

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

Company Name:
Group Number:
Broker Name & Phone: Stefanie Pigeon (802) 861-2900

Contact:
Company Phone:

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.

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. **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
Prescription Drug Benefit: \$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		Included in premium rates		

Blue CDHP (Comprehensive) with NEW 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. Wellness Drug Benefit: 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. Wellness Drug Benefit: 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

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

BlueCare CDHP (HMO) ** with NEW Wellness Drug Benefits – HSA/HRA Compatible		Single	2-Person	Family
	\$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 (stacked^) - 80%/20% coinsurance to \$3,500/\$7,000 out-of-pocket limit - 100% Preventive Coverage - Vision Exam \$20 co-pay. NEW Wellness Drug Benefit: \$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. Wellness Drug Benefit: 50% before deductible. Prescription Drug Benefit: 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. NEW 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

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 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.

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.