$2000/\$4000	80%/60%	\$5000/\$15000	\$40/\$70	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBPP2096	\$2250/\$4500	80%/60%	\$4500/\$13500	\$40/\$70	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBPP1096	\$2250/\$4500	80%/60%	\$6500/\$19500	\$40/\$70	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350
<input type="checkbox"/> MIBPP2116	\$2750/\$5500	90%/70%	\$4000/\$12000	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2126	\$2500/\$5000	80%/60%	\$5000/\$15000	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2136	\$2750/\$5500	80%/60%	\$6000/\$18000	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP1126	\$3000/\$6000	80%/60%	\$6500/\$19500	\$40/\$70	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2146	\$3500/\$7000	80%/60%	\$6000/\$18000	\$30/\$60	\$350	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP2166	\$4250/\$8500	80%/60%	\$6000/\$18000	\$40/\$70	\$350	\$15/\$25/\$65/\$105/\$250/\$350	\$5/\$15/\$45/\$85/\$250/\$350

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<input type="checkbox"/> MIBPP2176	\$5000/\$10000	80%/60%	\$6100/\$18300	\$50/\$80	\$450	\$15/\$25/\$80/\$130/\$250/\$350	\$5/\$15/\$60/\$110/\$250/\$350
<input type="checkbox"/> MIBPP1171	\$5000/\$10000	80%/60%	\$8550/\$25650	\$40/\$60	\$250	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250

Pharmacy benefits based on the Performance Full Drug List at Preferred Network pharmacies.  
Coinsurance applies after the medical deductible is met, as applicable.

#### Section 4 – HSA / FSA / HRA Plans:

Blue Cross and Blue Shield of Illinois has preferred relationships and integration with the vendors listed below. By selecting one of these vendors, employers agree to have the necessary data shared with the integrated vendor for the purposes of plan administration. A [vendor-specific employer setup form](#) is required to be submitted for first-time vendor integration.

<b>Integrated HSA Vendor:</b> * If HSA is selected, you have the option of selecting an HSA vendor with enrollment, balance and transaction displayed on Blue Access for Members, and claims integration. Note: Integration features vary by vendor. (If no selection is made, HSA Vendor will default to Other/None.)	<b>Integrated FSA Vendor:</b> * If FSA is selected, you have the option of selecting an FSA vendor with enrollment, balance and transaction displayed on Blue Access for Members, and claims integration. Clients who are renewing their FSA are required to resubmit employee elections with their renewal paperwork to continue the FSA plan. <b>Note: Integration features vary by vendor.</b> (If no selection is made, FSA Vendor will default to Other / None.)	<b>Integrated HRA Vendor:</b> * If HRA is selected, you have the option of selecting an HRA vendor with enrollment, balance and transaction displayed on Blue Access for Members, and claims integration. Clients who are renewing their HRA are required to resubmit employee elections with their renewal paperwork to continue the HRA plan. <b>Note: Integration features vary by vendor.</b> (If no selection is made, FSA Vendor will default to Other / None.)
<input type="checkbox"/> Flex®	<input type="checkbox"/> Flex®	<input type="checkbox"/> Flex®
<input type="checkbox"/> HealthEquity® If HealthEquity is selected, BCBSIL to send HSA enrollment to HealthEquity: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HealthEquity®	<input type="checkbox"/> HealthEquity®
<input type="checkbox"/> HSA Bank®	<input type="checkbox"/> HSA Bank®	<input type="checkbox"/> HSA Bank®
<input type="checkbox"/> Other Non-Integrated HSA Vendor/None (Select this option if using an HSA vendor other than above or are not offering an employer sponsored HSA vendor.)	<input type="checkbox"/> Other Non-Integrated FSA Vendor/None (Select this option if using an FSA vendor other than above or are not offering an employer sponsored FSA vendor.)	<input type="checkbox"/> Other Non-Integrated HRA Vendor/None (Select this option if using an FSA vendor other than above or are not offering an employer sponsored FSA vendor.)

