



## 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)			Phone
_____	_____	_____ - _____	_____ - _____ - _____
City	State	Zip Code	Fax
_____			_____ - _____ - _____
Group Benefit Administrator		Title	Phone
_____			_____ - _____ - _____
E-mail ID			Fax
_____			_____ - _____ - _____
Additional Contact		Title	Phone
_____			_____ - _____ - _____
E-mail ID			Fax

**Group Census Details**

Total Number of Employees \_\_\_\_\_ Total Eligible Employees \_\_\_\_\_ Total Employees Enrolling \_\_\_\_\_

Probationary Periods\* (in days) New Hires \_\_\_\_\_ Rehires \_\_\_\_\_

\*Instructions for Special Probationary Period (if any)

**Previous Carrier Details (answer this if your total number of employees enrolling is less than 50)**

_____	____ / ____ / _____	____ / ____ / _____
Previous Carrier Name (if any)	Effective Date	Termination Date



# BlueCross BlueShield of Vermont

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

www.bcbsvt.com

## The Vermont Health Plan (TVHP) -- Preferred Small Group Plans Third Quarter ~ 3 Tier - Monthly Rates Group Coverage Enrollment Agreement July 1, 2010 – September 30, 2010

Group Name: \_\_\_\_\_

**Note: The following Plans require the selection of a Primary Care Physician (PCP) for each covered member.**

Medical Plan Choice			
HSA BlueCare (HMO)	Single	2-Person	Family
\$2,000/\$4,000 deductible (aggregate*) - preventive services covered 100% - 100% coinsurance – out-of-pocket limit equals annual deductible	\$415.76	\$706.78	\$1,022.78
\$2,500/\$5,000 deductible (aggregate*) - preventive services covered 100% - 100% coinsurance – out-of-pocket limit equals annual deductible	\$386.24	\$641.17	\$926.99
\$2,500/\$5,000 deductible (stacked^)- preventive services covered 100% - 80% coinsurance – \$3,500/\$7,000 out-of-pocket limit	\$354.16	\$708.32	\$956.22
\$3,000/\$6,000 deductible (stacked^)- preventive services covered 100% - 100% coinsurance – out-of-pocket limit equals annual deductible	\$365.64	\$731.27	\$987.21
\$5,000/\$10,000 deductible (stacked^)- preventive services covered 100% - 100% coinsurance – out-of-pocket limit equals annual deductible	\$272.28	\$544.56	\$735.15
HSA Rider -- Available With HSA BlueCare Plans	Single	2-Person	Family
Pap smear screenings	\$1.28	\$2.56	\$3.46

BlueCare Options (POS) - When Purchasing Additional Pharmacy Rider	Single	2-Person	Family
3,000/\$6,000 inpatient/outpatient deductible – \$30 office visit -- preventive services covered 100% - 80% coinsurance – Emergency \$100 - \$5,000/\$10,000 out-of-pocket limit	\$345.09	\$690.17	\$931.72

BlueCare (HMO) - When Purchasing Additional Pharmacy Rider	Single	2-Person	Family
BlueCare Plan D: \$500 inpatient co-pay – \$200 outpatient co-pay - \$20 PCP office visit, \$30 specialist visit – preventive services covered 100% - DME 20% coinsurance – Emergency \$150, Ambulance \$50	\$495.82	\$991.65	\$1,338.71
BlueCare 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	\$464.60	\$929.20	\$1,254.41
BlueCare 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	\$434.39	\$868.77	\$1,172.83

BlueCare (HMO) – Diabetes Medications Only	Single	2-Person	Family
BlueCare Plan D: \$500 inpatient co-pay – \$200 outpatient co-pay - \$20 PCP office visit, \$30 specialist visit – preventive services covered 100% - DME 20% coinsurance – Emergency \$150, Ambulance \$50 - Diabetes Medication Only	\$499.46	\$998.94	\$1,348.55
BlueCare 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 - Diabetes Medication Only	\$468.24	\$936.49	\$1,264.25
BlueCare 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 - Diabetes Medication Only	\$438.03	\$876.06	\$1,182.67

Includes only coverage for diabetes supplies and medications -- not comprehensive pharmacy benefits.

**OVER →**

\*Aggregate Deductible – Full individual or entire family deductible must be satisfied.

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

<b>BlueCare Access (HMO) - When Purchasing Additional Pharmacy Rider</b>		<b>Single</b>	<b>2-Person</b>	<b>Family</b>
	\$1,500/\$750 inpatient/outpatient deductible - \$20 PCP office visit, \$30 specialist visit – preventive services covered 100% - DME 20% coinsurance - Emergency \$150 co-pay, Ambulance \$50 co-pay	\$459.58	\$919.16	\$1,240.86

Note: To qualify, no more than 30% of eligible employees may reside outside the BlueCare Access service area.

<b>BlueCare Access HSA (HMO)</b>		<b>Single</b>	<b>2-Person</b>	<b>Family</b>
	\$2,000/\$4,000 deductible (aggregate*)- preventive services covered 100% - 80% coinsurance – \$3,000/\$6,000 out-of-pocket limit	\$394.09	\$669.94	\$969.46
	\$3,000/\$6,000 deductible (stacked^)- preventive services covered 100% - 80% coinsurance – \$4,000/\$8,000 out-of-pocket limit	\$348.45	\$696.90	\$940.80

Note: To qualify, no more than 30% of eligible employees may reside outside the BlueCare Access service area.

<b>Pharmacy Riders (Riders Available With BlueCare HMO and POS Plans)</b>		<b>Single</b>	<b>2-Person</b>	<b>Family</b>
	\$0 deductible, then 50% coinsurance– no annual limit – diabetic medications same as any other	\$56.87	\$113.73	\$153.54
	\$100 deductible, then \$5 generic co-pay / 40% preferred coinsurance / 60% non-preferred coinsurance – no annual limit - diabetic medications same as any other	\$61.59	\$123.18	\$166.30
	\$100 deductible, then \$10 generic co-pay / \$30 preferred co-pay / \$45 non-preferred co-pay – no annual limit - diabetic medications same as any other	\$79.15	\$158.31	\$213.71
	\$100 deductible, then \$5 generic co-pay / \$25 preferred co-pay / \$50 non-preferred co-pay – no annual limit - diabetic medications same as any other	\$82.30	\$164.59	\$222.20
	\$100 deductible, then \$5 generic co-pay / \$20 preferred co-pay / \$45 non-preferred co-pay – no annual limit - diabetic medications same as any other	\$85.46	\$170.92	\$230.74

<b>Vision Option (Rider Available with BlueCare HMO and POS Plans Only)</b>		<b>Single</b>	<b>2-Person</b>	<b>Family</b>
	\$20 Exam/\$20 Materials	\$8.06	\$16.11	\$21.75

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.

Check here if the Broker/Agency designated above is a change for your group.

Check here if your group does not have a Broker/Agency.

II. Name \_\_\_\_\_ Title \_\_\_\_\_  
 (PRINT)

Authorized Signatory \_\_\_\_\_ Date \_\_\_\_\_  
 (REQUIRED)