



**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
Contract _____ Title _____ Phone ____ - ____ - _____

E-mail _____ Fax ____ - ____ - _____

Group Census Details

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

Probationary Period (no more than 90 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



BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association

Providing Health Plans For



Business Resource Services (BRS) Group Coverage Enrollment Agreement October 1, 2010 – December 31, 2011 (sold in Q4 2010)

Group Name: _____

BlueCare Access HSA (HMO)		Single	2-Person	Family
	\$2,000/\$4,000 deductible (aggregate*)- preventive services 100% - 80% coinsurance – \$3,000/\$6,000 out-of-pocket limit	\$410.17	\$697.29	\$1014.06
	\$3,000/\$6,000 deductible (stacked^)- preventive services 100% - 80% coinsurance – \$4,000/\$8,000 out-of-pocket limit	\$364.00	\$728.01	\$1004.42

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

^Stacked Deductible: Each member must satisfy individual deductible until family deductible is met.

BlueCare (HMO)		Single	2-Person	Family
	Plan D: \$500 inpatient co-pay – \$200 outpatient co-pay - \$20 PCP office visit, \$30 specialist visit – preventive services covered at 100% - DME 20% coinsurance – Emergency \$150, Ambulance \$50	\$565.64	\$1131.27	\$1560.80
	Plan I: \$1,000 inpatient/outpatient combined deductible – \$20 PCP office visit, \$30 specialist visit -- preventive services covered 100% - DME 20% coinsurance -- Emergency \$150, Ambulance \$50	\$534.05	\$1068.10	\$1473.64
	Plan K: \$2,000/\$1,000 inpatient/outpatient deductible – \$20 PCP office visit, \$30 specialist visit -- preventive services covered 100% - DME 20% coinsurance - Emergency \$150, Ambulance \$50	\$503.49	\$1006.99	\$1389.32
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 office visit \$30 specialist visit – preventive services covered at 100% - DME 20% coinsurance - Emergency \$150, Ambulance \$50	\$528.98	\$1057.95	\$1459.64
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		Single	2-Person	Family
	Vision option is available only with BlueCare HMO plans – not including BlueCare HSA plans-- \$20 Exam, \$20 Materials	\$7.91	\$15.83	\$21.84

Notes: BlueCare HMO Plans require a Primary Care Physician selection for each member. BlueCare Access plans have out of state eligibility limits, please contact Sales & Retention for additional information.

(continued on page 2)

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 _____

As with many association products, Business Resource Services (BRS) is rated as a group. Therefore, all members of BRS are required by law to comply with COBRA mandates regardless of the number of active employees. Failure to comply with COBRA requirements may result in serious penalties. BRS has primary COBRA and HIPAA compliance services available to members at no cost for up to 50 employees. See the brochure or website www.brsvt.com for details.

NOTE: The Association has a January 1 anniversary. Rates and Benefits are subject to change on January 1, 2012, unless another benefit design is chosen for January 1, 2011. All plans included are "Patient Protection and Affordable Care Act" compliant.