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**Section 5 - Ancillary Product Selection:**

**DENTAL PPO GROUP NUMBER:**

**Dental Products**

Blue Care Dental PPO							
Contributory DPPO				Voluntary DPPO			
Plan Pairings (Groups 10+)				Plan Pairings (Groups 10+)			
High Allocation		Low Allocation		High Allocation		Low Allocation	
DINHR30		DINLR36		DINHR43		DINLR47	
DINHR31		DINLM41		DINHM44		DINLR48	
DINHR32		DINLM51		DINHR45		DINLR54	
DINHR33		DINLR58		DINHM46		DINLR54	
DINHR34		DINLR62		DINHR53		DINLM55	
DINHR35				DINHM59		DINLM56	
DINHM38						DINLR60	
DINHM40				Any one of the above Voluntary High Allocation DPPO plans can be paired with any one of the Voluntary Low Allocation DPPO plans.			
DINHM42				Two High Voluntary plans that can be paired are DINHM59 and DINHR43.			
DINHR50				DINHM46 can be freely paired with any Voluntary High or Low Allocation Plan.			
DINHR57				<b>Participation Requirements</b>			
DINHR61				>25% Participation			
Any one of the above Contributory High Allocation DPPO plans can be paired with any one of the Contributory Low Allocation DPPO plans.				<50% Employer contribution			
Two High Contributory plans that can be paired are DINHM57 and DINHR33.							
DINHM42 can be freely paired with any Contributory High or Low Allocation Plan.							
<b>Participation Requirements</b>							
>70% Participation							
>50% Employer contribution							
Contributory DHMO				Voluntary DHMO			
Any one Contributory DHMO plan can be paired with any one Contributory DPPO Allocation Plan.				Any one Voluntary DHMO plan can be paired with any one Voluntary DPPO Allocation Plan.			
<b>Participation Requirements</b>				<b>Participation Requirements</b>			
>70% Participation				>25% Participation			
>50% Employer contribution							
Contributory DPPO							
IL Plan Code	Plan Type	Deductible In/Out (3x) Family Limit 1	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Ortho Life Maximum
					In-Network (Class I/II/III/IV)	Out-Of-Network (Class I/II/III/IV)	
<b>High Allocation</b>							
<input type="checkbox"/> DINHR30 <sup>4</sup>	Passive	\$25/\$25	\$5000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000
<input type="checkbox"/> DINHR31 <sup>4</sup>	Passive	\$25/\$25	\$3000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000
<input type="checkbox"/> DINHR32 <sup>4</sup>	Passive	\$50/\$50	\$2000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000
<input type="checkbox"/> DINHR33 <sup>4</sup>	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500
<input type="checkbox"/> DINHR34 <sup>4</sup>	Active	\$50/\$75	\$1500/\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000
<input type="checkbox"/> DINHR35 <sup>4</sup>	Active	\$0/\$0	\$2000	90 <sup>th</sup> R&C	100%/90%/60%/50%	100%/80%/50%/50%	\$2000
<input type="checkbox"/> DINHM38	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<input type="checkbox"/> DINHM40	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A
<input type="checkbox"/> DINHM42	Passive	\$25/\$75	\$750	MAC	100%/80% <sup>2</sup> /NA/NA	100%/80% <sup>2</sup> /NA/NA	N/A
<input type="checkbox"/> DINHR50	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINHM57 <sup>4</sup>	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500
<input type="checkbox"/> DINHR61	Passive	\$50/\$50	\$2000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<b>Low Allocation</b>							
<input type="checkbox"/> DINLR36	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINLM41	Active	\$75/\$75	\$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	N/A
<input type="checkbox"/> DINLM51	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<input type="checkbox"/> DINLR58 <sup>3</sup>	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<input type="checkbox"/> DINLR62	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000

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

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these services are covered in Type III.

R&C: Reasonable & Customary, MAC: Maximum Allowable Charge.

\*1 Waived Deductible applies to all Class I services and plans include 3x Family Deductible Limit.

\*2 Only Basic Restorative Services are covered under Class II.

\*3 Preventive & Diagnostic Services do not count toward the Annual Benefit Max.

\*4 Implants are covered at the same percentage as prosthodontics.

