

JANUARY 24, 2024

Retail Producer Portal Guide: Enrolling Clients in ACA QHPs

The Retail Producer Portal is a comprehensive sales and service tool for the Under 65 individual market and the Medicare markets. The portal enables you to design and deliver quotes, enroll members in Blue plans, manage prospects and serve and support active clients with a host of features. This section covers enrolling clients in retail ACA plans.

Enrolling Clients in Retail ACA Qualified Health Plans

| Enroll Existing Member in New Plan | 3 |
|---|---|
| Enroll via Producer Portal & Agent Assisted On-Exchange Enrollment Solution | 4 |
| Enroll via Producer Portal Only | 6 |

Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas, Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Enrolling Clients in Retail ACA Plans

Quoting and enrolling should begin while working within the Retail Producer Portal. After selecting an on-exchange plan for enrollment, you'll be transferred to our agent assisted on-exchange enrollment solution, powered by HealthSherpa, to complete the application and submission process. For off-exchange plans, you control the entire end-to-end application and submission process via the Retail Producer Portal. For either on- or off-exchange, you should start the online enrollment process from within your Retail Producer Portal account.

If your clients wish to enroll themselves, they can use our on-exchange enrollment solution for ALL application types.

| Types of Applications, includes both open and special enrollment | Begin with Retail Producer Portal with on-exchange enrollment solution | Retail Producer Portal End-to-End |
|---|--|--------------------------------------|
| 1. OFF exchange medical | | V |
| 2. ON exchange medical | V | |
| 3. OFF exchange medical with dental | | V |
| 4. ON exchange medical with dental | V | |
| 5. OFF exchange dental only | | V |
| 6. ON exchange dental only | V | |
| 7. OFF exchange child only (parents enrolling for a minor child) | | V |
| 8. ON exchange child only (parents enrolling for a minor child) | V | |
| OFF exchange authorized by personal representatives of applicants | | V |
| 10. ON exchange authorized by personal representatives of applicants | V | |

Enroll Existing Member in New Plan

Each year, members can opt to passively renew their existing plan, which requires no action by the member or producer.

When existing members want to choose a new plan, called an active renewal, you can help them complete the application process via the portal's Enroll Member feature. This feature saves significant time by prepopulating the online application with existing information from the active member's record.

Start by finding your client. Then follow these steps:

- 1. With the Client record open, click "Enroll Member."
- In the Producer Information panel, check the Writing Producer Number field. It will automatically populate with the producer ID number associated with the log in. Be sure to enter nine digits. If the producer ID number is less than nine digits (such as 123456), use leading zeros (such as 000123456).
- **3.** Select the "Start Application" button to begin the application process.

| | Home | Client Info | E-Communication | Quotes | Resources | Training | Enrollment | Show less A |
|----------|-------------------------------|---|---|---|-----------------------------------|--------------|--|-------------------------------|
| | Client | Search | Client Leads | Repor | ting | | | |
| ; | | | Add New Prospect Search for Prospects | • Crea • View | ite Report / My Custom Reports | Book of Bus | iness | |
| | Back to Search | h Results | Select | Transaction | ۲ GO | | | nit E-Question roll Member |
| | Acco Name Addre E-ma | unt Number: 0101 2: Jane 255: 123 Nape il Address: jane | 0101010 Doe Williams Rd erville, IL 60090 doe@yahoo.com | Home Phone: Cell Phone: Work Phone: | 123-456-7890 123-345-7891 | Spot Fax: | ise Cell Phone: | |
| Hor | ne Client | t Info E-Com | munication Quotes | Resource | s Training | Enrollment | | |
| gen | t Assisted E | nrollment | | | | | | |
| | Producer In | formation |] | | | | | |
| Pr Jo | roducer First Nar ohn | me | Producer Last Name Robinson | Con | npany Name C Insurance Agency | 2 | Writing Producer Num 999999999 B | ber* art Application |

Enroll via Producer Portal & Agent Assisted On-Exchange Enrollment Solution

Complete Applicant Info

- **1.** Select the Quotes tab.
- **2.** Complete the required name fields for the quote.
- **3.** Note that a "County" field appears under the zip code after the zip code has been entered. If more than one county is available, select from the drop down list.
- Enter all of the primary's information. Additional fields may appear, such as those for a spouse and children. Complete as needed.
- **5.** Select the "Continue" button.

| Click Here to learn about important changes for On-Exchange consume Click Here to register with HealthSherpa to enroll clients in on-exchange Attention: 2023 Dental Only forms are now available for submission on applicants | er enrollments, quote links and Express Links. e qualified health plans (QHPs) the Enrollment tab! |
|--|---|
| Plicants Enroll In Suppler Primary Applicant's Name: 2 First MI Last | n On Exchange QHPs Sign In to our Agent Assisted On- Exchange Enrollment solution. |
| Enroll in Suppler Primary Applicant's Name: 2 | n On Exchange QHPs Sign In to our Agent Assisted On- Exchange Enrollment solution. Nental Products Nental Products Sign In to our Agent Assisted On- Exchange Enrollment solution. Visit the Coverage Plus Central sit hosted by Trionfo, an independent licensed insurance agent. |
| Suppler Primary Applicant's Name: 2 First MI Last | mental Products () Visit the Coverage Plus Central sit hosted by Trionfo, an independent licensed insurance agent. |
| Primary Applicant's Name: 2 First MI Last | included instructed upon |
| | |
| Please note: Primary applicant first and last name are required for Save Proposal and Send Quote functions. | |
| What is the Applicant's Zip Zipcode 2 | |
| What is the Applicant's County? | |
| Applicant's Requested 11/01/2023 2 | |
| ease note: Requested Effective Dates cannot be today's date and must be the first of the month. | |
| Nho will this health insurance plan be covering? | |
| Sex: Birthday: | 6 |

