NEW SMALL GROUP CHECKLIST

BlueCross BlueShield of Vermont

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

☑ **Please return the following items to BCBSVT for new small group enrollment:**

☐ Completed and signed Small Group Enrollment Agreement form.

☐ Completed Small Group Certification form including the Employee Census Information on side two.

☐ Provide proof of business:

IF YOU HAVE ...	PROVIDE ...
...filed business taxes	■ Vermont Quarterly Wage Report (C-101)
...NOT filed business taxes	■ most recent payroll register OR ■ letter Indicating the official start date of your business AND a copy of your state of Vermont Trade Name Registration form OR ■ Certificate of Authority form

☐ Completed Small Group Coverage Employee Enrollment and Change Form for each employee enrolling in the group plan.

Each employee and dependent(s) must select a participating Primary Care Physician (Nurse Practitioners, Physician's Assistants, Specialists and facilities are NOT acceptable).

☐ A check for your first month's premium, made payable to Blue Cross and Blue Shield of Vermont. Mailed to:

Blue Cross and Blue Shield of Vermont
PO BOX 186
Montpelier, VT 05601-0186

☐ Enrollees can complete a Continuity of Care form if they are being treated for a life threatening /disabling degenerative condition, are in their second or third trimester of pregnancy, have an upcoming surgery OR are on a medication for which prior approval has been given by the previous carrier.

☐ Employers must provide a copy of the Summary of Benefits and Coverage (SBC) to all eligible employees 30 days prior to effective date or within seven days of election of new coverage. To obtain a copy of your SBC, please contact Consumer & Business Support Services (CBSS) at **(800) 255-4550** or via email at **consumersupport@bcbsvt.com**. Your SBC can also be found by visiting our website at **www.bcbsvt.com/qhpsmallbusiness**.

SMALL GROUP ENROLLMENT AGREEMENT

New group

BlueCross BlueShield of Vermont

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

If all of the requested information is NOT complete, this form will be returned to you.

Section 1: GROUP INFORMATION		
Business name:	**Effective date of coverage**	
DBA name (if applicable)	Federal tax ID (required)	
Nature of business or organization	Four-digit SIC code (required)	
Vermont physical address		
City	State	ZIP
Phone	Fax	
Mailing address (if different)		
City	State	ZIP
Group benefit administrator	Title	
Phone	Email	
Additional group contact	Title	
Phone	Email	
Business owner(s): (please list business owners, if different than above)		
Are the owners and their spouse the only policy holders on the business health plan? ☐ Yes ☐ No	Does the business offer other insurance in addition to products offered through BCBSVT? ☐ Yes ☐ No	

Section 2: BROKER INFORMATION (if applicable)		
☐ Using a broker / agent / producer. If you are using a broker please list them below. By completing the information below you are listing the broker as an authorized contact for your group.		
Broker name:	Agency name:	
Street address		
City	State	ZIP
Phone	Email	

Section 3: FINANCIAL ACCOUNTS

BCBSVT offers integrated Consumer Driven Health Plan (CDHP) account services. All plans are eligible for HRA accounts. Only specified CDHP plans are eligible for HSA accounts. As an employer you can offer financial accounts to employees to manage their health care expenses and savings at no additional cost.

If you have completed a Plan Design Guide for the following accounts, please check the box below.

☐ Health Reimbursement Arrangement (HRA) ☐ Health Savings Account (HSA)

For more information regarding our financial account products, please visit: **www.bcbsvt.com/mymoney** or contact our MyMoney financial account sales and support team at (866) 999-2605.

Section 4: SIGNATURE

SIGN HERE

▶ Group Benefit Administrator's signature (required) _____ date _____ ◀

Please return your business paperwork to:

Blue Cross and Blue Shield of Vermont (BCBSVT)
P.O. Box 186
Montpelier, VT 05601-0186.

or e-mail: **consumersupport@bcbsvt.com**

or FAX: (802) 371-3329

Please note BCBSVT requires the first month premium payment to process your business paperwork.

Please mail check to the address above and include a copy of the check with the required paperwork.

The monthly premium is based on the plan selection and tier for all employees included in the initial paperwork.