Voluntary DPPO							
IL Plan Code	Plan Type	Deductible In/Out (3x) Family Limit 1	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Ortho Life Maximum
					In-Network (Class I/II/III/IV)	Out-Of-Network (Class I/II/III/IV)	
<b>High Allocation</b>							
<input type="checkbox"/> DINHR43	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500
<input type="checkbox"/> DINHM44	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A
<input type="checkbox"/> DINHR45	Active	\$25/\$75	\$2000	90 <sup>th</sup> R&C	100%/90%/60%/50%	100%/80%/50%/50%	\$2000
<input type="checkbox"/> DINHM46	Passive	\$25/\$75	\$750	MAC	100%/80% <sup>2</sup> /NA/NA	100%/80% <sup>2</sup> /NA/NA	N/A
<input type="checkbox"/> DINHR53	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINHM5	Passive	\$50/\$50	\$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	\$1500
<b>Low Allocation</b>							
<input type="checkbox"/> DINLR47	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINLR48	Passive	\$50/\$50	\$1500	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<input type="checkbox"/> DINLM49	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINLR54	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A
<input type="checkbox"/> DINLM55	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<input type="checkbox"/> DINLM56	Active	\$50/\$100	\$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	N/A
<input type="checkbox"/> DINLR60 <sup>3</sup>	Passive	\$50/\$50	\$1000	90 <sup>th</sup> R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000
<b>Contributory DHMO</b>							
<input type="checkbox"/> DNCAP710	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A
<input type="checkbox"/> DNCAP730	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A
<b>Voluntary DHMO</b>							
<input type="checkbox"/> DNCAP810	N/A	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A
<input type="checkbox"/> 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 Waived Deductible applies to all Class I services and plans include 3x Family Deductible Limit.

\*2 Only Basic Restorative Services are covered under Class II.

\*3 Preventive & Diagnostic Services do not count toward the Annual Benefit Max.

**C. Supplemental Health and Vision Products**

**GROUP NUMBER:**

<b>Standalone Vision</b>		<b>Yes <input type="checkbox"/></b>		<b>No <input type="checkbox"/></b>			
<b>Standalone Vision Plans</b>							
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
<b>Basic Standalone Vision</b>							
<input type="checkbox"/> Plan 1	12/12/24	\$25	\$100	No	No	No	No
<input type="checkbox"/> Plan 2	12/12/24	\$10	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 3	12/12/24	\$10	\$130	Yes	No	Yes	Yes
<input type="checkbox"/> Plan 4	12/12/12	\$10	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 5	12/12/24	\$10	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 6	12/12/12	\$10	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 7	12/12/12	\$10	\$150	No	Yes	Yes	Yes
<input type="checkbox"/> Plan 8	12/12/24	\$25	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 9	12/12/24	\$25	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 10	12/12/12	\$25	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 11	12/12/12	\$25	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 12	12/12/12	\$10	\$200	No	No	Yes	Yes
<input type="checkbox"/> Plan 13	12/12/12	\$25	\$200	No	No	Yes	Yes
<input type="checkbox"/> Plan 14	12/12/24	\$25	\$200	No	No	Yes	Yes
<b>Voluntary Standalone Vision</b>							
<input type="checkbox"/> Plan 1	12/12/24	\$25	\$100	No	No	No	No
<input type="checkbox"/> Plan 2	12/12/24	\$10	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 3	12/12/24	\$10	\$130	Yes	No	Yes	Yes
<input type="checkbox"/> Plan 4	12/12/12	\$10	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 5	12/12/24	\$10	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 6	12/12/12	\$10	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 7	12/12/12	\$10	\$150	No	Yes	Yes	Yes
<input type="checkbox"/> Plan 8	12/12/24	\$25	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 9	12/12/24	\$25	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 10	12/12/12	\$25	\$150	No	No	Yes	Yes
<input type="checkbox"/> Plan 11	12/12/12	\$25	\$130	No	No	Yes	Yes
<input type="checkbox"/> Plan 12	12/12/12	\$10	\$200	No	No	Yes	Yes
<input type="checkbox"/> Plan 13	12/12/12	\$25	\$200	No	No	Yes	Yes
<input type="checkbox"/> Plan 14	12/12/24	\$25	\$200	No	No	Yes	Yes
<b>Critical Illness</b>		<b>Yes <input type="checkbox"/></b>		<b>No <input type="checkbox"/></b>			
<b>Critical Illness Plans</b>							
Plan Name	Plan Benefit			Benefit Maximum			
<b>Basic Critical Illness</b>							
<input type="checkbox"/> Plan 1	\$5,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
<input type="checkbox"/> Plan 2	\$10,000 Employee / \$5,000 Spouse / \$2,500 Child			Up to 3 times benefit amount			
<input type="checkbox"/> Plan 3	\$10,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
<b>Voluntary Critical Illness</b>							
<input type="checkbox"/> Plan 1	\$5,000 Employee / \$2,500 Spouse / \$2,500 Child			Up to 3 times benefit amount			
<input type="checkbox"/> Plan 2	\$10,000 Employee / \$5,000 Spouse / \$2,500 Child			Up to 3 times benefit amount			

