



**Business Resource Services (BRS)
Group Coverage Enrollment Agreement
January 1, 2012 – December 31, 2012**

Group Name: _____

Health Coverage Options

Vermont Freedom Plans (PPO)		Single	2-Person	Family	Carve-out
\$750/\$1,500 deductible - \$30 office visit - 80%/20% coinsurance to \$3,750/\$7,500 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay		\$656.55	\$1,313.11	\$1,935.63	\$431.69
\$1,500/\$3,000 deductible - \$30 office visit - 80%/20% coinsurance to \$7,500/\$15,000 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay		\$609.06	\$1,218.12	\$1,805.48	\$386.78
\$2,500/\$5,000 deductible - \$30 office visit - 80%/20% coinsurance to \$7,500/\$15,000 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay		\$573.58	\$1,147.14	\$1,706.40	\$352.04
\$5,000/\$10,000 deductible - \$30 office visit - 80%/20% coinsurance to \$7,500/\$15,000 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay		\$537.33	\$1,074.67	\$1,606.95	\$317.65
\$10,000/\$20,000 deductible - \$30 office visit - out-of-pocket limit equals annual deductible - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay		\$491.35	\$982.72	\$1,478.60	\$295.87
Prescription Drug Benefit: \$100 annual deductible, then \$5 co-pay for generic drugs, 40% coinsurance for Preferred Brand-name drugs and 60% coinsurance for Non-preferred Brand-name drugs		Included in premium rates			

Note: Carve-out is available for members who are eligible for Medicare with a Small Employer Exception from CMS.

Blue CDHP (Comprehensive) with NEW Wellness Drug Benefits -HSA/HRA Compatible		Single	2-Person	Family	Carve-out
\$2,250/\$4,500 deductible (aggregate*) - 80%/20% coinsurance to \$3,250/\$6,500 out-of-pocket limit -100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$614.67	\$1,104.51	\$1,725.47	\$481.77
\$4,000/\$8,000 deductible (aggregate*) - 80%/20% coinsurance to \$5,000/\$10,000 out-of-pocket limit -100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$525.31	\$858.83	\$1,355.78	\$484.86

Note: Carve-out is available for members who are eligible for Medicare with a Small Employer Exception from CMS.

Wellness Drugs are credited towards the out-of-pocket limit, for the list of wellness drugs we cover, visit www.bcbsvt.com/wellnessRx

Vision Care Rider for Vermont Freedom Plan or Blue CDHP Plans		Single	2-Person	Family	Carve-out
\$20 co-pay for Vision Materials (\$20 Vision Exam included in ALL plans)		\$6.36	\$12.72	\$25.48	\$6.36

BlueCare CDHP (HMO)** with NEW Wellness Drug Benefits – HSA/HRA Compatible		Single	2-Person	Family
\$2,000/\$4,000 deductible (aggregate*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$483.08	\$821.23	\$1,206.25
\$2,500/\$5,000 deductible (aggregate*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$450.51	\$747.84	\$1,097.48
\$2,500/\$5,000 deductible (aggregate*) - 80%/20% coinsurance to \$5,950/\$11,900 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: 50% before deductible - Prescription Drug Benefit: 50% for all Prescriptions after deductible		\$390.23	\$647.77	\$950.63
\$3,000/\$6,000 deductible (stacked^*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$426.72	\$853.43	\$1,191.63
\$5,000/\$10,000 deductible (stacked^*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible		\$325.72	\$651.45	\$909.60

Wellness Drugs are credited towards the out-of-pocket limit, for the list of wellness drugs we cover, visit www.bcbsvt.com/wellnessRx

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BlueCare Access CDHP (HMO) ** ^^ - with NEW Wellness Drug Benefits- HSA/HRA Compatible	Single	2-Person	Family
\$2,000/\$4,000 deductible (aggregate*) - 80%/20% coinsurance to \$3,000/\$6,000 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible	\$465.83	\$791.90	\$1,163.16
\$3,000/\$6,000 deductible (stacked^) - 80%/20% coinsurance to \$4,000/\$8,000 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. Wellness Drug Benefit: \$5/40%/60% before deductible	\$416.95	\$833.90	\$1,164.35

Wellness Drugs are credited towards the out-of-pocket limit, for the list of wellness drugs we cover, visit www.bcbsvt.com/wellnessRx

