Independence Blue Cross
1901 Market Street, Philadelphia, PA 19103

Blue Solutions® Plus
Application for New Employer Health Benefits – 51-99

This form and the Blue Solutions suite of plan designs can only be used when a group has between 51 and 99 total employees.
Total employees represents all active full-time, part-time, and seasonal employees on the payroll as of the requested effective date.

Section I: Company Information

Full Legal Name of Company:		
Tax ID#:	**CID/Group # (internal use only):**	
Customer Address:		
City:	**State:**	**Zip:**
Customer Contact:	**Phone: ( )**	**Fax: ( )**
Nature of Business:	**Year in Business:**	**Customer Email Address:**
Is there any Group Health Plan now in force and to be continued: Yes ( ) No ( ) Name of Carrier:		
Total number of eligibles:	**Total number of employees:**	

Amount of Premium paid by employer: ☐ **100%** ☐ **Partial_____%** ☐ **Other**

Number of Hours Worked per Week for Eligibility:_____

Section II: Third Party Representation

Marketing Representative Name/Code:	
Producing Agent:	
Primary Broker/Association:	**Broker/Association ID#:**

Section III: Quote Conditions Signature

Available Benefits

- Groups with 51-99 employees may select a maximum of three Blue Solutions® Plus medical options and up to two drug options. Groups may also choose from the vision or dental benefits listed on the rate sheet.

Participation Requirements

☐ Groups with 51-99 eligible lives (employees that qualify for benefits) must have 75 percent participation, which includes all product lines.
☐ IBC will count waivers in the eligibility calculations.
☐ Credit is given for those eligible employees who opt out because they have coverage through a spouse, as an eligible dependent to 26, or are enrolled in Medicare or Medicaid. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 75 percent participation requirement.
☐ For groups covering retirees, 100 percent participation is required for retired employees and the group must consist of a minimum of 75 percent active employees. Retiree-only groups will not be accepted.

Employer contribution requirement

☐ For contributory plan offerings, you must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single tier rate for each plan offered.

Rate tiers

☐ A four-tiered standard rating structure is required.

Submission guidelines

☐ **All offerings are subject to final Underwriting review and acceptance. This document is not intended to be inclusive of all Underwriting guidelines, additional guidelines and policies may apply.**

Additionally, I have appointed (Broker Agency / Association) to represent our employment group. I understand that, if eligible, commissions on the account will be paid by the carrier and additional compensation known as “override commissions” may be earned from the carrier for meeting overall sales and retention goals..

Print Name _____ **Title:** _____

Signature: _____ **Date:** _____

Independence Blue Cross/Keystone Health Plan East Benefit Plans

Blue Solutions® Plus

Application for New Employer Health Benefits – 51-99

Company Name: _____ **Effective Date:** _____

Copay Plans (calendar year)

OPTION 1

Product: POS

Plan:
- ☐ POS Plus 1B
- ☐ POS Plus 2B
- ☐ POS Plus 3B
- ☐ POS Plus 4B

Product: Direct POS

Plan:
- ☐ DPOS Plus 1B
- ☐ DPOS Plus 2B
- ☐ DPOS Plus 3B

Product: PPO

Plan:
- ☐ PPO Plus 1B
- ☐ PPO Plus 2B
- ☐ PPO Plus 3B
- ☐ PPO Plus 4B

OPTION 2

Product: POS

Plan:
- ☐ POS Plus 1B
- ☐ POS Plus 2B
- ☐ POS Plus 3B
- ☐ POS Plus 4B

Product: Direct POS

Plan:
- ☐ DPOS Plus 1B
- ☐ DPOS Plus 2B
- ☐ DPOS Plus 3B

Product: PPO

Plan:
- ☐ PPO Plus 1B
- ☐ PPO Plus 2B
- ☐ PPO Plus 3B
- ☐ PPO Plus 4B

Deductible Plans (calendar/contract year*)

OPTION 1

Product: POS

Plan:
- ☐ POS Plus 5B
- ☐ POS Plus 6B
- ☐ POS Plus 7B
- ☐ POS Plus 8B
- ☐ POS Plus 9B
- ☐ POS Plus 1C
- ☐ POS Plus 2C
- ☐ POS Plus 3C
- ☐ POS Plus 4C

Product: Direct POS

Plan:
- ☐ DPOS Plus 4B
- ☐ DPOS Plus 5B
- ☐ DPOS Plus 6B
- ☐ DPOS Plus 7B
- ☐ DPOS Plus 8B
- ☐ DPOS Plus 1C
- ☐ DPOS Plus 2C
- ☐ DPOS Plus 3C
- ☐ DPOS Plus 4C
- ☐ DPOS Plus 5C
- ☐ DPOS Plus 6C
- ☐ DPOS Plus 7C

Product: PPO

Plan:
- ☐ PPO Plus 5B
- ☐ PPO Plus 6B
- ☐ PPO Plus 7B
- ☐ PPO Plus 8B**
- ☐ PPO Plus 9B**
- ☐ PPO Plus 10B**