Life and Disability insurance is 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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<input type="checkbox"/> Plan 3	\$10,000 Employee / \$2,500 Spouse / \$2,500 Child	Up to 3 times benefit amount		
<b>Accident Plans</b>				
Plan Name	Benefit Description	24-hour coverage	Benefit Coverage	Wellness
<b>Basic Accident</b>				
<input type="checkbox"/> Plan 1	Benefit for treatment and injuries due to an accident	No	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40
<input type="checkbox"/> Plan 2	Benefit for treatment and injuries due to an accident	No	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50
<input type="checkbox"/> Plan 1 – 24 Hr	Benefit for treatment and injuries due to an accident	Yes	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40
<input type="checkbox"/> Plan 2 – 24 Hr	Benefit for treatment and injuries due to an accident	Yes	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50
<input type="checkbox"/> Smart Plan 1	Benefits for treatment due to an accident	No	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 2	Benefits for treatment due to an accident	No	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 1 – 24 Hr	Benefits for treatment due to an accident	Yes	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 2 – 24 Hr	Benefits for treatment due to an accident	Yes	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0
<b>Voluntary Accident</b>				
<input type="checkbox"/> Plan 1	Benefit for treatment and injuries due to an accident	No	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40
<input type="checkbox"/> Plan 2	Benefit for treatment and injuries due to an accident	No	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50
<input type="checkbox"/> Plan 1 – 24 Hr	Benefit for treatment and injuries due to an accident	Yes	Emergency Room - \$75 / Hospital Confinement - \$150 / Ground Ambulance - \$200	\$40
<input type="checkbox"/> Plan 2 – 24 Hr	Benefit for treatment and injuries due to an accident	Yes	Emergency room - \$150 / Hospital confinement - \$250 / Ground Ambulance - \$200	\$50
<input type="checkbox"/> Smart Plan 1	Benefits for treatment due to an accident	No	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 2	Benefits for treatment due to an accident	No	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 1 – 24 Hr	Benefits for treatment due to an accident	Yes	Emergency Room - \$175 / Hospital Confinement - \$200 / Ground Ambulance - \$400	\$0
<input type="checkbox"/> Smart Plan 2 – 24 Hr	Benefits for treatment due to an accident	Yes	Emergency Room - \$200 / Hospital Confinement - \$300 / Ground Ambulance - \$400	\$0

Plan Name	Hospital Admission Once per calendar year	Daily Hospital Confinement Up to 30 days per calendar year	Intensive Care Unit Admission - once per calendar year	Daily ICU Confinement-up to 10 days per calendar year	Newborn Confinement – (Routine Nursery care)	Wellness – Once per calendar year
<b>Basic Hospital Indemnity</b>						
<input type="checkbox"/> Plan 1	\$500	\$100/day	\$500	\$100/day	\$50/day	\$50/day
<input type="checkbox"/> Plan 2	\$1,000	\$100/day	\$1,000	\$100/day	\$50/day	\$50/day
<input type="checkbox"/> Plan 3	\$2,000	\$200/day	\$2,000	\$200/day	\$50/day	\$50/day
<b>Voluntary Hospital Indemnity</b>						
<input type="checkbox"/> Plan 1	\$500	\$100/day	\$500	\$100/day	\$50/day	\$50/day
<input type="checkbox"/> Plan 2	\$1,000	\$100/day	\$1,000	\$100/day	\$50/day	\$50/day
<input type="checkbox"/> Plan 3	\$2,000	\$200/day	\$2,000	\$200/day	\$50/day	\$50/day

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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.