Select the Plan

- 6. If you don't need a quote or proposal, and you're helping your client enroll, select "Apply for This Plan" next to the desired plan.
- If the selected plan is an on-exchange plan, you will be redirected to the agent assisted on-exchange enrollment solution sign-on page. (Refer to Agent Assisted On-Exchange Enrollment Solution powered by HealthSherpa Training Materials for further instructions).
- 8. If the selected plan is an off-exchange plan a pop-up box will display, you'll see a "Continue to RPP Enrollment" button to enroll in the plan via the Retail Producer Portal.

Sign into your account

Sign in

Privacy Notice and Terms & Conditions

EMAIL ADDRESS

PASSWORD

BlueCross BlueShield.



Enroll via Producer Portal Only

Use the Retail Producer Portal to manage the entire online enrollment process for all off-exchange policies:

- ✓ Stay attached to the application/policy throughout.
- Enroll faster the portal was designed for you so the process is streamlined with all steps on one page.
- See all stages of the application's progress; application is received and viewable in the portal within 24 hours.
- ✓ Start and save applications, complete and submit later (up to 90 days!) if needed.
- ✓ Receive all enrollment notifications.
- ✓ Give agency office personnel ability to submit subproducers' apps.
- ✓ Reduce overall applicant-to-member timeframes.

Producer Information

When you select the Enrollment tab, check the information displayed in the Producer Information section.

- **1.** Select the Enrollment tab.
- 2. In the Producer Information panel, check the Writing Producer Number* field. It will automatically populate with the producer ID number associated with the log in. However, some users may have the ability to change this number. For example, if you log in as the agency principal, you can enter the producer ID numbers of any of your subproducers. This feature allows office personnel to submit applications for their sales agents. Be sure to enter nine

| t Info | E-Communication | Quotes | Resources | Training | Enrollmer | it | | |
|----------|-------------------------------|---|--|---|--|---|--|---|
| nrollme | ent | | | | | | | |
| formatic | on | | | | | | | |
| me | Producer Last ! | lame | Compa | nny Name | 0 | Writing Produ | cer Number* | |
| | Doe | | ABC H | lealth Insurance | Agency | 999999999 | | |
| | t Info nrollme formatic | t Info E-Communication nrollment formation me Producer Last # Doe | t Info E-Communication Quotes nrollment formation me Producer Last Name Doe | t Info E-Communication Quotes Resources | t Info E-Communication Quotes Resources Training | t Info E-Communication Quotes Resources Training Enrollmen nrollment me Producer Last Name Company Name Portal Demo Doe ABC Health Insurance Agency | t Info E-Communication Quotes Resources Training Enrollment Inrollment Inrollment Inrollment Inrollment Inrollment Inrollment Inrollment Inro | t Info E-Communication Quotes Resources Training Enrollment nrollment formation me Producer Last Name Portal Demo ABC Health Insurance Agency Writing Producer Number* portal Demo ABC Health Insurance Agency |

digits. If the producer ID number is less than nine digits (such as 123456), use leading zeros (such as 000123456).

3. Select the "Start Application" button to begin the application process.

* ENSURE THE WRITING PRODUCER NUMBER IS ACCURATE! This is the nine-digit producer identification number included in your "Welcome" email when you completed contracting (producers and agencies) or onboarding (subproducers). If you contracted or onboarded to sell in multiple states, you have a unique ID number for each state.

Application Information

- Once you select the "Start Application" button, verify the Writing Producer Number. Once you begin with the producer ID number displayed here, it can't be changed. If it's incorrect here, click the Enrollment tab to start over.
- 2. When you first begin applying, the applicant name won't be populated. As you move through the application, the field will update.
- **3.** Choose your application, either a Medical/Dental combined application or a Dental only application. The time of year and the plan year selected determine if a special enrollment is required. If so, special enrollment fields will populate. Note that if you apply for special enrollment, you'll need to select a qualifying life event and supply supporting documentation.
- **4.** This will reflect the next available effective date, but the field could change as you enter more information.
- The estimated monthly premium will not populate until you select a plan and enter specific information such as zip code, date of birth and tobacco use. It will update as you add dependents.

| nt Assisted Enrollme | nt | | | | | | |
|---|--|---|--|--|------------|-------------------------------|--|
| Application Informa | ation | | | | | | |
| Authorization | Applicant Name | 3 | Choose 2023 M Select 2024 M 2024 D 2023 M 2023 D | e Application Form * iedical/Dental Application >> One edical/Dental Application iedical/Dental Application iedical/Dental Application ental Application | £ | Effective Date | Estimated Monthly Premium \$565.11 |
| ⊃ I confirm/attest that my will keep a record of the pap | client has completed and s ser application for minimu | igned a paper app n of two years fro | lication, and as m the submit d | s the producer of record, I late. | will be co | mpleting and submitting the a | pplication on their behalf. I |
| ○ I confirm/attest that I an presented and communicate | n assisting my client in per ed to my client. | son. That all the to | erms, agreeme | nts, acknowledgements an | d authori | zations displayed on the pape | r application have been |

Authorization

When completing an online application in the Retail Producer Portal, there are two types of client authorizations.