Product: PPO

Plan:
- ☐ PPO Plus 1C**
- ☐ PPO Plus 2C**
- ☐ PPO Plus 3C**
- ☐ PPO Plus 4C**
- ☐ PPO Plus 5C
- ☐ PPO Plus 6C

OPTION 2

Product: POS

Plan:
- ☐ POS Plus 5B
- ☐ POS Plus 6B
- ☐ POS Plus 7B
- ☐ POS Plus 8B
- ☐ POS Plus 9B
- ☐ POS Plus 1C
- ☐ POS Plus 2C
- ☐ POS Plus 3C
- ☐ POS Plus 4C

Product: Direct POS

Plan:
- ☐ DPOS Plus 4B
- ☐ DPOS Plus 5B
- ☐ DPOS Plus 6B
- ☐ DPOS Plus 7B
- ☐ DPOS Plus 8B
- ☐ DPOS Plus 1C
- ☐ DPOS Plus 2C
- ☐ DPOS Plus 3C
- ☐ DPOS Plus 4C
- ☐ DPOS Plus 5C
- ☐ DPOS Plus 6C
- ☐ DPOS Plus 7C

Product: PPO

Plan:
- ☐ PPO Plus 5B
- ☐ PPO Plus 6B
- ☐ PPO Plus 7B
- ☐ PPO Plus 8B**
- ☐ PPO Plus 9B**
- ☐ PPO Plus 10B**

Product: PPO

Plan:
- ☐ PPO Plus 1C**
- ☐ PPO Plus 2C**
- ☐ PPO Plus 3C**
- ☐ PPO Plus 4C**
- ☐ PPO Plus 5C
- ☐ PPO Plus 6C

HRA and HSA Plans w/ Integrated RX (contract year)

OPTION 1

Product: PPO HRA HDHP

Plan:
- ☐ HRA Plus 1B
- ☐ HRA Plus 2B
- ☐ HRA Plus 3B

Product: PPO HSA HDHP

Plan:
- ☐ HDHP Plus 1B
- ☐ HDHP Plus 2B
- ☐ HDHP Plus 3B
- ☐ HDHP Plus 4B
- ☐ HDHP Plus 5B
- ☐ HDHP Plus 1C
- ☐ HDHP Plus 2C
- ☐ HDHP Plus 3C
- ☐ HDHP Plus 4C
- ☐ HDHP Plus 5C
- ☐ HDHP Plus 6C
- ☐ HDHP Plus 7C
- ☐ HDHP Plus 8C

OPTION 2

Product: PPO HRA HDHP

Plan:
- ☐ HRA Plus 1B
- ☐ HRA Plus 2B
- ☐ HRA Plus 3B

Product: PPO HSA HDHP

Plan:
- ☐ HDHP Plus 1B
- ☐ HDHP Plus 2B
- ☐ HDHP Plus 3B
- ☐ HDHP Plus 4B
- ☐ HDHP Plus 5B
- ☐ HDHP Plus 1C
- ☐ HDHP Plus 2C
- ☐ HDHP Plus 3C
- ☐ HDHP Plus 4C
- ☐ HDHP Plus 5C
- ☐ HDHP Plus 6C
- ☐ HDHP Plus 7C
- ☐ HDHP Plus 8C

Total Number of Personal Choice Applications Attached: _____

Total Number of Keystone Applications Attached: _____

*Deductible Plan Plus B options (except 8B, 9B and 10B) are calendar year. Deductible Plan Plus C options and 8B, 9B and 10B options are contract year.

**Option includes Integrated Rx.

Independence Blue Cross/Keystone Health Plan East Benefit Plans

Blue Solutions® Plus

Application for New Employer Health Benefits – 51-99

Company Name: _____ **Effective Date:** _____

Rx Riders	**IBC (Davis) Vision Riders Biennial Benefit**		**IBC Dental Riders POS and DPOS**	**Dependent / Student Age:**
☐ $10/$20/$35*** ☐ $20/$40/$60***	**Option 1**	**Option 2**	☐ Basic	
☐ $10/$40/$70 ☐ $250 (waived for generics)/	☐ $35	☐ $35	☐ Value	**26 / 26**
☐ $10/$45/$75 $10/$45/$75	☐ $100	☐ $100	☐ Pediatric	
☐ $15/$35/$50*** ☐ $250/$20/$40/$60				
☐ $7/50% ($125)				
☐ $4/Brand Discount				

Supplemental Options	**Freestanding IBC (Davis) Vision**	
United Concordia Dental		
☐ Concordia Flex ☐ Concordia Preferred	☐ Annual	☐ $35 ☐ $125
☐ Concordia Plus ☐ Concordia Choice	☐ Biennial	☐ $50 ☐ $200
☐ Option _____		☐ $75 ☐ $250
		☐ $100

***Only Rx Riders available with Plus C options and Plus 8B, 9B and 10B options.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.