Vernon County Government 2016 Enrollment Form - Health

NAME: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED

DATE OF HIRE: _____ / _____ / _____ SIGNATURE: _____

☐ By checking this box and signing, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse).

☐ I wish to continue my enrollment at the current level & not make any changes to my coverage.

Blue Cross and Blue Shield of Kansas City (Preferred-Care Blue)

☐ **Low PPO**: $500 Deductible Plan / $1,500 Family - $3,500 Out-of-Pocket / $7,000 Family –
Office Visit Copay $25* –RX Tier 1 $15 Copay / Tier 2 $70 Copay / Tier 3 $110 Copay/Specialty $200

Type of Coverage	Employee Cost (Per Month)
Employee Only	$503.36
Spouse	$669.48
Child(ren)	$669.48
Spouse + Child(ren)	$885.92

☐ **High PPO**: $1,500 Deductible Plan / $4,500 Family - $4,500 Out-of-Pocket / $9,000 Family –
Office Visit Copay $35* –RX Tier 1 $15 Copay / Tier 2 $70 Copay / Tier 3 $110 Copay/Specialty $200

Type of Coverage	Employee Cost (Per Month)
Employee Only	$432.89
Spouse	$575.85
Child(ren)	$575.85
Spouse + Child(ren)	$762.09

☐ **BlueSaver (HSA)**: $3,000 Deductible Plan / $6,000 Family - $3,000 Out-of-Pocket / $6,000 Family –
Office Visit: Deductible – RX Tier 1: Deductible / Tier 2: Deductible / Tier 3: Deductible

Type of Coverage	Employee Cost (Per Month)
Employee Only	$367.45
Spouse	$488.77
Child(ren)	$488.77
Spouse + Child(ren)	$646.83

☐ **High Deductible**: $3,000 Deductible Plan / $6,000 Family - $3,000 Out-of-Pocket / $6,000 Family –
Office Visit Copay $40* -RX Tier 1 $15 Copay / Tier 2 $70 Copay / Tier 3 $110 Copay/Specialty $200

Type of Coverage	Employee Cost (Per Month)
Employee Only	$372.49
Spouse	$495.31
Child(ren)	$495.31
Spouse + Child(ren)	$655.38

*Copayment applies to the Office Visit Charge Only. Other procedures performed in a Physician's office are subject to the Preferred Provider Deductible and Coinsurance level unless otherwise specified in the Benefit Schedule.