**Broker Authorization for Group Changes**

For Accident, Critical Illness, Hospital Indemnity, and Vision insurance, I authorize the Broker of Record, including any subsequently named Broker of Record, to submit policy change requests on our behalf for the policy contracts identified under the Group Policy Number above. I also agree that the policy change requests will not become effective until approved. It is also agreed to implement or revoke this consent, the Policyholder must submit a request in writing to Blue Cross Blue Shield of Illinois, Attn: Policy Administration, 701 East 22nd Street, Lombard, IL 60148. This consent will not become effective until it is received by us and shall remain in effect until we receive revocation of the authorization in accord with the above.

**Section 6 – Signatures:**

Signatures		
Employer / Authorized Purchaser	Title	Date

Life and Disability insurance is 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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# Employer Group Information

Indicate N/A in any sections that do not apply to your group.

Revised – April 2025

SECTION A: GROUP INFORMATION	
Employer Name – Legal Name of Company:	
Employer Identification Number (EIN):	
Physical Address (number & street), City, State, ZIP:	
Account Number(s):	Group Number(s):

## MEDICARE SECONDARY PAYER EMPLOYER ACKNOWLEDGEMENT FORM

Under federal law, it is the employer’s responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and the employer’s group health plan. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the instructions and more frequently asked questions that follow this form for more details on how to complete this Medicare Secondary Payer section.

Employers are required to provide this information ANNUALLY during the data collection period by submitting the MSP form through Blue Access for Employers<sup>SM</sup> or by completing a stand-alone MSP Employer Acknowledgement Form and emailing it to data\_collection@bcbsil.com. This is required even when there has been no change to the information from the previous year.

Understand that you are also obligated to promptly notify Blue Cross and Blue Shield of Illinois of any change in the number of individuals employed by the company that may affect the order of payment under the MSP statute. Complete a CHANGE or ERROR CORRECTION stand-alone MSP EAF and email it to data\_collection@bcbsil.com.

**IMPORTANT: In the absence of employer-provided employee counts, CMS requires that the employer’s group health plan coverage be considered primary to Medicare. Therefore, the failure to timely provide this information and to submit annual employee counts will result in the group health plan being primary to Medicare, and could impact the coverage and benefits your Medicare-enrolled plan enrollees experience. To the extent CMS imposes civil money penalties on the Plan, as a result of the Policyholder’s inaccurate or untimely reporting of employee counts, the Policyholder agrees that it is responsible for such civil money penalties and is required to reimburse the Plan.**

**All fields below are REQUIRED.**

**Please indicate the effective year for which the form is being completed.**

**Effective Year:** \_\_\_\_\_

My company is a NEW client of BCBSIL (check one):	
<input type="checkbox"/> My company was NOT in business in the last calendar year	<input type="checkbox"/> My company WAS in business in the last calendar year
Do you have any affiliates or subsidiaries? <input type="checkbox"/> Yes <input type="checkbox"/> No If “yes”, list name of each:	





**SECTION C: COBRA AND CONTINUATION OF COVERAGE**

CONTINUATION OF COVERAGE: COBRA IS FEDERALLY MANDATED AND APPLIES TO EMPLOYERS WITH 20 OR MORE FULL-TIME OR PART-TIME EMPLOYEES. IN ADDITION, ILLINOIS LAW REQUIRES GROUP PLANS, WHEN SUBJECT TO ILLINOIS INSURANCE LAW, TO OFFER CONTINUATION OF COVERAGE TO EMPLOYEES AND THEIR SPOUSES/DEPENDENTS SHOULD A SPECIFIC QUALIFYING EVENT OCCUR. WHERE APPLICABLE, THE REQUIREMENTS UNDER STATE LAW MAY OPERATE IN ADDITION TO ANY FEDERAL COBRA CONTINUATION OF COVERAGE REQUIREMENTS.

EMPLOYER PENALTIES FOR NONCOMPLIANCE MAY APPLY.

1. Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you subject to the Consolidated Omnibus Reconciliation Act (COBRA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are any employees/former employees or their spouses/dependents currently receiving Continuation of Coverage benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes", list names and number of individuals (qualified beneficiaries) currently on continuation of coverage (i.e., COBRA):

Name of COBRA/ Continuation of Coverage Individual	COBRA/State Continuation	Coverage Type (Individual or Family)	Projected COBRA/ Continuation Qualifying Event Date (MM/DD/YYYY)	Type of Coverage Extended
	<input type="checkbox"/> COBRA <input type="checkbox"/> State	<input type="checkbox"/> Individual <input type="checkbox"/> Family		<input type="checkbox"/> Health <input type="checkbox"/> Dental
	<input type="checkbox"/> COBRA <input type="checkbox"/> State	<input type="checkbox"/> Individual <input type="checkbox"/> Family		<input type="checkbox"/> Health <input type="checkbox"/> Dental
	<input type="checkbox"/> COBRA <input type="checkbox"/> State	<input type="checkbox"/> Individual <input type="checkbox"/> Family		<input type="checkbox"/> Health <input type="checkbox"/> Dental

It is your responsibility to annually inform BCBSIL of whether COBRA is applicable to you based upon your full and part-time employee count in the prior calendar year. Failure to advise BCBSIL of a change of status could subject you to governmental sanctions.

\*All as defined by ERISA and/or other applicable law/regulations.

**Workers' Compensation**

Are any employees currently receiving Workers' Compensation benefits?  Yes  No

If "yes", list names and date last worked:

Employee Name	Date Last Worked (MM/DD/YYYY)



**SECTION D: MEDICAL LOSS RATIO AVERAGE EMPLOYEE COUNT / WRITTEN ASSURANCE**

**FOR MLR AND MARKET SEGMENT PURPOSES ONLY**

The Affordable Care Act established Medical Loss Ratio standards for health insurers. Generally, the MLR is the percentage of earned premiums that the insurer spends on health care services and quality improvement activities. If the insurer's MLR is less than the ACA's MLR standards for a group market in the state, the insurer may be required to provide premium rebates in that market. The ACA requires that BCBSIL report annually whether coverage it issues in the individual, small group or large group markets in Illinois meet MLR standards. Your assistance is needed to classify your coverage for each MLR reporting year.

This section and the information you provide will assist us in completing our ACA-MLR report and distributing any ACA-MLR rebates that may be provided for an ACA-MLR reporting year. Please complete the information requested below. This section and the information you provide will also assist us in determining your market segment, products and rates.

**1. Average Employee Count – Employer Size**

For the purpose of determining employer size:

- An "employee" is defined as any individual employed by an employer. An employee includes full-time, part-time and seasonal employees.
- Employers treated as a single employer under Internal Revenue Code Section 414(b), (c), (m) or (o) should be treated as a single employer.
- If your company is wholly owned by an individual (or an individual and his/her spouse), do not include the individual and his/her spouse in your response below.
- Partners in a partnership should not be counted as employees.

Check the box that applies to your company (employer):

- My company (employer) **existed** during the preceding calendar year.  
What is the average number of employees that your company (employer) employed on business days during the calendar year (January 1–December 31) preceding the effective date of coverage? For example, if your effective date is July 1, 2021 then you would base your answer on calendar year 2020. \_\_\_\_\_
- My company (employer) **did not exist** at any time during the preceding calendar year.  
What is the average number of employees that your company (employer) is reasonably expected to employ on business days during the current calendar year? \_\_\_\_\_

Is your company a partnership?  Yes  No

**2. Church Plan Written Assurance (Substitute MLR Written Assurance Form)**

To provide a rebate to a policyholder that sponsors a church plan, the MLR regulations require that an insurer obtain a written assurance from the policyholder that any rebate will be used for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)). **If the written assurance is not provided, the MLR regulations require that an insurer distribute any rebate directly to certain subscribers of the plan (rather than to the policyholder).**

Does the policyholder listed below sponsor a church plan in connection with the policyholder's Blue Cross and Blue Shield of Illinois coverage? Church plan has the meaning given the term in Internal Revenue Code Section 414(e).

- No, the group health plan is NOT a church plan. (If "no", proceed to Section E: Signature / Attestation.)**

OR

- Yes, the group health plan is a church plan. If "yes" (check one of the following):**

- The policyholder WILL use any MLR rebate for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)).
- The policyholder WILL NOT use any MLR rebate for the benefit of subscribers as described above. I understand that, if this option is selected, BCBSIL will distribute any MLR rebate directly to certain subscribers of the plan.

If this Written Assurance Form is not completed, signed and received from a church account, BCBSIL will provide any MLR rebate directly to certain subscribers of the plan.



