

2027 PLAN SELECTION FORM

Please provide all information
printed in ink or type.

Employer and Employee use only

(800) 255-4550 (TTY/TDD: 711)

bluecrossvt.org/smallbusiness

Requested Effective Date

/ /

Submit form to:

This form must be returned to:

Group Benefits Administrator

Submit by:

Date

SECTION 1: EMPLOYER/EMPLOYEE INFORMATION

Group name:

Member ID #:

First name:

Last name:

SECTION 2: PLAN SELECTION

Vermont Preferred Plans			Vermont Select Plans			Standard Plans						
Vermont Preferred Gold	Vermont Preferred Silver	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP	Vermont Select Bronze CDHP	Platinum	Gold	Silver	Bronze	Bronze Integrated	Silver CDHP	Bronze CDHP
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Blue Cross VT Health Plans Offered by Employer
Employer Selection (may choose up to 13 plans)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Employee Selection (choose plan below)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Aggregate Deductibles
Once all members on the health plan meet their collective deductible, the health plan pays accordingly.

Stacked Deductibles
Once a member meets their deductible, the health plan pays accordingly, even for a two-person or family plan.

Aggregate Deductibles
Once all members on the health plan meet their collective deductible, the health plan pays accordingly.

The following amount will be paid toward your premiums: ☐ Weekly ☐ Bi-weekly ☐ Monthly

\$ _____ \$ _____ \$ _____ \$ _____

Employee-only Two-person Employee + Child(ren) Family

SECTION 3: ACCEPT OR DECLINE ENROLLMENT

☐ I select the plan above as my 2027 health plan selection.

I understand that I can find the plans Summary of Benefits and Coverage (SBC) at bluecrossvt.org/smallbusiness or my employer has provided me a copy.

☐ I decline

If you are declining enrollment for yourself or your dependents (including your spouse) because of another health plan or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependent lose eligibility for a public benefit program, such as Dr. Dynasaur, you or your dependent may be eligible for coverage under this group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of eligibility, marriage, birth, adoption, or placement for adoption.

SECTION 4: EMPLOYEE SIGNATURE

SIGN HERE

► Employee Signature _____

Date _____ ◀

Note: This form is not a substitute as an application for new enrollment or membership changes. Please complete the Small Group Employee Enrollment & Change Form.

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit bluecrossvt.org/contracts, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at bluecrossvt.org/privacypolicies.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at civilrightscoordinator@bcbsvt.com.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email civilrightscoordinator@bcbsvt.com. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at

<https://www.hhs.gov/ocr/complaints/index.html>

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC
العربية

للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).

BOSNIAN
BOSANSKI

Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).

BURMESE
မြန်မာဘာသာ

အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။

DARI
دری

د وړيا ژبني مرستې خدماتو لپاره، له شميرې سره اړيکه ونيسئ (800) 247-2583 (TTY/TDD: 711)

FRENCH
FRANÇAIS

Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).

KIRUNDI
IKIRUNDI

Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).

NEPALI
नेपाली

निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस्, (800) 247-2583 (TTY/TDD: 711). Nihşulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).

PASHTO
پښتو

برای خدمات رایگان کمک زبانی، با شماره (800) 247-2583 (TTY/TDD: 711) تماس بگیرید

SIMPLIFIED
CHINESE
简体中文

如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。

SOMALI
SOOMAALI

Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).

SPANISH
ESPAÑOL

Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).

SWAHILI
KISWAHILI

Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).

THAI
ไทย

สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). Sǎhrəb brikār cȟwy̌heľūx dân phāš'ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN
УКРАЇНСЬКА
МОБА

Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)

VIETNAMESE
TIẾNG VIỆT

Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).