SMALL GROUP CERTIFICATION

New group

BlueCross BlueShield of Vermont

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

If all of the requested information is NOT complete, this form will be returned to you.

Section 1: GROUP INFORMATION		
Business name	Federal tax ID	
Physical address (Vermont)		
City	State	ZIP
Phone	Fax	
Mailing address (if different)		
City	State	ZIP

Section 2: GROUP CENSUS DETAILS		
Total number of employees: (this includes both full time & part time)	Company minimum eligibility policy for health insurance: (required, even if only one employee participates) _____ hours per week	
Probationary period (no more than 90 days)	New hires _____ days	New rehires _____ days
My Money account with integrated claims feed (no additional cost)	☐ Health Savings Account (HSA)	☐ Health Reimbursement Arrangement (HRA)

I. EMPLOYEE CENSUS

As of 2016 the Affordable Care act defines a Small Employer as an entity with up to 100 full-time equivalent employees. To calculate the number of employees, include all employees that work full-time. Full-time, for this purpose, is defined as an employee that works at least 30 hours per week, or 130 hours in a calendar month. Fulltime equivalents equal the total part-time employee hours worked in a month divided by 120. Those numbers are added together give the monthly number. The 12 month totals are then averaged for the final count. Employers with less than 100 full-time equivalents are considered a small group and are allowed to purchase a Qualified Health Plan.

II. PROOF OF BUSINESS/INSURANCE

When returning your Small Group Certification Form you must include your Employer's Quarterly Wage and Contribution Report. Please indicate terminated, seasonal and part-time employees and the number of hours worked per week by each employee. You may remove Social Security numbers and financial information. If you are not required to file an Employer's Quarterly Wage and Contribution Report (Form C-101) with the Vermont Department of Employment and Training, or with any other state in which you do business, please submit one of the following: IRS Schedule C (Proprietorship); IRS Schedule SE (Self Employed); or IRS Schedule K-1 (Partnership or "S" Corporation).

III. CERTIFICATION

I verify that I have completed the Census information requested on the back of this form. I certify that I qualify as a Small Employer as described in section I. and have 100 or fewer full-time and full-time equivalent employees as calculated pursuant to IRS code §4890H(c)(2). I further certify that if I am required to file an "Employer's Quarterly Wage and Contribution Report" with the Department of Employment and Training I have attached a copy of the most recent report to this form or I am a self-employed proprietor and I have attached one of the following: IRS Schedule C (Proprietorship), IRS Schedule SE (Self-Employed) or IRS Schedule K1 (Partnership or "S" Corporation).

I certify that the information provided above is true and complete. I understand that if the above information is incomplete, untrue or is not provided in a timely manner, then group health benefits do not have to be offered or continued.

Signature of Officer, Partner or Owner	Date
Signature of Officer, Partner or Owner	Date

Please return your business paperwork to:

Blue Cross and Blue Shield of Vermont (BCBSVT). P.O. Box 186, Montpelier, VT 05601-0186

or e-mail: **consumersupport@bcbsvt.com**

or FAX: (802) 371-3329

EMPLOYEE CENSUS INFORMATION

BlueCross BlueShield of Vermont

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

Please complete the following census OR include all of the requested information on the attached copy of your most recent Quarterly Wage and Contribution Report. Census must include current active employees, terminated employees included on the insurance under VIPER/COBRA, and retirees. List of current active employees should include: the owner(s), officer(s), manager(s) and employee(s) of the employer and the partners, if the employer is a partnership. The individuals on this list should match those listed on the Quarterly Wage Report that you are providing to us. If you're a business owner, please complete the form listing yourself as an employee.