The FIRST type of client authorization is when you have a signed paper app in-hand and you enter the data from the paper app into the online app. You keep the paper app with your client's signature for your records. You have a paper application signed by the client in every area that requires a signature. If your office submits applications on the sales agent's behalf, you should select this option. Note that you'll need to maintain signed copies of paper applications for a minimum of two years

| Home | Client Info | E-Communication | Quotes | Resources | Training | Enrollment |
|---|---|--|---|---|----------|------------|
| Autho | orization | | | | | |
| I confir | rm/attest that my c | lient has completed and signed | ed a paper app | lication and | | |
| SUDDOP | ting documents, an | d as the producer of record. | I will be comp | leting and | | |
| suppor submit applica | ting documents, an ting the application tion for minimum o | d as the producer of record, on their behalf. I will keep a f two years from the submit o | I will be comp record of the p date. | leting and pape r | | |
| suppor submit applica I confir | ting documents, an ting the application tion for minimum o rm/attest that I am | d as the producer of record, on their behalf. I will keep a f two years from the submit o assisting my client in person | I will be comp record of the p date. . That all the te | leting and baper rms, agreements, | | |

The SECOND type of client authorization says you're assisting your client "in person." Until further notice, we consider the phrase "in person" to mean a telephone or online conference (such as Skype, FaceTime or Zoom) or any other real-time communication. Your client understands all terms, acknowledgments and authorizations and agrees to them. To meet the requirements for this second type of authorization, you have three options.

1. You can obtain it by either emailing or printing and mailing required documents and requesting a signature and return. A fax or a copy of an original written signature page is acceptable for this purpose.

If an authorization can't be obtained in the manner described in (1.) above, you could obtain it one of these ways:

- 2. By the client/applicant indicating approval of the document in another manner such as an email.
- 3. By the producer obtaining a signature authorization verbally.

We recommend creating an attestation statement *each time* a signature is obtained by method (2.) or (3.). You could use the following example attestation. Be sure to save attestations for your records.

I fully discussed the contents of the attached [DOCUMENT NAME] and hereby attest that [CLIENT/APPLICANT NAME] represented to me that they understood the contents of the [DOCUMENT NAME] and conveyed their approval of the contents of the [DOCUMENT NAME] to me. I explained that the [DOCUMENT NAME] would be submitted by me on their behalf.

Plan Selection

- **1.** Input the zip code of your client.
- **2.** If the zip code covers more than one county, select the correct county.
- **3.** If the Medical/Dental Application form is selected; choose the medical coverage plan in which your client would like to enroll. Be sure to remember the medical coverage plan name; you'll need that information when using the Provider Finder to search for, find, and enter a primary care physician (PCP) or medical group number for plans that require it.
- **4.** Then choose the dental coverage plan in which your client would like to enroll.

| Writing Producer Number | Applicant Name | | Choose Application Form | * | Effective Date | Estimated Monthly |
|---|------------------|---------------|-------------------------|---|--------------------|-------------------------|
| 999999999 | Jane M Doe | 5 | 2024 Dental Application | ~ | 01/01/2024 | More Information Needed |
| Authorization | | | | | | |
| Special Enrollmen | it Information | | | | | |
| Plan Selection | | | | | | |
| | | | | | | |
| Zip* | County | | | | | |
| Zip* 60171 | County Cook 🗸 | | | | | |
| Zip* 60171 Select Dental Coverage | Cook 🗸 | | | | | |
| Zip* 60171 Select Dental Coverage Select One | County Cook 💙 | | | | | |
| Zip* 60171 Select Dental Coverage Select One | County Cook V | 2. 5 | | | | |
| Zip* 60171 Select Dental Coverage Select One Select One | County Cook 🗸 | | | | | |
| Zip* 60171 Select Dental Coverage Select One Select One BlueCare Dental IA | County Cook 🛩 | | | | | |
| Zip* 50171 Select Dental Coverage Select One Select One BlueCare Dental 1A BlueCare Dental 1B | County Cook 🛩 | Euro and Evit | | | Submit Application | • |
| Zip* 60171 Select Dental Coverage Select One Select One BlueCare Dental 1A BlueCare Dental 1B BlueCare Dental 1B BlueCare Dental 1C | County Cook V | Save and Exit | | | Submit Application | |

