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PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

GROUP MASTER APPLICATION BENEFIT SELECTIONS

SMALL GROUP

This form is part of the Group Master Application

GROUP NAME _____

GROUP ID _____

(Completed by Premera Blue Cross Blue Shield of Alaska)

All cost shares represent the member's share of the cost.

1. BENEFIT COVERAGE SELECTION

If you are differentiating your benefit coverage selection by class of employee, you will need to complete a benefit coverage selection worksheet for each separate class of employee you wish to cover. What class does this worksheet cover?

☐ All Employees ☐ Management ☐ Salaried ☐ Hourly ☐ Part-time ☐ Full-time ☐ Other, please specify _____

2. MEDICAL PLAN OPTIONS

Note: *For Metallic plans, if this plan is for dental only, complete only section **4** of this form.*

A. Plus PPO

☐ Gold Plus $500/20%/$6000/$25
☐ Gold Plus $1000/20%/$6000/$25
☐ Gold Plus $1500/20%/$6000/$25
☐ Bronze Plus $7900/0%/$7900/$0
☐ Silver Plus $2000/30%/$7900/$35
☐ Silver Plus $2500/30%/$7900/$35
☐ Silver Plus $3000/20%/$7900/$35
☐ Silver Plus $4000/20%/$7900/$35
☐ Bronze Plus $5500/30%/$7900/$55
☐ Bronze Plus $6350/30%/$7900/$55

B. Plus HSA

☐ Gold Plus HSA $1500/20%/$3000
☐ Silver Plus HSA $2700/25%/$5400
☐ Bronze Plus HSA $6000/30%/$6650
☐ Silver Plus HSA $3500/20%/$5000
☐ Bronze Plus HSA $5250/30%/$6550

C. Select PPO

☐ Gold Select $1500/20%/$6000/$50
☐ Silver Select $3000/30%/$7900/$75

D. Select HSA

☐ Bronze Select HSA $5250/30%/$6550

3. ADULT VISION BENEFIT OPTIONS

Note: *These optional vision benefits are available to members age 19 and older. Common enrollment required if enrolled in medical plan. Standalone vision not available.*

☐ Mandated offering Vision exam/test and hardware, subject to $350 maximum per calendar year.
☐ Core vision exam/test subject to $125 maximum per calendar year; hardware subject to $150 maximum per calendar year.
☐ Not Covered

4. ADULT DENTAL PLAN OPTIONS

***Note*:** *These optional dental benefits are available to members age 19 and older.*

A. Adult Core Dental —Available for Groups with 2-9 Enrolled Employees

☐ Adult Core Dental

B. Adult Dental Optima —Available for Groups with 2-9 Enrolled Employees

Note: *The deductible is waived for Preventive and Diagnostic services.*

☐ Adult Dental Optima 1000
☐ Adult Dental Optima 1500
☐ Adult Dental Optima 1500 Enhanced*

**Enhanced plan covers endodontic and periodontal treatment under basic services*

C. Adult Core Dental —Available for Groups with 10+ Enrolled Employees

☐ Adult Core Dental

D. Adult Dental Optima - Available for Groups with 10+ Enrolled Employees

Note*: The deductible is waived for Preventive and Diagnostic services.*

☐ Adult Dental Optima 1000
☐ Adult Dental Optima 1500
☐ Adult Dental Optima 1500 Enhanced*
☐ Adult Dental Optima 2000 Enhanced*
☐ Adult Dental Optima 2500 Enhanced*

**Enhanced plans cover endodontic and periodontal treatment under basic services*

E. Adult Voluntary Dental Plan —Available for Groups with 2+ Enrolled Employees

Note: *The deductible is waived for Preventive and Diagnostic services. Includes 12-month waiting period for major services*

☐ Adult Dental Optima Voluntary 1000

F. Adult Orthodontia Benefit Options

Note*: Option only available to non-voluntary, Adult Dental Optima groups with 26 or more employees enrolled that have selected a dental benefit.*

☐ Not Covered
☐ $1,500 overall lifetime limit

G. ☐ Not Covered