

**Group Hospitalization and Medical Services, Inc.**  
doing business as  
**CareFirst BlueCross BlueShield (CareFirst)**  
and  
**CareFirst BlueChoice, Inc. (CareFirst BlueChoice)**  
840 First Street, NE  
Washington, DC 20065  
202-479-8000

Independent licensees of the Blue Cross and Blue Shield Association

Insurers identified above are responsible for the obligations in this Group Contract Application.

**Point-of-Service**

**GROUP CONTRACT APPLICATION**  
**Non-Grandfathered Small Groups**  
**For Products offered outside of the SHOP Exchange**

Point-of-Service products are jointly offered products with in-network benefits provided under separate contract by CareFirst BlueChoice, Inc. (CareFirst BlueChoice) and out-of-network benefits provided under separate contract by CareFirst (collectively referred to in this Application as CareFirst/CareFirst BlueChoice). With this point-of-service product the Member may choose each time that services are sought to qualify for HMO benefits under the in-network plan or to receive traditional indemnity benefits under the out-of-network plan.

If this Application is being completed for a new Group, or an existing Group selecting a new product or making a jurisdictional change, the Group is required to complete this Application in its entirety, in black ink, and sign, date and return it to the Group's Sales Representative.

If this Application is being completed for an existing Group amending the Group's current coverage or changing general information, the Group is required to complete, in black ink, *only* the sections in which the information is changing, sign, date and return this Application to the Group's Sales Representative.

**No retroactive effective dates for new groups or amendments will be permitted.**

**Do not alter this document except to fill in the blanks and check the boxes provided. Due to regulatory requirements, this Application will not be accepted if any other changes are made.**

**GENERAL INFORMATION**

Group Number (if available): \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Physical Location:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if other than above):

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Address (if other than above):

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Administrator (Person to Contact):

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_

Email Address: \_\_\_\_\_

Chief Executive Officer/President

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_

Email Address: \_\_\_\_\_

Type of Organization  Sole Proprietorship  Partnership  
 Corporation  Other \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Federal Tax Identification Number: \_\_\_\_\_

**EMPLOYER CONTRIBUTION**

To be eligible for CareFirst/CareFirst BlueChoice Group dental and/or vision benefits coverage, the employer must identify the contribution level that applies to the dental and/or vision benefits coverage in the checkboxes below. If the employer’s contribution for enrolled employees is an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees, then the employer should select employer-sponsored below. If the employer’s contribution is less than 50% of the cost of the Individual Coverage, the plan will be considered Voluntary, and the employer should select Voluntary below. If the employee or participant in the Group agrees to pay the entire premium for the coverage to the Group, then the employer should select Voluntary below.

If the Group selects dental benefit coverage, the Group must specify if the coverage will be:

- Employer-sponsored or
- Voluntary

If the Group selects vision benefit coverage, the Group must specify if the coverage will be:

- Employer-sponsored or
- Voluntary

**GROUP ELIGIBILITY REQUIREMENTS**

It is understood and agreed that in order to be eligible for coverage and maintain such eligibility, the Group must meet the following requirements:

**Small Employer:**

The Group must meet all the requirements for a “Small Employer” as such is defined by Title 45, §144.103, of the Code of Federal Regulations, promulgated pursuant to the Patient Protection and Affordable Care Act of 2010, as amended.

If the Group's actual enrollment varies such that the Group is not eligible for coverage as a Small Employer, the Group will be required to apply for other coverage by completing a new application and will be charged different premium rates. A Group Sales Representative or broker can help you obtain additional detailed information about federal and state law requirements as it relates to Small Employers.

**Annual Enrollment Certification:** CareFirst/CareFirst BlueChoice reserves the right to inspect the records of the Group after sixty (60) days from the effective date of the Group coverage in order to verify the eligibility of employees and their dependents. In addition, the Group may be required to complete and return to CareFirst/CareFirst BlueChoice an eligibility audit and/or census report annually.

