CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION

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. The attached rate sheet describes the benefits and corresponding rates for the coverage selected by the Group.

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.

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

Medical Products
CareFirst BlueChoice reserves the right to revise rates, or to refuse to renew any CareFirst BlueChoice health benefit plan issued to the Group, if the Group does not contribute an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees.

CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of any rate change.

GROUP MINIMUM ENROLLMENT REQUIREMENTS

Medical Benefits Products- Minimum Enrollment Requirements:
CareFirst BlueChoice reserves the right to revise rates, or to refuse to renew any CareFirst BlueChoice health benefit plan issued to the Group, if the employer does not meet the following requirements:

Groups must enroll and maintain enrollment of 75% of all employees eligible for medical coverage (or 100% if the employer pays the entire Individual Coverage premium). If at any time there are less than 75% enrolled in any of medical health benefits products offered by the Group, CareFirst BlueChoice reserves the right to revise the rates for the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

If at any time total enrollment increases or decreases by 10% or more, CareFirst BlueChoice reserves the right to revise the rates at renewal or to refuse to renew any of the medical health benefits products offered by the Group.

The Group cannot enroll in their HMO programs (other than CareFirst BlueChoice, Inc.) 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 a staff model HMO.

The basis for determining whether an enrollment increase or decrease has occurred will be the total enrollment

1. For purposes of renewal: On the contract renewal date versus the total enrollment proposed at the time the rates were developed.

2. For premium rate adjustments: On the first day of any month during the contract period versus the total enrollment proposed at the time the rates were developed.

CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change.

Other Minimum Enrollment Requirements Applicable to All Products:
At least one employee must be employed full-time and enrolled under the Group's coverage on the first

day of the plan year. (Note: 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 at this time should contact their CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

Exclusions from Minimum Enrollment Requirements (Applicable to All Products):
The following eligible employees should be excluded from the above counts:

1. Those eligible 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 eligible employees enrolled in other CareFirst BlueChoice coverage or covered under any CareFirst affiliate.

Annual Enrollment Certification:
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 BlueChoice an eligibility audit and/or census report annually.

EMPLOYEE ELIGIBILITY REQUIREMENTS

The following individuals identified below ("Subscribers") are eligible to enroll themselves (and any dependents), as long as they meet the additional eligibility and enrollment requirements stated in the Evidence of Coverage and any attachments thereto.

Full-Time Employees: All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week on a regular basis. 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 any dependents), enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements.

Specify the following additional Subscribers that 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.

- ☐ Part-time employees who works at least 17.5 hours per week for more than six months each year.
- ☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retired prior to the effective date of this coverage. (Available only if covered under the Group's prior health coverage)
- ☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retire on or after the effective date of this coverage.
- ☐ All former employees who terminated employment due to disability prior to the effective date of this coverage may enroll for a period of not more than 2 years. (Available only if covered under the Group's prior health coverage.)
- ☐ All eligible individuals who terminate employment due to disability after the effective date of this coverage may enroll for a period of not more than 2 years.
- ☐ Other _____(Specify)

Note: No individual is eligible to enroll under the Group's coverage both as a Subscriber and as a dependent. If the Group employs both spouses of a family (or both partners to a Civil Union or Domestic Partners, if applicable), they may <u>not</u> both select a Type of Coverage that is Individual and Adult Coverage or Family Coverage.

DOMESTIC PARTNER ELIGIBILITY

Specify below whether Domestic Partners of Subscribers will be eligible to enroll as dependents.

☐ YES ☐ NO Domestic Partners of Subscribers are eligible

Note: A Subscriber's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse.

ENROLLMENT EFFECTIVE DATES

Coverage of the following eligible individuals becomes effective on the date that the Group Contract becomes effective:

1. Existing eligible individuals who are currently enrolled under the Group's prior health coverage;

2. Former employees, who are currently enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements; and

3. Eligible individuals who enroll during an open enrollment period prior to the effective date of the Group Contract.

Coverage for an individual newly eligible to enroll as a Subscriber, and any eligible and enrolled dependents, is effective as stated below:

Select one:

☐ On the first day of the month following employment or eligibility, whichever is later.

☐ On the date of employment or eligibility, whichever is later.

☐ On the day after the Subscriber satisfies the Group's Waiting Period of ____ days after employment or eligibility, whichever is later. (Day range cannot exceed a total of ninety (90) days)

☐ On the first day of the month following the Subscriber satisfies the Group's Waiting Period of ____ days after employment or eligibility, whichever is later. (Day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).

☐ Other _____ (Specify).

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers and/or their enrolled Dependents who are no longer eligible (other than on the basis of a dependent child's limiting age) terminates on the date stated below:

Select One:

☐ The date on which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.

☐ The last day of the month in which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.

☐ Other _____ (Specify).

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children are covered until:

Select One:

- ☐ The last day of the month of their 26th birthday.
- ☐ On the date of their 26th birthday
- ☐ The last day of the calendar year of their ____ birthday. (Specify an age over the age of 26.)
- ☐ The last day of the month of their ____ birthday. (Specify an age over the age of 26.)
- ☐ On the date of their ____ birthday (Specify an age over the age of 26.)

Dependent students may remain eligible after the age selected above as long as they are enrolled as full-time students in an institution and students over age 26 must have a student certification on file with CareFirst/CareFirst BlueChoice until:

Select One:

- ☐ The last day of the month of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The date of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The last day of the calendar year of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The last day of the month of the student dependent's graduation or the end of the month of their ____ birthday, whichever occurs last. (Specify an age of 27 or over.)
- ☐ The last day of the calendar year of the student dependent's graduation or the last day of the calendar year of their ____ birthday, whichever occurs last. (Specify an age of 27 or over.)

Note: Dependent eligibility must end in the same manner for dependent children and dependent students, i.e. at the end of the year, or the end of the month, or on the birthday. For example, the Group may not select end of the month for dependent children and end of the year for dependent students.

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 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 BlueChoice, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided 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 BlueChoice.

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 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, an insurer 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: _____