CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559
A private not-for-profit health service plan incorporated under the laws of the State of Maryland
and
CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

Independent licensees of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION

Point-of-Service is a jointly offered product 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 a 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.

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: ____________________

GROUP CONTRIBUTION

Medical Products

CareFirst/CareFirst BlueChoice reserves the right to revise rates or to refuse to renew any CareFirst/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/CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change.

Freestanding Dental and Vision Products

To be eligible for CareFirst 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 MINIMUM ENROLLMENT REQUIREMENTS

Minimum Enrollment Requirements for Medical Products

The Group agrees to the following minimum enrollment requirements for the CareFirst/CareFirst BlueChoice product(s) that it has selected:

1. 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).

2. During the contract term, the Group's total enrollment has not increased or decreased by 10% or more from total enrollment proposed at the time the rates were developed.

3. The plan is the sole health plan offered by the Group to its employees.

4. For any CareFirst BlueChoice product selected, no more than 10% of the Group's eligible employees live outside of the CareFirst BlueChoice Service Area.

5. The Group cannot enroll more than 25% of the total number of eligible employees in any other HMO program it offers (other than another HMO program offered by CareFirst BlueChoice). If applicable, the Group cannot enroll new eligible employees in any staff model HMO program offered by the Group.

6. If the Group has fewer than 100 eligible employees and CareFirst BlueChoice coverage is selected, the Group cannot enroll its eligible employees in a health plan offered by any other HMO other than CareFirst BlueChoice.

If the Group does not meet the above requirements, CareFirst/CareFirst BlueChoice reserves the right to revise rates at any time or to refuse to renew any CareFirst/CareFirst BlueChoice health benefit plan issued to the Group.

1. For rate adjustments: Compliance with the minimum enrollment requirements is measured on the first day of any month during the contract period based on all information that has been information obtained by CareFirst/CareFirst BlueChoice including, but not limited to: (i) enrollment information; (ii) any eligibility audit information and/or Group census report; and (iii) the information obtained by CareFirst/CareFirst BlueChoice (including information received regarding proposed enrollment) at the time the rates were developed.

2. For purposes of renewal: Compliance with the minimum enrollment requirements is measured 120-days prior to the contract renewal date based on information obtained by CareFirst/CareFirst BlueChoice including, but not limited to: (i) enrollment information; (ii) any eligibility audit information and/or Group census report; and (iii) the information obtained by CareFirst/CareFirst BlueChoice (including information received regarding proposed enrollment) at the time the rates were developed.

At least one employee must be employed full-time and enrolled under the Group's medical 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/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

Minimum Enrollment Requirements for Freestanding Dental and Vision Products

When a Group selects employer-sponsored freestanding 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; 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 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 20% of all employees eligible for the Voluntary dental coverage. If at any time there are less than 20% 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 20% requirement, or refuse to renew the product that does not meet the 20% requirement.

If the Group offers dental or vision benefits only and at any time total enrollment increases or decreases by 10% or more, CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate this Group Contract, or refuse to renew this Group Contract.

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

1. On the effective date or contract renewal date versus the total enrollment proposed at the time the rates were developed; and

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

At least one employee must be employed full-time and enrolled under the Group's dental or vision 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/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

Excluded Eligible Employees
The following eligible employees will be excluded from any count of eligible employees for purposes of calculating compliance with any minimum enrollment requirement:

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/CareFirst BlueChoice coverage or covered under any CareFirst/CareFirst BlueChoice affiliate.

Former employees, if eligible below, will not be included in the total number of eligible employees or the total number of enrolled employees for purposes of calculating compliance with any minimum enrollment requirement.

Annual Enrollment Certification
CareFirst/CareFirst BlueChoice reserves the right to inspect the records of the Group after 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 agrees to complete and return to CareFirst/CareFirst BlueChoice an eligibility audit and/or census report annually.

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

MEMBER ENROLLMENT 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 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 any dependents), enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements or the Maryland Continuation of Coverage provisions.

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: Former employees, if eligible below, will not be included in the total number of eligible employees or the total number of enrolled employees for purposes of calculating compliance with any minimum enrollment requirement.

- ☐ Part-time employees who works at least 17.5 hours per week on a regular (not seasonal or temporary) basis 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 two 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 two years.
- ☐ All individuals, not described above, who are defined as being eligible for coverage as a Subscriber in the Group's written employee benefit policies, as amended from time to time.

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 Domestic Partners, if applicable), they may <u>not</u> both select a Type of Coverage that is Individual and Adult Coverage or Family Coverage.

CareFirst/CareFirst BlueChoice may at reasonable times examine the Group's pertinent records (including payroll records) with respect to eligibility and premium payments. CareFirst may establish reasonable requirements of proof to confirm the eligibility of Members. The Group agrees to provide, within 31 days of request, any information that verifies its compliance with the enrollment guidelines.

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.

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 or the Maryland Continuation of Coverage provisions; 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 date 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).

☐ On the day following the completion of the Group's Waiting Period. The Group's Waiting Period for professional employees is ___ days from the date of employment or eligibility, whichever is later and, for non-professional employees, is ___ days from the date of employment or eligibility, whichever is later (day ranges cannot exceed a total of ninety (90) days).

☐ On the first day of the month following the completion of the Group's Waiting Period. The Group's Waiting Period for professional employees is ___ days from the date of employment or eligibility, whichever is later, and, for non-professional employees, is ___ days from the date of employment or eligibility, whichever is later. (Day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).

☐ Coverage will be effective at the time stated in the Group's written employee benefit policies, as amended from time to time.

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers or any 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.

☐ The time stated in the Group's written employee benefit policies, as amended from time to time.

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children are covered until:

Select One:

☐ The last day of the month of their ___ birthday. (Specify an age of 26 or over.)

☐ On the date of their ____ birthday. (Specify an age of 26 or over.)

☐ The last day of the calendar year of their ____ birthday. (Specify an age of 26 or over.)

☐ The time stated in the Group's written benefit policies, as amended from time to time. (All dependent children must be covered to at least age 26.)

Dependent children may remain eligible after the age selected above as long as they are enrolled as full-time students in a public or private high school, college, university, graduate school, trade school, or other school, and 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 date of their graduation or on his or her ____ birthday, whichever occurs last. (Specify an age of 27 or over.)

☐ The last day of the calendar year of their graduation or the last day of the calendar year of their ____ birthday, whichever occurs first. (Specify an age of 27 or over.)

☐ The time stated in the Group's written benefit policies, as amended from time to time. (All dependent children must be covered to at least age 26.)

CareFirst/CareFirst BlueChoice has the right to verify student dependent eligibility status.

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 participants enrolled through the Maryland Continuation of Coverage provisions, and their dependents, if any; 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 and their dependents and COBRA participants, and participants enrolled through the Maryland Continuation of Coverage provisions, the Evidence of Coverage including all attachments, and all relevant notices furnished by CareFirst/CareFirst BlueChoice, 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 enrollees 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 (as amended and codified).

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

IMPORTANT NOTE: The Group's rate sheet, which describes the benefits and corresponding rates for the CareFirst/CareFirst BlueChoice 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.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If the Group has any questions concerning the benefits and services that are provided by or excluded under the coverage for which the Group is applying, please contact a customer services representative before signing this Application.

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: _____________