| nome | Client Info | E-Communication | Quotes | Resources | Training | | |
|--|--|--|---------------------------------------|------------------------------------|------------------------------------|------------------------------|---|
| | | | | | | | |
| gent As | sisted Enrolim | ent | | | | | |
| App | lication Inforn | nation | | | | | |
| Writing Number 9999999 | Producer 1999 | Applicant Name Jane M Doe | | Choose Applical 2024 Medical/De | tion Form * ental Application 🗸 | Effective Date 01/01/2024 | Estimated Monthly Premium More Information Needed |
| • Auti | norization | | | | | | |
| Sp Plate | ecial Enrollme an Selection | ent Information | | | | | |
| - | | | | | | | |
| Zip* 60171 | 1 | 2 County | | | | | |
| Zip* 60171 Selec | t Medical Coverage | 2 County Cook ~ | ental Coverage | - 1 | | | |
| Zip* 60171 Select Select Or | t Medical Coverage | 2 County Cook V e * Select D BlueCan | e ntal Coverage e Dental 1A | - 4 | | | |
| Zip* 60171 Select Select Or Blue Cho | t Medical Coverage te ice Preferred Bronze P | 2 County Cook ~ a * Select D BlueCar PO 201 | ental Coverage | • 4 | | | |
| Zip* 60171 Select Select Or Blue Cho Blue Cho | t Medical Coverage te ice Preferred Bronze P ice Preferred Bronze P | County Cook Cook Cook BlueCar BlueCar PO 201 PO 202 | ental Coverage e Dental 1A | - 4 | | | |
| Zip* 60171 Select Or Blue Cho Blue Cho Blue Cho | t Medical Coverage te ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P | County Cook County Cook Select D BlueCan BlueCan PO 201 PO 302 PO 302 PO 302 | ental Coverage | · 4 | | | |
| Zip* 60171 Select Select Or Blue Cho Blue Cho Blue Cho | t Medical Coverage te ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P | County Cook County Cook Select D BlueCan BlueCan PO 202 PO 302 PO 502 PO 502 | ental Coverage | · 4 | | | |
| Zip* 60171 Select Or Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho | t Medical Coverage te ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P ice Preferred Bronze P | County Cook County Cook Select D BlueCan BlueCan PO 201 PO 302 PO 502 PO 601 PO 701 | ental Coverage | - 4 | | | |
| Zip* 60171 Select Or Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho | t Medical Coverage | County Cook County Cook Select D BlueCan BlueCan PO 202 PO 302 PO 302 PO 502 PO 601 PO 701 PO 705 | ental Coverage | - 4 | | | |
| Zip* 60171 Select Or Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho Blue Cho | t Medical Coverage te ice Preferred Bronze P ice Preferred Bronze P | County Cook County Cook Select D BlueCan BlueCan PO 202 PO 302 PO 302 PO 502 PO 701 PO 705 PO 705 PO 708 | ental Coverage | - 4 | | | |

5. If the Dental Application form is selected; then you only need to choose the dental coverage plan in which your client would like to enroll.

Applicant Information

In the Applicant Information panel, complete required fields (see red asterisks). Some fields populate based on information already provided. For example, a tobacco question populates if the applicant is 18 or over.

- **1.** Enter primary applicant data.
- Provide residential and mailing addresses. Confirm the address with an address verification tool such as <u>Google Maps</u>[™].
- **3.** When census fields are completed, the "Estimated Monthly Premium" updates. As you add dependents, this number changes.
- 4. Enter phone number and an email address.
- 5. Primary Care Physician (PCP) or Medical Group number fields will populate if the applicant is choosing a medical plan that requires it. You can input a PCP or Medical Group number here. If needed, use the Provider Finder to search for a PCP/Medical Group. Know the plan name before you search – you must search within the correct network to see PCP or Medical Group numbers.

| nt Assisted Enroll | ment | | | | | |
|---|---|--|---|-------------------------|-------------------------------------|--------|
| Application Infor | mation | | | | | |
| Vriting Producer lumber | Applicant Name Jane M Doe | Ch 20 | 1005e Application Form * 124 Medical/Dental Applicatio | Effective D 01/01/20 | Estimated Mo Premium \$553.38 | onthly |
| Authorization | | | | | | |
| Special Enrollm | ent Information | | | | | |
| Plan Selection | | | | | | |
| Applicant Inform | ation | | | | | |
| | | | | | | |
| Primary | | | | | | |
| First Name* | MI | Last Name* | SSN | Sex* | Date of Birth* | |
| Jane | M | Doe | ###-##-#### | OMale ©Fema | le 09/25/1975 | |
| Within the past six mo religious or ceremonia | nths, have you used tobacco I uses.* ○ Yes ®No | ? 4 or more times per v | week on average, excludin | Ig | | |
| Home Address | | | | | | |
| Home Address | | 61. š | Chata | 7:- | Country | |
| Home Address Address Line 1* 300 E. Randolph | Address Line 2 | City* | State | Zip 60171 | County Cook | |
| Home Address Address Line 1* 300 E. Randolph Is Mailing Address diff | Address Line 2] erent than Home Address? ^a (| City*] Chicago)Yes ® No | State IL | Zip 60171 | County Cook | |
| Home Address Address Line 1* 300 E. Randolph Is Mailing Address diff Primary Phone* | Address Line 2] erent than Home Address?*(Email Address | City*] [Chicago]Yes ® No | State IL | Zip 60171 | County Cook | |
| Home Address Address Line 1* 300 E. Randolph Is Mailing Address diff Primary Phone* (312) 555-5555 | Address Line 2 erent than Home Address?*(Email Address]@ | City* Chicago Ves ® No] | State IL | Zip 60171 | County Cook | |
| Home Address Address Line 1* 300 E. Randolph Is Mailing Address diff Primary Phone* [(312) 555-5555 @Mobile OLandline | Address Line 2 erent than Home Address?*(Email Address] | City*] [Chicago] Ves ® No] | State IL | Zip 60171 | County Cook | |

6. A new "Optional HRA" panel is displayed under the Primary Applicant panel only. The Type of HRA, Start Date, Employer Name and Monthly Contribution amount can be entered for all enrollments including open enrollments and special enrollments. If a special enrollment is being completed the Type of HRA and the Start Date will be pre-populated from the Special Enrollment information section.

| Optional HRA | 5 | | |
|-----------------------------|---|--|--|
| Type of HRA OICHRA OQSEHRA | | | |
| Start Date MM/DD/YYYY | | | |
| Employer Name | | | |
| Monthly Contribution \$0.00 | | | |

Applicant Information: Dependents

Complete all of the required census information (fields marked with a red asterisk) for each dependent.