**SECTION E: SIGNATURE / ATTESTATION**

By signing below, I:

- (1) Represent that I am a duly authorized representative of the employer and that the information contained in this form is true, accurate and complete;
- (2) Certify that should any of the answers or information I provided above change in any way, I will inform BCBSIL of such change as soon as I am able. I understand that failure to timely notify BCBSIL of such changes may impact the coverage/eligibility of the group, its members, or any other persons who now or who may then be eligible for coverage under such plan and/or may impact the compliance of the group with respect to specific state or federal requirements;
- (3) Understand and agree that the information contained in this form prospectively supersedes any prior information provided to BCBSIL (including for the purposes of 45 C.F.R. 158.242(b)(3)); and
- (4) Agree that the answers or information I provided above should be considered accurate and complete unless or until a subsequent stand-alone version of the corrected Average Employee Count, Church Plan Written Assurance, or Medicare Secondary Payer form is submitted either in a subsequent calendar year or in the event of a change in such information.

Date (MM/DD/YYYY) \_\_\_\_\_ Name: (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_ Position/Title: \_\_\_\_\_



# Instructions

## COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT FORM

### Important Note

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the attached instructions for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare.**

Employers should provide this information ANNUALLY during the data collection period and submit their information through BAE or submit a completed stand-alone MSP EAF to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com).

Understand that you are obligated to notify BCBSIL if and when your status changes, by completing a stand-alone MSP EAF as a CHANGE or ERROR CORRECTION. Email to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com).

### Background

When an individual is covered by both Medicare and an employer's group health plan, Medicare secondary payer rules specify that the employer's total size, not group health plan enrollment size, is a factor in determining whether Medicare benefits are primary or secondary. Employer size is a factor in MSP order of payment determinations when the covered individual is Medicare-entitled due to either age ("working aged") or disability.

### Employer Information — Who is the Employer?

For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. In some situations, it may not be clear which corporation or individual is the employer for MSP purposes. In these cases, employers must use Internal Revenue Service aggregation rules provided in the Internal Revenue Code [IRC 26 U.S.C. Sections 52(a), 52(b), 414(n) (2)]. In general, these rules specify that single employers include:

- all employees of all corporations that are members of the same controlled group of corporations, and
- all employees of trades or business (whether incorporated or not), e.g., employees of partnerships, LLCs, proprietorships that are under common control.

The Centers for Medicare & Medicaid Service's MSP Manual provides additional guidance about aggregation for affiliated service groups and religious orders, as well as authoritative information about employer size and other MSP topics. The MSP Manual is available online at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017>

For purposes of this MSP EAF, please understand that you are obligated to notify BCBSIL if and when your status changes, by completing a stand-alone MSP EAF as a **CHANGE** or **ERROR CORRECTION** and email to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com).

An **Error Correction** is necessary when a previous MSP EAF was submitted **TIMELY** during the data collection time frame and a correction is needed.

### Question 1 — Did you file a separate Federal Tax Return?

If you filed a federal tax return that did not include information about any other individual or entity, check "Yes." If you filed a federal tax return consolidated with another individual or entity, check "No." If you are not required to file a federal tax return, check "N/A."

### Question 2 — Employer Size from Your Federal Tax Return Information

How many employees did all the entities listed on the tax return have on the payroll (whether full-time, part-time, seasonal or partners) during the prior calendar year? It is important that you enter the total number of employees for all entities (including parent,



subsidiaries and affiliated entities) listed on the tax return, since this may determine whether or not Medicare will be the primary payer of claims. Subsidiaries of foreign companies must count the number of employees of the organization worldwide.

### **Question 3 — Are you part of a multi-employer group health plan?**

Authoritative guidance for determining multiple employer group health plan participation can be found in the Code of Federal Regulations at 29 CFR § 2510.3-37.

### **Questions 4 and 5 — Working Aged Rule & Employer Size**

Under the MSP “working aged” rule, Medicare is secondary to the employer’s GHP coverage if the employer’s size equals 20 or more employees for each working day in each of 20 or more calendar weeks in the current or prior calendar year. (Question 4 refers to this standard as “the threshold.”) Note: The year of your upcoming renewal is the ‘current’ year. If your company is a new client to BCBSIL AND if there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes, by completing a stand-alone MSP EAF as a CHANGE and submitting it to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com). This also applies to multi-employer and multiple employer group health plans in which at least one employer employs 20 or more employees.

