

GROUP MASTER APPLICATION BENEFIT SELECTIONS

SMALL GROUP

This form is part of the Group Master Application

GROUP NAME _____

GROUP ID _____

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

(Completed by Premera Blue Cross Blue Shield of Alaska)

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Plus Platinum \$250/20%/\$2500/\$25/\$50 | <input type="checkbox"/> Plus Gold \$2000/20%/\$6000/\$30/\$60 | <input type="checkbox"/> Plus Bronze \$5500/30%/\$8550/\$55/\$120 |
| <input type="checkbox"/> Plus Platinum \$500/20%/\$2500/\$25/\$50 | <input type="checkbox"/> Plus Silver \$2000/30%/\$8150/\$35/\$85 | <input type="checkbox"/> Plus Bronze \$6350/30%/\$8550/\$55/\$120 |
| <input type="checkbox"/> Plus Gold \$500/20%/\$6400/\$25/\$50 | <input type="checkbox"/> Plus Silver \$2500/30%/\$8150/\$35/\$85 | <input type="checkbox"/> Plus Bronze \$8150/0%/\$8150 |
| <input type="checkbox"/> Plus Gold \$1000/20%/\$6400/\$25/\$50 | <input type="checkbox"/> Plus Silver \$3000/20%/\$8150/\$35/\$85 | <input type="checkbox"/> Plus Bronze \$8550/0%/\$8550 |
| <input type="checkbox"/> Plus Gold \$1500/20%/\$6000/\$25/\$50 | <input type="checkbox"/> Plus Silver \$4000/20%/\$8150/\$35/\$85 | |

B. Plus HSA

- Plus HSA Qualified Gold \$1500/20%/\$3500 Plus HSA Qualified Bronze \$5950/50%/\$6900
- Plus HSA Qualified Silver \$2800/25%/\$5400
- Plus HSA Qualified Silver \$3500/20%/\$5000

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 Adult Vision: Exam/test and hardware, subject to \$350 maximum per calendar year.
- Core Adult Vision: Exam/test subject to \$125 maximum per calendar year; hardware subject to \$150 maximum per 2 consecutive calendar years.
- Adult Vision 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 \$50/0%-30%-50%/\$1000

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 \$50/0%-20%-50%/\$1000

Adult Dental Optima \$50/0%-20%-50%/\$1500

Adult Dental Optima \$50/0%-20%-50%/\$1500 Enhanced*

Adult Dental Optima \$50/0%-20%-50%/\$1500 Enhanced+ Max Waiver**

Adult Dental Optima \$50/0%-20%-50%/\$2000 Enhanced*

Adult Dental Optima \$50/0%-20%-50%/\$2000 Enhanced + Max Waiver**

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

Adult Core Dental \$50/0%-30%-50%/\$1000

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

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

Adult Dental Optima \$50/0%-20%-50%/\$1000

Adult Dental Optima \$50/0%-20%-50%/\$1500

Adult Dental Optima \$50/0%-20%-50%/\$1500 Enhanced*

Adult Dental Optima \$50/0%-20%-50%/\$1500 Enhanced+ Max Waiver **

Adult Dental Optima \$50/0%-20%-50%/\$2000 Enhanced*

Adult Dental Optima \$50/0%-20%-50%/\$2000 Enhanced + Max Waiver**

Adult Dental Optima \$50/0%-20%-50%/\$3000 Enhanced*

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 \$50/0%-20%-50%/\$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

Adult Dental Orthodontia \$0/50%/\$1,500 lifetime limit

G. Adult Dental Not Covered

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

***Max Waiver plans waive preventive/diagnostic services (Class 1) from annual maximum*