- 7. You can complete the optional applicant information or bypass this section, which is included for each person added to the application. Click on the "Optional Language, Ethnicity & Race" header to expand or collapse the panel.
- 8. When you click on the "Add Dependent" button, all of the dependent applicant fields appear. You can add up to 19 dependents on a single application.
- **9.** The dependents will be numbered in the order in which they are added. Once you enter all of the dependent's information, you can delete any of the exiting dependent records if needed.

| F irst Name* | MI | Last Name* | SSN ###-##-#### | Sex* | Date of Birth* 09/25/1964 |
|--|---|--|--|------|------------------------------|
| Relationship to Primary' Spouse/Partner 🗸 | Within the past six mont per week on average, ex O No | chs, have you used tobacco? ccluding religious or ceremon | 4 or more times ial uses.* ○ Yes | | |
| s Mailing Address differer | nt than Home Address? 〇 Yes | s 💿 No | | | |
| Primary Phone | | | | | |
| (###) ###-#### | Mobile OLandline | | | | |
| Email Address | | | | | |
| | ago Ethnicity & Idont | ity 7 | | | |
| Optional Langu | lage, Ethnicity & Ident | ity – | | | |

Payment

 Choose a payment type for the initial premium. Choices include paying right away via one-time bank draft, credit card or debit card *or* paying later. We eliminated the requirement to pay the initial premium to submit an online app.

Proxy & Other Coverage Information

- 2. In the Proxy & Other Coverage Information panel, you can click on the proxy statement link to review it. Select to agree to the statement if your client consents.
- **3.** If your client or any dependents on the application had previous coverage in the last 60 days, select "Yes" for Other Coverage. Enter the required information; it must be completed before submission. Note that applicant names will populate based on data previously entered.
- **4.** If your client is replacing coverage, select "Yes" and enter the required information.



| Proxy & Other Coverage Information | | | | | |
|---|---|------------------------------------|------------------|-----------------------|--------------------|
| I agree to the Proxy Statement (optional) | | | | | |
| Coverage You are Replacing Will this plan replace health coverage for 2024 you alread | dy have? • Yes O No | | | | |
| Covered Person(s) | Name of Insurance Company | Policy Number | Termination Date | | |
| Select One 💙 | | | MM/DD/YYYY | Add Previous Coverage | |
| Other Medical, Dental or Vision Coverage You or Yo Does any person applying for coverage currently have, o • 8 BCSSIL coverage? | our Dependent(s) May Have r did they previously have within the last 60 da | γs: | ® Yes ○ No | | |
| Health coverage with any other insurance company? | ? | | | | |
| Coverage under a tax-supported or government pro- | gram, including Medicare? | | | | |
| Applicant Name | N | ame on Other Policy (if different) | Member Number | Group ID | |
| Select One 🗸 | [| | | | Add Other Coverage |
| | | | | | |

Signatures Information

Be sure to include if the application is signed by someone other than the applicant or parent for a minor child, and if other adults are allowed to answer questions arising from the application.

Cancel, Save and Exit, or Submit

- **1. Cancel:** The application data entry window will close without saving any changes.
- 2. Save and Exit: At minimum, these fields must be populated to save an incomplete application to the portal:
 - ✓ Writing Producer Number
 - ✓ Zip Code/County
 - ✓ Medical Plan or Dental Plan
 - Primary Applicant First and Last Name
 - Primary Date of Birth
 - ✓ Tobacco Use (if 18+)

If you don't complete the fields above, you can't click on Save and Exit; the button will be gray and disabled.

After clicking "Save and Exit," reopen the app from the Incomplete Applications table on the Enrollment tab.

- **Proxy & Other Coverage Information** □ I agree to the Proxy Statement (optional) Coverage You are Replacing Will this plan replace health coverage for 2024 you already have? O Yes O No Other Medical, Dental or Vision Coverage You or Your Dependent(s) May Have ● Yes ○ No Does any person applying for coverage currently have, or did they previously have within the last 60 days o BCBSIL coverage? Health coverage with any other insurance company Coverage under a tax-supported or government program, including Medicare Applicant Nam Name on Other Policy (if different) Member Numbe Group ID Jane M Doe Robert M Doe Signatures Information Authorized Representative If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the follow □ I am an authorized representative filling out this application on behalf of the primary applicant Do you permit any other adult spouse or dependent listed on this application to answer questions about your application? \bigcirc Yes \bigcirc No Cancel Save and Exit Submit Application 3
- 3. Submit Application: If you don't complete all necessary fields required for submission, the "Submit Application" button will be gray and disabled. It will become blue and enabled when you've completed all fields. Upon submission, you will be directed to our vendor payment site to make the initial premium payment, but only if you selected one-time bank draft or credit or debit card for an initial payment. Once enrolled, you can locate the policy by using the Client Search function in the Client Info tab.

Make Initial Payment

Users must select a payment method: credit card or bank account. Once a payment method is selected other fields will be displayed.