### **Minimum Enrollment Requirements:**

The Group must enroll and maintain enrollment (unless otherwise approved by CareFirst) as stated below:

#### Medical coverage minimum enrollment requirements:

If BlueChoice *Plus* is selected, this must be the sole health plan offered by the Group to its employees.

A maximum of 10% of eligible employees enrolled in HMO products may live outside of the CareFirst BlueChoice Service Area.

If BlueChoice Advantage or HealthyBlue is selected, a maximum of 25% of eligible employees may live outside of the CareFirst BlueChoice Service Area.

Groups must enroll and maintain enrollment of 75% of all employees eligible for medical coverage and for each ancillary product purchased, if offered (or 100% if the employer pays the entire Individual Coverage premium). The ancillary products are dental and vision benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, CareFirst reserves the right to rescind the proposal (if prior to the effective date of the Group Contract), revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

The Group cannot enroll in their HMO programs (other than an HMO product offered by CareFirst BlueChoice) more than 25% of the total number of employees enrolled in all health programs offered through the Group. If applicable, the Group cannot continue to enroll new employees in their staff model HMO.

At least one common law employee must be employed full-time and enrolled under the Group's coverage at all times. (Note: The sole proprietor or spouse of the sole proprietor and those employees with complementary to Medicare coverage do not count toward the one employee minimum enrollment requirement.) Enrolled Groups that drop to less than one full-time employee should contact their CareFirst/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

Notwithstanding the preceding paragraphs, a Group that submits this Application to select a new medical product between November 15<sup>th</sup> and December 15<sup>th</sup> of any calendar year is not required to maintain the minimum enrollment requirements for medical coverage stated above.

Otherwise, all other Groups have to enroll and maintain the minimum enrollment requirements for medical coverage.

#### Dental and/or vision coverage minimum enrollment requirements:

When a Group selects employer-sponsored dental and/or vision benefit coverage, the Group must enroll and maintain enrollment of at least 75% of all eligible employees for the employer-sponsored dental and/or vision coverage. If at any time there are less than 75% enrolled in the employer-sponsored dental and/or vision products; the Company reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

When a Group selects Voluntary dental benefit coverage, the Group must enroll and maintain enrollment of the lesser of ten (10) eligible employees or 35% of all employees eligible for the Voluntary dental coverage. If at any time there are less than ten (10) eligible employees or 35% enrolled in the Voluntary dental coverage, CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the requirements, or refuse to renew the product that does not meet the requirements.

For Groups that select Voluntary vision benefit coverage, there are no minimum enrollment requirements for the Voluntary vision benefit coverage.

Exclusions from minimum enrollment requirements:

The following employees should be excluded from the above counts:

1. Those employees who have coverage under their spouse's or parent's group coverage, TRICARE, Medicare as primary under TEFRA, or their prior employer's plan under COBRA.
2. Those employees enrolled in other CareFirst/CareFirst BlueChoice coverage or covered under any CareFirst/CareFirst BlueChoice affiliate.
3. Those employees that obtain coverage through the Individual Exchange where the employer does not offer affordable coverage and minimum essential coverage as defined under the Affordable Care Act.

If the Group offers another medical health benefits program through CareFirst, the total Group enrollment in all such plans will be combined to determine enrollment.

Other requirements:

If at any time the Group fails to meet any minimum enrollment requirement stated in this Application for a group medical product; CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to the effective date of the applicable Group Contract), terminate the applicable Group Contract(s) for the product that does not meet a minimum enrollment requirement, or refuse to renew the applicable Group Contract(s) for the product that does not meet a minimum enrollment requirement.

CareFirst/CareFirst BlueChoice will notify the Group for any rate adjustments allowed under the terms of this Group Contract no later than 45 days prior to the effective date of the rate change.

***EMPLOYEE ELIGIBILITY REQUIREMENTS***

The following employees (and their dependents) are eligible for coverage, as long as they meet the additional eligibility requirements stated in the Evidence of Coverage and any attachments thereto.

All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week are eligible to enroll. Seasonal employees and independent contractors, such as subcontractors, who received a 1099, are not eligible to enroll. The IRS has issued guidance on when individuals could be treated as either an employee or independent contractor. Employers are encouraged to review this guidance and consult with an attorney or accountant, if needed.