- Counting individuals for the “20-or-more” employer size
  - Employees counted in the 20-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or who are expected to report for work on a particular day.
  - Those not counted in the 20-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer’s group health plan.
- Employer size increases to 20 or more during the year

If the employer’s size was below 20 during the prior year, the employer’s GHP coverage becomes primary as soon as the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The 20 calendar weeks do not have to be consecutive. Then, the employer’s GHP coverage is primary for the remainder of the year and during the following year.

For example, the employer’s size meets the 20-or-more employee threshold as of October 1 of the current calendar year. The employer’s GHP coverage becomes primary for services provided from October 1 of the current calendar year through December 31 of the following year.

**Please note:** If you check “No” for the current year in MSP EAF **Question 4** and your answer changes to “Yes” at any time, you must promptly notify BCBSIL by completing a stand-alone MSP EAF and indicating the date the change occurred in the space provided in **Question 4**.

- Employer size fails to meet the threshold of ‘20 or more employees during 20 or more weeks’ during the year

If the employer’s size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks for the prior year, but during the current calendar year the employer size never meets that threshold, the employer’s group health plan remains primary until the end of the current year.

For example, during the last calendar year the employer’s size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks. However, during the current calendar year the employer’s size never meets this threshold. The employer’s group health plan coverage remains primary through the current year, ending on December 31.

- Individuals affected by the working aged rule

The “working aged rule” applies to individuals who are Medicare-entitled due to age (age-65 or older) and

- Are covered under their employer’s GHP and have “current employment status” and the employer meets the “20-or-more” employer size requirements (above), or
- Are covered under their spouse’s (of any age) employer’s GHP and the spouse has current employment status and the employer meets the “20-or-more” employer size requirements (above).



## Questions 6 and 7 — Disability Rule & Employer Size

Under the MSP “disability” rule, Medicare benefits are secondary to an employer’s large group health plan benefits when the employer size equals 100 or more full-time and/or part-time employees on 50 percent or more of the employer’s business days during the prior calendar year. The business days do not have to be consecutive.

For multi-employer plans, Medicare is the secondary payer for all individuals enrolled in the plan as long as at least one of the employers employs 100 or more employees. The 100-employee threshold is not based on the aggregate number of employees of all employers. If you are a multi-employer, please keep this in mind when completing questions 6 and 7.

- Counting individuals for the “100-or-more” employer size
  - Employees counted in the 100-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or are expected to report for work on a particular day.
  - Those not counted in the 100-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer’s group health plan.
- Employer size increases to 100 or more during the year

If the employer’s size meets the 100-or-more employee threshold on 50 percent or more of the employer’s business days during the current year, the employer’s group health plan coverage will be primary to Medicare during the following year.

For example, an employer met the 100-or-more employee threshold on 50 percent or more of the employer’s business days on October 1 of the current calendar year. The employer’s GHP coverage will be primary for services provided the following year from January 1 through December 31 of the following year.

**Please note:** If you answer “No” to **Question 6**, you must promptly notify BCBSIL by completing a stand-alone MSP EAF as a CHANGE if your answer changes to “Yes” at the beginning of the next calendar year and sending to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com).

- Employer size doesn’t meet the threshold of ‘100 or more employees during 50 percent of business days’ during the year

If the employer’s size does not meet the 100-or-more employee threshold during the year, the employer’s GHP coverage is secondary to Medicare during the following year.

For example, during the current calendar year the employer’s size never meets the threshold of 100 or more full-time and/or part-time employees on 50 percent or more of the employer’s business days. The employer’s group health plan coverage will be secondary to Medicare for services provided the following year from January 1 through December 31.

- Individuals affected by the disability rule.

The “disability rule” applies to individuals who are Medicare-entitled due a Social Security Administration determination of disability and

- Are covered under their employer’s GHP and have “current employment status” and the employer meets the “100-or-more” employer size requirements (above), or
- Are covered under their family member’s (of any age) employer’s GHP and the family member has current employment status and the employer meets the “100-or-more” employer size requirements (above).