



## Vermont State Dental Society (VSDS) Group Coverage Election Form January 1, 2012 – December 31, 2012

**Company Name:** «Policy\_Name»

**Group Number:** «Customer\_»

**Broker Name & Phone:** Stefanie Pigeon (802) 861-2900

**Contact:** «Contact\_Name»

**Company Phone:** «Contact\_Info»

Please update any company information in the spaces above. By designating the above named Broker, I hereby acknowledge the Broker will be compensated based upon the BCBSVT commission schedule.

**Your Current Health Coverage:**

«Policy\_» «BP\_Desc»

«Policy2» «BP\_Desc\_2»

**If you wish to retain your current coverage,** no response is required, simply remit your January premium as billed.

**If you wish to make a change,** select your desired health coverage(s), **sign** in the space provided on the reverse side and **mail** to BCBSVT in the enclosed postage paid envelope. Each available option is summarized below with the monthly premium for single, two-person and family coverage. Full benefit descriptions can be found on our website at [www.bcbsvt.com/VSDS](http://www.bcbsvt.com/VSDS). **Election forms are due no later than December 31, 2011.**

**If you wish to cancel your coverage,** we must receive the request in writing by December 31, 2011 for a January 1, 2012 cancel date.

### Health Coverage Options

Vermont Freedom Plans (PPO)	Single	2-Person	Family
\$500/\$1,000 deductible - \$20 office visit - 80%/20% coinsurance to \$1,500/\$3,000 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$562.49	\$1,124.97	\$1,647.33
\$1,000/\$2,000 deductible - \$25 office visit - 80%/20% coinsurance to \$3,000/\$6,000 out-of-pocket limit - 100% Preventive Coverage - Emergency \$250, Ambulance \$50, Vision Exam \$20 co-pay	\$527.66	\$1,055.30	\$1,549.71
\$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	\$431.40	\$862.81	\$1,280.99
<b>Prescription Drug Benefit:</b> \$50 annual deductible, then 50% coinsurance to an annual out-of-pocket maximum of \$2,500 for an individual and \$5,000 for a family	<b>Included in premium rates</b>		

Blue CDHP (Comprehensive) with <b>NEW</b> Wellness Drug Benefits -HSA/HRA Compatible	Single	2-Person	Family
\$3,250/\$6,500 deductible (aggregate*) - 80%/20% coinsurance to \$4,250/\$8,500 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. <b>Wellness Drug Benefit:</b> 50% before deductible	\$446.87	\$756.31	\$1,173.52
\$5,950/\$11,900 deductible (aggregate*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. <b>Wellness Drug Benefit:</b> 50% before deductible	\$405.11	\$681.17	\$1,060.57

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

Vision Care Rider for Vermont Freedom Plan or Blue CDHP Plans	Single	2-Person	Family
\$20 co-pay for Vision Materials (\$20 Vision Exam included in ALL plans)	\$6.36	\$12.72	\$24.56

<b>BlueCare CDHP (HMO) ** with NEW Wellness Drug Benefits – HSA/HRA Compatible</b>	<b>Single</b>	<b>2-Person</b>	<b>Family</b>
\$2,500/\$5,000 deductible (aggregate*) - 100% coverage after deductible - 100% Preventive Coverage - Vision Exam \$20 co-pay. <b>Wellness Drug Benefit:</b> \$5/40%/60% before deductible	\$450.51	\$747.84	\$1,097.48
\$2,500/\$5,000 deductible (stacked^ ) - 80%/20% coinsurance to \$3,500/\$7,000 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. <b>NEW Wellness Drug Benefit:</b> \$5/40%/60% before deductible	\$421.77	\$843.55	\$1,177.82
\$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. <b>Wellness Drug Benefit:</b> 50% before deductible. <b>Prescription Drug Benefit:</b> 50% for <u>all</u> prescriptions after deductible	\$390.23	\$647.77	\$950.63
\$5,000/\$10,000 deductible (stacked^ ) - 100% coverage after deductible - 100% Preventive Coverage- Vision Exam \$20 co-pay. <b>NEW Wellness Drug Benefit:</b> \$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](http://www.bcbsvt.com/wellnessRx)

<b>Vision Care Rider for BlueCare Plans</b>	<b>Single</b>	<b>2-Person</b>	<b>Family</b>
\$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 is 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.

**Full benefit descriptions can be found on our website at [www.bcbsvt.com/VSDS](http://www.bcbsvt.com/VSDS).**

GROUP BENEFITS MANAGER'S SIGNATURE  
(REQUIRED)

DATE

Please return **BOTH SIDES** of this form by **December 31, 2011** to: BCBSVT P.O. Box 186, Montpelier, VT 05601-0186. If you need any assistance, please call Sales and Retention at (800) 255-4550 option 1, 1, 3 or your insurance broker.

Blue Cross and Blue Shield of Vermont | P.O. Box 186, Montpelier, VT 05601-0186 | (800) 255-4550