Please use the following letters to complete the "EMPLOYMENT STATUS" column below:

- F: Full-time employee
- P/E: Part-time or Seasonal employee, eligible for benefits
- P/I: Part-time or Seasonal employee, ineligible for benefits
- U: Union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement
- C: Continuee under State or Federal Law (VIPER/COBRA)
- R: Retiree, eligible for benefits
- T: Terminated employee

EMPLOYEE NAME: LAST NAME, FIRST INITIAL	HIRE DATE (IF WITHIN PAST 12 MOS.)	NUMBER OF HOURS WORKED PER WEEK	EMPLOYMENT STATUS	STATE WHERE EMPLOYED (IF OTHER THAN VT.)	EMPLOYEE OPTING OUT OF INSURANCE
1.					☐ yes ☐ no
2.					☐ yes ☐ no
3.					☐ yes ☐ no
4.					☐ yes ☐ no
5.					☐ yes ☐ no
6.					☐ yes ☐ no
7.					☐ yes ☐ no
8.					☐ yes ☐ no
9.					☐ yes ☐ no
10.					☐ yes ☐ no
11.					☐ yes ☐ no
12.					☐ yes ☐ no
13.					☐ yes ☐ no
14.					☐ yes ☐ no
15.					☐ yes ☐ no
16.					☐ yes ☐ no
17.					☐ yes ☐ no
18.					☐ yes ☐ no
19.					☐ yes ☐ no
20.					☐ yes ☐ no

2022 COVERAGE ELECTION FORM

Qualified health plan (QHP) coverage election form for small groups

BlueCross BlueShield of Vermont

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

Please provide all informationand print in ink or type.

Requested effective date / /

Section 1: GROUP INFORMATION

Group Name:	Group Number:
Group Benefit Administrator's name:	

Section 2: PLAN SELECTION

Select from the options listed below (Choose up to 13 different plan options)

Standard Plans					Standard CDHP Plans		Vermont Preferred Plans			Vermont Select Plans		
Platinum	Gold	Silver Reflective	Bronze	Bronze Integrated	Silver CDHP Reflective	Bronze CDHP	Vermont Preferred Gold	Vermont Preferred Silver Reflective	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP Reflective	Vermont Select Bronze CDHP
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stacked Deductibles– Plan pays for an individual once the individual deductible is met (including family plans)					**Aggregate Deductibles**– Full, single or entire family deductible must be satisfied before benefits are paid.							

For assistance, please call our sales & service consultants at (800) 255-4550, Monday through Friday, 8 a.m. to 4:30 p.m.
Employers are responsible to provide their employees with a Summary of Benefits and Coverage (SBC) which can be found on our website at: **www.bcbsvt.com/qhpsmallbusiness**.

☐ I found the SBC on the website and will provide them to my employees

☐ Email the SBC to me at _____

☐ Mail a copy to me at the billing address on file

Section 3: BROKER / AGENT / PRODUCER (if applicable)

☐ Using a broker / agent / producer.
If you are using a broker please list them below. By completing the information below you are listing the broker as an authorized contact for your group.

Broker Name:	Agency Name:

Section 4: SIGNATURE

SIGN HERE

▶ Group Benefit Administrator's signature (required) _____ date _____ ◀

Please return this form to: Blue Cross and Blue Shield of Vermont (BCBSVT)
P.O. Box 186
Montpelier, VT 05601-0186.

Email: consumersupport@bcbsvt.com
Fax: (802) 371-3719

For assistance, please call our sales consultants at (800) 255-4550, Monday through Friday, 8 a.m. to 4:30 p.m. or email **consumersupport@bcbsvt.com**.
For more information, visit **www.bcbsvt.com/qhpsmallbusiness**.