Make a Payment

For Bank or Debit Card payment

- 1. You'll be directed to our checkout page and select either 'New Bank Account' or 'New Card' in the drop down menu
- 2. If you select 'New Bank Account', other fields will be displayed (right image)
- **3.** Once the fields are filled out, you can save this payment method for future use
- 4. Enter a Payment Method Nickname
- Slide Autopay 'On' or 'Off' (If you slide it 'On' go to page 18 for next steps)
- **6.** Agree and select 'Terms of Use and Privacy Statement' ('Review Payment Details' button will turn blue once checked off)
- 7. Click 'Review Payment Details'

| Mala a Daver and | Make a Payment |
|--|--|
| make a Payment | Current Balance |
| Current Balance | \$1,080.70 |
| \$1,080.70 | |
| hter payment information begin your coverage, payment of your first monthly emium is required. Please enter your payment tails below. Your payment will not process until ur application has completed processing. ment Amount Image: Current Balance : \$1,080.70 tout displayed may be less than required for tory issuance if retroactive effective date. ment Date | Enter payment information To begin your coverage, payment of your first month premium is required. Please enter your payment details below. Your payment will not process until your application has completed processing. Payment Amount © current Balance : \$1,080.70 Amount displayed may be less than required for policy issuance if retroactive effective date. Payment Date 08 / 31 / 2023 Payment Method |
| / 31 / 2023 | First name |
| 1517 2025 | Jessica |
| ment Method | Last name |
| lect payment method | Test |
| lect payment method | Routing number |
| ew Bank Account | 122199983 |
| w Card | Account number |
| | 10610008944 |
| I understand and accept the Terms of Use and | |
| Privacy Statement. | Checking or saving account |
| | Cnecking |
| | Personal or business account |
| Review Payment Details | Personal |
| Cancel | Save this payment method for future use Payment Method Nickname Primary Checking |
| | Autopay Auto Bill Pay payments will be applied to all future bills once enrollment is complete. The balance will be paid automatically on the last business day of each |

- 8. If you leave Autopay 'Off', a window will pop up to 'Dismiss' or 'Set Up Now'
- **9.** If you click 'Dismiss', a payment summary window will pop up. This is NOT a confirmation window. You can click 'Edit Payment' to edit the information.
- **10.** Agree and select that payments may be taken
- **11.** Click 'Submit Payment and Proceed'

Set Up Auto Bill Pay 🛽 😣 You haven't set up Auto Bill Pay yet. Would you like to set it up now to make automatic monthly payments? Dismiss Set Up Now

| | Review Payme | ent Details |
|--|--|---|
| 9 | | 🖨 Print |
| You | r payment is not co | omplete. |
| Please clicking payme cancell | make sure the below informat "Submit Payment and Proceec nt. Please note that your paym ed after it's been submitted. | ion is correct before d" to complete your ent can't be changed or |
| Paym | ent Amount | Edit Paymen |
| \$1 , | 080.70 | |
| Paym | ent Date | |
| 0075 | 172025 | |
| Paym Card> | e nt Method :0160 | |
| Paym 10283 | ent Confirmation Numbe 3336 | r |
| Auto | opay utopay: Off | |
| | | |
| | l agree payments may be payment method listed a receive emails about my | e taken from the above. I also agree to payments. |
| | | |
| | Submit Payment | and Proceed |

For Credit Card payment (left photo)

- 1. Enter in the credit card and Zip code details
- 2. Once the fields are filled out, you can save this
- 3. Enter a payment method nickname
- Slide Autopay 'On' or 'Off' (If you slide it 'On' go to page 18 for next steps)
- 5. Agree and select 'Terms of Use and Privacy Statement'
- 6. Click 'Review Payment Details'
- If you leave Autopay 'Off', a window will pop up to 'Dismiss' or 'Set Up Now'
- 8. If you click 'Dismiss', a payment summary window will pop up. This is NOT a confirmation window. You can click 'Edit Payment' to edit the information.
- **9.** Agree and select that payments may be taken from payment method listed above
- **10.** Click 'Submit Payment and Proceed'



| Make a Payment | Review Payment Details |
|--|--|
| | |
| \$1,080.70 | 8 |
| Enter payment information To begin your coverage, payment of your first monthly premium is required. Please enter your payment | Your payment is not complete. |
| details below. Your payment will not process until your application has completed processing. | clicking "Submit Payment and Proceed" to complete your payment. Please note that your payment can't be changed or cancelled after it's been submitted. |
| Payment Amount | |
| Current Balance : \$1.080.70 | Payment Amount Edit Payr |
| Amount displayed may be less than required for policy issuance if retroactive effective date. | \$1,080.70 |
| policy issuance in real outline enceave duce. | Payment Date |
| Payment Date | 08 / 31 / 2023 |
| 08 / 31 / 2023 | Payment Method |
| Payment Method | Cardx0160 |
| New Card | |
| Card auratica | Payment Confirmation Number |
| | 10283336 |
| | |
| Expiration date | Autopay |
| | |
| Security Code | 3 Autopay: Off |
| | |
| Zie ande | |
| | I agree payments may be taken from the |
| | receive emails about my payments. |
| VISA accel me was nyce pulse stre | |
| Save this payment method for future use | Submit Payment and Proceed |
| Payment Method Nickname | |
| Primary Checking | Cancel |

Autopay Signup (right photo)

Autopay requires a bank account (no credit/debit cards). If the user enters credit card information for the initial payment, the user will have to enter bank account information for Autopay.