BlueCare (HMO) **	Single	2-Person	Family
Plan D: \$500 inpatient co-pay – \$200 outpatient co-pay - \$20 PCP visit - \$30 specialist visit - 100% Preventive Coverage - DME 20% coinsurance - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$624.08	\$1,248.15	\$1,742.76
Plan I: \$1,000 inpatient/outpatient combined deductible - \$20 PCP visit - \$30 specialist visit - 100% Preventive Coverage - DME 20% coinsurance - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$589.04	\$1,178.08	\$1,644.91
Plan K: \$2,000/\$1,000 inpatient/outpatient deductible - \$20 PCP visit - \$30 specialist visit - 100% Preventive Coverage - DME 20% coinsurance - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$555.14	\$1,110.28	\$1,550.25
Prescription Drug Benefit: \$100 annual deductible, then \$5 co-pay for generic drugs, 40% coinsurance for Preferred Brand-name drugs and 60% coinsurance for Non-preferred Brand-name drugs	Included in premium rates		

BlueCare Access (HMO) ** ^^	Single	2-Person	Family
\$1,500/\$750 inpatient/outpatient deductible - \$20 PCP visit - \$30 specialist visit - 100% Preventive Coverage - DME 20% coinsurance - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$583.69	\$1,167.38	\$1,629.97
Prescription Drug Benefit: \$100 annual deductible, then \$5 co-pay for generic drugs, 40% coinsurance for Preferred Brand-name drugs and 60% coinsurance for Non-preferred Brand-name drugs	Included in premium rates		

Vision Care Rider for BlueCare Plans	Single	2-Person	Family
\$20 co-pay for Vision Materials (\$20 Vision Exam included in ALL plans)	\$8.56	\$17.11	\$23.90

CDHP – Consumer-Directed Health Plan

* Aggregate Deductible: Full single or entire family deductible must be satisfied before benefits are paid.

^ Stacked Deductible: Plan pays for an individual once the individual deductible has been met.

** If you are choosing a BlueCare plan for the first time, each subscriber must complete a new enrollment form and select a Primary Care Physician (PCP) for each member.

^^ BlueCare Access allow for up to 40% of subscribers to live outside of the BlueCare Access Service Area. No dual option.

I. Broker Name _____ Agency Name: _____
(REQUIRED) (REQUIRED)

By designating the above named Broker/Agency, I hereby acknowledge the Broker/Agency will be compensated based upon the BCBSVT commission schedule. If your group does not have an insurance broker or agency, please write "Not Applicable" in the space above.

II. Checks are payable to "Blue Cross Blue Shield of VT". If a check is enclosed, the amount is \$ _____

III. Name _____ Title _____
(PRINT)
 Authorized Signatory _____ Date _____
(REQUIRED)

Groups of any size are required by law to offer Continuation Coverage. Failure to comply with these laws may result in serious penalties. BRS offers COBRA/HIPAA and Vermont Continuation compliance services to members at no cost for up to 50 employees. Please see website www.brsvt.com or call BRS for details.

NOTE: The Association has a January 1 anniversary. Rates and Benefits are subject to change on January 1, regardless of the month your group became effective.



**BlueCross BlueShield
of Vermont**

An Independent Licensee of the Blue Cross and Blue Shield Association.



**The Vermont
Health Plan**

An independent licensee of the Blue Cross and Blue Shield Association.

Group Enrollment Agreement

Group Name (Company Name) _____ Effective Date ____/____/____

Physical Address (Vermont) _____ Phone ____ - ____ - _____

City _____ State ____ Zip Code _____ Fax ____ - ____ - _____

Nature of Business _____ Federal Tax ID # _____

Mailing and Billing Address
(if other than physical address) _____

City _____ State ____ Zip Code _____

Group Benefit Administrator _____ Title _____ Phone ____ - ____ - _____

E-mail _____ Fax ____ - ____ - _____

Additional Contact _____ Title _____ Phone ____ - ____ - _____

E-mail _____ Fax ____ - ____ - _____

Group Census Details

Total Number of Employees _____ Total Eligible Employees _____ Total Employees Enrolling _____

Probationary Period (in days) _____ New Hires _____ days Rehires _____ days

Instructions for Special Probationary Period (if any)

Previous Carrier Detail

Carrier Name (if applicable) _____ Effective Date ____/____/____ Termination Date ____/____/____

Please return to:

Sales & Retention Department
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186