CDHP: Consumer-Directed Health Plan

2022 plan details and premiums are on next page ⇨

STANDARD PLANS		Single	Two Person	Adult and Child(ren)	Family
Standard Platinum	$400/$800 medical deductible, then 10% co-insurance up to the medical out-of-pocket maximum of $1,400/$2,800. $15 PCP/MH, $20 Chiro/PT, $40 Specialist co-pay for office visits. $10 generic, $50 preferred brand, 50% non-preferred brand prescriptions.	$882.05	$1,764.10	$1,702.36	$2,478.56
Standard Gold	$1,200/$2,400 medical deductible, then 30% co-insurance up to the medical out-of-pocket maximum of $5,400/$10,800. $20 PCP/MH, $30 Chiro/PT, $50 Specialist co-pay for office visits. $12 generic, $150/$300 prescription deductible then $55 preferred brand, 50% non-preferred brand prescriptions.	$741.08	$1,482.16	$1,430.28	$2,082.43
Standard Silver Reflective	$3,400/$6,800 medical deductible, then 50% co-insurance up to the out-of-pocket maximum of $8,550/$17,100. $35 PCP/MH, $45 Chiro/PT, $80 Specialist co-pay for office visits. $15 generic, $400/$800 prescription deductible then $60 preferred brand, 50% non-preferred brand prescriptions.	$611.47	$1,222.94	$1,180.14	$1,718.23
Standard Bronze	$6,450/$12,900 medical deductible, then 50% co-insurance up to the out-of-pocket maximum of $8,700/$17,400. $15 generic, $1,100/$2,200 prescription deductible then $85 preferred brand, 60% non-preferred brand prescriptions.	$516.08	$1,032.16	$996.03	$1,450.18
Standard Bronze Integrated	$8,700/$17,400 combined medical & prescription deductible & out-of-pocket maximum. $40 PCP/MH, $50 Chiro/PT, $100 Specialist co-pay for office visits. $30 co-pay for generic prescriptions.	$523.08	$1,046.16	$1,009.54	$1,469.85
Standard Silver CDHP Reflective	$1,850/$3,700 combined medical & prescription deductible, then 30% co-insurance up to the maximum of $6,900/$13,800[1]. *Deductible is waived for select wellness drugs[2].*	$637.05	$1,274.10	$1,229.51	$1,790.11
Standard Bronze CDHP	$5,700/$11,400 combined medical & prescription deductible, then 50% co-insurance up to the maximum of $7,050/$14,100[1]. *Deductible is waived for select wellness drugs[2].*	$530.38	$1,060.76	$1,023.63	$1,490.37

To learn more about each plan, please review the Summary of Benefits Coverage (SBC) available on our website at **www.bcbsvt.com/qhpsmallbusiness**.

[1]Regardless of all other cost-sharing, if one individual's out-of-pocket costs reach $8,700 in a year, we begin paying 100 percent of the allowed amount for that person's covered services and supplies

[2]To view our select wellness drugs on the National Performance Formulary (NPF), visit www.bcbsvt.com/formulary-lists.

VERMONT PREFERRED PLANS		Single	Two Person	Adult and Child(ren)	Family
Vermont Preferred Gold	Combined 3-6-9 PCP/MH office visits apply with no cost-sharing before the deductible. Combined medical & prescription deductible of $1,550/$3,100. After the deductible co-pays vary based on services up to the $5,150/$10,300[1] out-of-pocket maximum. *Deductible is waived for select wellness drugs*[2].	$686.61	$1,373.22	$1,325.16	$1,929.37
Vermont Preferred Silver Reflective	Combined 3-6-9 PCP/MH office visits apply with no cost-sharing before the deductible. Combined medical & prescription deductible of $3,000/$6,000. After the deductible, co-pays vary based on services up to the $8,150/$16,300[1] out-of-pocket maximum. *Deductible is waived for select wellness drugs*[2].	$590.43	$1,180.86	$1,139.53	$1,659.11
Vermont Preferred Bronze	Combined 3-6-9 PCP/MH office visits with no cost-sharing before the deductible. Combined medical & prescription deductible and out-of-pocket maximum of $8,700/$16,700[1]. *Deductible is waived for select wellness drugs*[2].	$522.54	$1,045.08	$1,008.50	$1,468.34
VERMONT SELECT PLANS		**Single**	**Two Person**	**Adult and Child(ren)**	**Family**
Vermont Select Gold CDHP	Combined medical & prescription deductible & out-of-pocket maximum of $2,550/$5,100[1]. *Deductible is waived for select wellness drugs*[2].	$723.92	$1,447.84	$1,397.17	$2,034.22
Vermont Select Silver CDHP Reflective	Combined medical & prescription deductible & out-of-pocket maximum of $4,600/$9,200[1]. *Deductible is waived for select wellness drugs*[2].	$603.66	$1,207.32	$1,165.06	$1,696.28
Vermont Select Bronze CDHP	Combined medical & prescription deductible & out-of-pocket maximum of $7,050/$14,100[1]. *Deductible is waived for select wellness drugs*[2].	$516.99	$1,033.98	$997.79	$1,452.74

To learn more about each plan, please review the Summary of Benefits Coverage (SBC) available on our website at **www.bcbsvt.com/qhpsmallbusiness**.