- 1. Slide Autopay: On
- 2. Select same payment information as above or select new bank account in the drop down menu
- **3.** Autopay will be applied to all future bills once enrollment is complete
- **4.** If the applicant is the bank account holder (owner), they must check this box.
- **5.** If the bank account holder is not the applicant, they must enter the email address for the bank account holder here.
- 6. The owner must read and agree to the 'Terms of Use and Privacy Statement'
- 7. Click 'Review Payment Details'
- 8. A payment summary window will pop up. This is NOT a confirmation window. You can click 'Edit Payment' to edit the information.
- **9.** Agree and select that payments may be taken from payment method listed above
- **10.** Click 'Submit Payment and Proceed'

| | Autopay |
|---|--|
| Auto Bill Pay Email | Auto Bill Pay payments will be applied to all future bills once enrollment is complete. The balance will be |
| | paid automatically on the last business day of each |
| Communication Settings | month. |
| Applicant's email address | Autopay: On |
| testtx@me.com | |
| This email will be used for Autopay communication. | Use same payment information as above |
| Bank account holder is the policy holder. | Payment Method |
| | Select payment method |
| | Select payment method |
| Auto Bill Pay Email | New Bank Account |
| | \$1,080.70 |
| Communication Settings | |
| Applicant's amail address | If the payment amount listed above |
| testtx@me.com | changes, you will be notified by email. |
| This email will be used for Autopay communication. | Next Payment Date |
| | 01 / 31 / 2024 |
| Bank account holder is the policy holder. | *Balance will be paid automatically on the last business day |
| | of each month. |
| Bank account holder's email address | Applicant's email address |
| John Doe | testtx@me.com |
| | This email will be used for Autopay communication. |
| Auto Bill Pay communications will be sent to the bank | |
| account holder's email address only. | |
| | |
| | Lunderstand and accept the Terms of Use and |
| | Privacy Statement. |
| | |
| | |
| 6 | Review Payment Details |
| | |
| | Cancel |

Submit Payment

- Once all payment information is entered, the owner agrees to the terms and clicks the "Submit Payment and Proceed" button, the payment will then be authorized.
- 2. When the payment is authorized, the user will receive a confirmation that the payment has been submitted with a client application ID number. In case you need to refer to the transaction, we recommend keeping this number until the application has been processed and you have access to the E-Application number.
- **3.** You can View Application PDF and "Print" the confirmation

2 Application Submitted

Application PP154399 has been submitted successfully. Note: If you are searching for this application ID, please allow up to 24 hours to see this application in Client Search or Create Report

Would you like to view a copy of your completed Application?



Not at this Time



Accessing Incomplete Applications

In the Incomplete Applications table, view and open saved apps that haven't been submitted. Only 1000 applications will appear.

- **1.** Sort the table by clicking on any column header.
- **2.** This field displays the date you started the application.
- **3.** This field displays the last time the application was saved. A saved application that has not been altered in the last 90 days will be deleted on the 90th day from the last saved date.
- 4. The "App Expiry Date" displays when the app is automatically deleted from the portal. When you first view the Incomplete Applications panel, the order defaults to the "App Expiry Date" with the oldest saved app first and the most recently saved app last.
- **5.** To open a previously saved application, click on the last name. If you have clients with similar names, hover over the last name to see the applicant's zip code and date of birth to help identify the correct client without opening the application.
- 6. You can use the selection box to select one, multiple or all apps for export, deletion or print.
- **7.** Click on the "Delete Selected Rows" button to remove the selected apps from the portal.
- 8. Click on the "Export Selected Rows" button to export the selected apps from the portal.
- **9.** Click on the "Print Selected Rows" button to print the selected apps from the portal.

| | 8 | 7 | 0 | Show 25 | ✓ entries | | | | |
|---|------------------|-------------|--|------------------------------|-----------------------------------|------------------------------|----------------|-------------------|-----------|
| | 0 | | | First Previous | s Next Last | | | | |
| | Last Name 🗘 | First Name | ♦ Product Name ♦ | Coverage Effective Date ≎ | Writing Producer Name 🗘 | Writing Producer Number ≎ | Date Created 🗘 | Last Saved Date ≎ | App Expir |
| | search | search | search | search | search | search | search | search | search |
| כ | Kao | Razi | Blue Choice Preferred Bronze PPO 202 BlueCare Dental 1A | 09/01/2023 | | | 08/28/2023 | 08/28/2023 | 10/08/202 |
| כ | ™ 5 | Vidhya | Blue Choice Preferred Bronze PPO 201 BlueCare Dental 1A | 09/01/2023 | | | 08/30/2023 | 08/30/2023 | 10/10/202 |
|) | Khan | Yamuna | Blue Choice Preferred Bronze PPO 201 BlueCare Dental 1A | 10/01/2023 | | | 09/01/2023 | 09/01/2023 | 10/12/202 |
| ו | Lewis | Amanda | Blue Choice Preferred Gold PPO 204 Select One | 01/01/2024 | | | 09/05/2023 | 09/05/2023 | 10/16/202 |
| כ | PQFVWL | AFZHLP | Blue Precision Bronze HMO 205 BlueCare Dental 1A | 10/01/2023 | EHEALTHINSURANCE SERVICES. | 037083000 | 09/11/2023 | 09/11/2023 | 10/22/202 |
|) | Reynosa | Amaya | BlueCare Dental 1B | 12/01/2023 | EHEALTHINSURANCE SERVICES. | 037083000 | 09/20/2023 | 09/20/2023 | 10/31/202 |
| כ | VishalL | vishalF | Blue Choice Preferred Gold PPO 707 Select One | 01/01/2024 | EHEALTHINSURANCE SERVICES, | 037083000 | 09/20/2023 | 09/20/2023 | 10/31/202 |
|) | vickyL | vickyF | Blue Choice Preferred Bronze PPO 201 Select One | 01/01/2024 | EHEALTHINSURANCE SERVICES. | 037083000 | 09/20/2023 | 09/20/2023 | 10/31/202 |
| כ | sdgvkjsdjdhbhsjd | vvkjhsvhjsd | Blue Choice Preferred Bronze PPO 701 - Rx Copays Select One | 01/01/2024 | EHEALTHINSURANCE SERVICES, | 037083000 | 09/21/2023 | 09/21/2023 | 11/01/202 |
| 2 | Nolan | Richard | Blue Choice Preferred Gold PPO 707 Select One | 02/01/2024 | EHEALTHINSURANCE SERVICES. | 037083000 | 09/26/2023 | 09/26/2023 | 11/06/202 |
|) | Wrecker | Ralph | Blue Choice Preferred Gold PPO 707 Select One | 02/01/2024 | EHEALTHINSURANCE SERVICES, | 037083000 | 09/26/2023 | 09/26/2023 | 11/06/202 |
|) | Taylor | Christian | Blue Choice Preferred Gold PPO 204 - Rx Copays Select One | 02/01/2024 | EHEALTHINSURANCE SERVICES, INC | 037083000 | 09/27/2023 | 09/27/2023 | 11/07/202 |