All former employees and their dependents whose eligibility for group coverage has been extended due to COBRA requirements or state continuation of coverage statute requirements are eligible to enroll.

Note: No individual is eligible under the Group's coverage both as a Subscriber and as a Dependent. If the Group employs both Spouses, partners to a Civil Union, or Domestic Partners (if applicable), they may not both have Individual + Adult Coverage or Family Coverage.

Specify as many of the following additional categories of employees or retirees as the Group wishes to

cover, even if the Group does not currently have such individuals in the Group. NOTE: These individuals cannot be included in the total number of eligible employees for the Group.

YES  NO Part time employees working at least 17.5 hours a week for more than six months each year. (Those working less than these required time periods are not eligible).

Specify below whether Domestic Partners of employees or retirees will be eligible to enroll, even if the Group does not currently have such individuals in the Group.

YES  NO Domestic Partners of subscribers.

NOTE: The employee's or retiree's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse.

### ***EMPLOYEE EFFECTIVE DATES***

Coverage for current employees, other individuals currently covered if selected above, and former employees whose eligibility for group coverage has been extended due to COBRA requirements, and their eligible dependents becomes effective on the date that the Group Contract becomes effective.

Coverage for new employees is effective as stated below (if different for different classes of employees, state all in "Other" section):

- On the date of employment.
- On the first day of the month following the date of employment.
- On the first of the month following 30 days of employment or eligibility.
- On the first of the month following 60 days of employment or eligibility.
- Other \_\_\_\_\_ (Specify. Date cannot exceed a total of ninety (90) days. This date must comply with federal and state law and regulation.)

### ***TERMINATION OF COVERAGE***

Coverage for enrolled Subscribers and their enrolled Dependents terminates on the date stated below:

- On the date on which the Subscriber's employment or eligibility terminates.
- On the last day of the month in which the Subscriber's employment or eligibility terminates.

### ***GROUP'S RESPONSIBILITY TO EMPLOYEES***

In any case in which the employee is responsible for a portion of the monthly premiums, the Group must:

1. Advise the employee of his/her eligibility for coverage under the Group Contract;
2. Advise the employee when s/he may enroll for such coverage in accordance with the provisions stipulated in this Application and the Group Contract including the Evidence of Coverage;
3. Advise the employee when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;
4. Advise the employee of the cost of such coverage to the employee and the method in which payment is to be made; and
5. Obtain from the employee a completed enrollment form and a signed agreement by the employee to pay the applicable portion of the monthly rates.

### ***GROUP STATEMENTS***

The Group agrees that in the making of this Application, it is acting for and on behalf of itself and as the agent representative of its employees and COBRA participants, and their dependents; and it is agreed and understood that the Group is not the agent or representative of CareFirst/CareFirst BlueChoice for any purpose of this Application or any Group Contract issued pursuant to this Application.

The Group agrees to receive on behalf of its eligible employees, COBRA participants, and their dependents, the Evidence of Coverage including all attachments, and all relevant notices furnished by CareFirst, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided CareFirst/CareFirst BlueChoice with information regarding the eligibility of employees (and their dependents) that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C).

This Group Contract Application is part of the Agreement between the Group and CareFirst.

**IMPORTANT NOTE: The Group's rate sheet which describes the benefits and corresponding rates for the coverage selected must be signed by the Group before coverage can be made effective. CareFirst/CareFirst BlueChoice reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, CareFirst/CareFirst BlueChoice may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**ACCEPTED FOR:**

\_\_\_\_\_  
(Name of Organization)

BY: \_\_\_\_\_  
(Printed Name of Authorized Officer)

\_\_\_\_\_  
(Signature of Authorized Officer)

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**Broker (if applicable)**

\_\_\_\_\_

(Printed Name of Broker)

\_\_\_\_\_

(Signature of Broker)

Email Address: \_\_\_\_\_

Date: \_\_\_\_\_

Effective Date of Group Contract: \_\_\_\_\_