[1]Regardless of all other cost-sharing, if one individual's out-of-pocket costs reach $8,700 in a year, we begin paying 100 percent of the allowed amount for that person's covered services and supplies.

[2]To view our select wellness drugs on the National Performance Formulary (NPF), visit www.bcbsvt.com/formulary-lists.

SMALL GROUP COVERAGE

Employee enrollment and change form

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Submit one of three ways: email, fax, or mail, see page 2.
Please provide all information and print in ink or type.

Requested effective date / /

Section 1: EMPLOYEE INFORMATION

Employer Group name:

Group Number/Division:

Standard Plans:
☐ Platinum ☐ Gold ☐ Silver Reflective ☐ Bronze
☐ Bronze Integrated ☐ Silver CDHP Reflective ☐ Bronze CDHP

Vermont Preferred Plans:
☐ Vermont Preferred Gold ☐ Vermont Preferred Silver Reflective
☐ Vermont Preferred Bronze

Vermont Select Plans:
☐ Vermont Select Gold CDHP ☐ Vermont Select Silver CDHP Reflective
☐ Vermont Select Bronze CDHP

Last name:	First name:	Social Security Number (SSN)[1]:	Date of birth (DOB):
Physical address:	City:	State:	Zip code:
Mailing address:	City:	State:	Zip code:
Phone number:	Email address:	Sex: ○ Male ○ Female	
Primary Care Provider (Pcp) name, or npi number[3] Are you a current patient? ☐ Yes ☐ No	Marital status: ☐ Single ☐ Domestic Partner[2] ☐ Married/party to a civil union	Employment status: ☐ Active ☐ Retired ☐ Continuation	

Health coverage type:
☐ Employee only ☐ Employee & spouse (including party to a civil union/domestic partner) ☐ Employee & Child or Children ☐ Family

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

☐ New group ☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA/VIPER) ☐ Spouse turning age 65
☐ Special Enrollment Period (SEP) ***please indicate qualifying event in Section 3*** ☐ Transferred from another BCBSVT plan
☐ Transferred from another BCBSVT plan, Member ID _____

Section 3: CHANGE/CANCELLATION

CHANGE: (including SEP qualifying events)
Effective date ___/___/____
☐ Pregnancy
☐ Birth
☐ Adoption placement date
___/___/____

☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change[2]
☐ Loss of coverage[2]

CANCEL:
Date of cancellation ___/___/____

○ Voluntary cancel (signature required)

_____

○ Left employment (group benefits administrator signature)

_____

Other (explain) _____

Please see section 6 on page 2 for subscriber signature

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information Important note: federal law mandates our collection of SSN for all members.[1]			Primary Care Provider (PCP) Information[3]
○ Add ○ Remove Spouse/party to a civil union/domestic partner Last name: First name:	SSN[1] DOB	Sex ○ Male ○ Female	PCP Name: NPI No.[3] Are you a current patient? ○ Yes ○ No
○ Add ○ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ○ Male ○ Female	PCP Name: NPI No.[3] Are you a current patient? ○ Yes ○ No
○ Add ○ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ○ Male ○ Female	PCP Name: NPI No.[3] Are you a current patient? ○ Yes ○ No
○ Add ○ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ○ Male ○ Female	PCP Name: NPI No.[3] Are you a current patient? ○ Yes ○ No

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)? ☐ Yes (please complete the applicable section below) ☐ No

MEDICAL			
Insurance company (name and address)			
Policyholder name	Policy certificate no.	Group no.	
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family		

DENTAL			
Insurance company (name and address)			
Policyholder name	Policy certificate no.	Group no.	
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family		

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross and Blue Shield of Vermont.
I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

▶ Employee signature ______________________________ Date ________________ ◀

If you are applying for coverage on behalf of another person other than your dependent, that person will need to complete an authorization form.

Submit one of three ways:

Email:	**Fax:**	**Mail:**
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

If you are adding a dependent child, 26 or older, contact customer service at (800) 247-2583 for further instructions.

[1] SSN required all members (Federal mandate requires the collection of SSN)
[2] Additional documentation required
[3] See our "Find-a-Doctor" tool at **www.bcbsvt.com/findadoctor**