Special Enrollment

If you're helping your client enroll in an off-exchange plan due to a qualifying life event, the steps are similar to those when enrolling during open enrollment. One difference is you must choose a life event in order to proceed and then submit supporting documentation.

- **1.** Choose the application. The time of year and the plan year you select determine if the Special Enrollment Information panel populates.
- **2.** Confirm how the client has provided or will provide consent in the Authorization panel.
- 3. In the Special Enrollment Information panel, select "Yes."
- 4. Select the qualifying life event. Select all that apply.*
- 5. Enter the date of the event.
- **6.** The "Effective Date" will adjust depending on the event and event date entered.

After completing and submitting the online application, you should upload your qualifying event documentation. Submitting documents via the portal is simple. They should be in ONE digital file no more than 10 MB in size. Documents must be readable and complete. Under Document Type, be sure to select "SEP Documentation."

| /riting Producer umber | Applicant Name | Choose Applic | ation Form * | Effective Date | Estimated Monthly Premium | |
|---|---|--|--|----------------------------------|------------------------------|---|
| 99999999 | Jane M Doe | 2024 Medical/D | ental Application 🗸 | 01/01/2024 | More Information Needed | |
| | | | | | | |
| Authorization | | | | | | |
| | | | | | | |
| I confirm/attest that n their behalf. I will ke | my client has completed and s ep a record of the paper applic | igned a paper application, and a ation for minimum of two years | s the producer of record, from the submit date. | I will be completing and | submitting the application | |
|) I confirm/attest that pplication have been p | I am assisting my client in per resented and communicated to | son. That all the terms, agreem my client. | ents, acknowledgements | and authorizations displa | yed on the paper | |
| | | | | | | |
| Special Enrolln | nent Information | | | | | |
| | | | | | | |
| Is this a Special Enrol | llment Period or "SEP" applicat | ion Yes No | | | | |
| | | | | | Date of Event | |
| 1. My dependent(s) and | I/or I lost Minimum Essential Cover | age: | | | | |
| a. For reasons beyo date. | nd my control (not including reaso | ns like failure to pay my full premiur | m or and disregard on my pai | rt for the plan's rules) as of t | nis 11/15/2023 * | |
| b. Because I turned | age 26, or 30 if an unmarried mili | ary veteran, or the policyholder bed | ame eligible for Medicare. | | | |
| C. Because the poli | cyholder died as of this date. | | | | | |
| d. Because I lost m | y job, I lost hours, my employer sto | pped making payments, or my COBR | A benefits ended as of this o | late. | | |
| e. Because someon | e on my plan was legally separated | or divorced as of this date. | | | | |
| 📋 f. Because my plan | stopped covering people in my situ | ation as of this date. | | | | |
| 2. Because I got marrie | d on this date. | | | | | |
| Because I had a baby court order as of this d | y, adopted a child, had a child plac ate. | ed with me for adoption, took in a fo | oster child or was ordered to | cover a dependent through | a | |
| Because there was a me as of this date. | mistake when I signed up for my la | ast health plan, or I have shown proc | of that my previous health pl | an or issuer broke its contrac | t with | |
| 5. Because someone or non-Exchange plan bro | n my plan had a change in income a ke government rules as of this date | nd lost advance payment of premiur | n tax credit, cost-sharing rec | ductions, or Medicaid, or my | last | |
| 6. Because I got new h | ealth plan options when I moved on | this date. | | | | |
| 7. Because my current | poucy ends on a date other than D | ecemper 31, which is this date. | Courses Health Dainthum | And a second second second | | |
| Qualified Small Employ | er Health Reimbursement Arrangen | nent (QSEHRA). | a coverage nealth keimburse | ment Arrangement (ICHRA) (| JI G | |
| Av employer is n | A USEHKA | HRA or OSEHRA as of this date | | | | |
| b. I am a new empl | oyee and my employer is offering p | articipation in an ICHRA or QSEHRA | as of this date. | | | |
| Plan Selection | | | | | | |
| | | | | | | |
| Zip* | | | | | | |
| | | | | | | |
| 10 | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | * |
| | | | | | • | |
| | | | | | | |
| | | | | | | |