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

A not-for-profit health service plan

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

Non-Grandfathered Maryland Small Groups
For Point-of-Service Products Offered off of the Maryland Health Benefits Exchange

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 that is amending general information or selections submitted on a prior Application, the Group is required to complete, in black ink, *only* the sections in which the information is changing, and 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. This Application will not be accepted if any other changes to it are made.

GENERAL INFORMATION

CareFirst 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: _____

Federal Tax Identification Number: _____

GROUP ELIGIBILITY REQUIREMENTS

The Group must meet the following requirements.

Group Eligibility Requirements -- To be eligible for coverage and maintain its eligibility, the Group must meet all requirements for a Small Employer as provided in Section 31-101(z) of the Maryland Insurance Code:

"Small Employer" means an employer that, during the preceding calendar year, employed an average of not more than:

A. Fifty (50) employees for plan years that begin before January 1, 2016; and

B. One-hundred (100) employees for plan years that begin on or after January 1, 2016, or another number of employees or date as provided under federal law.

For purposes of this definition:

A. "Plan year" means a Calendar Year or other consecutive 12-month period during which a health benefit plan provides coverage for health care services.

B. All persons treated as a single employer under § 414(b), (c), (m), or (o) of the Internal Revenue Code shall be treated as a single employer;

C. An employer and any predecessor employer shall be treated as a single employer;

D. The number of employees of an employer shall be determined by adding:

1. The number of full-time employees; and

2. The number of full-time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

E. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

F. An employer that makes enrollment in qualified health plans available to its employees through the Maryland Health Benefits Exchange (the "SHOP Exchange"), and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Except as provided above, 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. The Group Sales Representative or broker can help obtain additional detailed information about Maryland law requirements as it relates to Small Employers.

Minimum Enrollment Requirements

Minimum Enrollment Requirements do NOT apply to a Small Employer who submits this Application between November 15th and December 15th of any calendar year.

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

The Group must enroll and maintain enrollment of at least 75% of all Eligible Employees. To determine enrollment, the Plan considers all Eligible Employees, except those who:

1. Are Eligible Employees who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Group Contract; and

2. Are Eligible Employees who are under the age of 26 years who are covered under their parent's health benefit plan.

If the Group offers another health benefits program through CareFirst/CareFirst BlueChoice and/or through another CareFirst/CareFirst BlueChoice affiliated or related entity, the total Group enrollment in all such plans will be combined to determine enrollment.

In addition, the group must meet the following enrollment requirements:

At least one full-time currently employed Eligible Employee must be enrolled under the Group's coverage at all times. Enrolled Groups that drop to less than one full-time employee should contact their Group Sales Representative or the Maryland Health Benefits Exchange to arrange for individual direct pay coverage.

If at any time the Group does not satisfy 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 Group Contract for product that does not meet a minimum enrollment requirement, or refuse to renew the Group Contract product that does not meet a minimum enrollment requirement.

Minimum Enrollment Requirements for Dental and/or Vision Coverage:

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; CareFirst reserves the right to rescind the proposal(if prior to the effective date of the applicable Group Contract), terminate the dental and/or vision product that does not meet the 75% requirement, or refuse to renew the dental and/or vision product that does not meet the 75% requirement.

If the 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 the

Group has less than ten (10) Eligible Employees, it is not eligible to select Voluntary dental benefit coverage. If at any time there are less than ten (10) eligible employees enrolled or 35% of all employees eligible for the Voluntary dental coverage enrolled, CareFirst reserves the right to rescind the proposal (if prior to the effective date of the applicable Group Contract), terminate the dental product that does not meet this requirement, or refuse to renew the dental product that does not meet this requirement.

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

The following employees are excluded from the counts in this provision relating to dental and/or vision coverage: those employees who have coverage under their spouse's or parent's group coverage, CHAMPUS, Medicare as primary under TEFRA, or their prior employer's plan under COBRA.

EMPLOYER CONTRIBUTION

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 premium cost of Individual Coverage for enrolled Eligible Employees, then the employer should select employer-sponsored below. If the employer's contribution is less than 50% of premium cost of Individual Coverage for enrolled Eligible Employees, 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

EMPLOYEE ELIGIBILITY REQUIREMENTS

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

A. Full-Time Employees (including owners and partners), who work, with respect to a calendar month, on average, at least 30 hours per week.

Full-Time Employee does not include a seasonal employee as defined in federal law.

B. Former employees and their dependents whose eligibility for group coverage has been extended due to COBRA requirements or the Maryland Continuation of Coverage provisions.

C. Other Eligible Employees: 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.

☐ YES ☐ NO Part-time employees with a normal workweek of at least 17.5 hours and who are not full-time employees. (Those part-time employees working less than this required time period per normal workweek are not eligible).

DOMESTIC PARTNER ELIGIBILITY

Specify below whether Domestic Partners of Eligible Employees will be eligible to enroll.

☐ YES ☐ NO Domestic Partners of Eligible Employees.

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 by CareFirst/CareFirst BlueChoice to complete and return to CareFirst/CareFirst BlueChoice an eligibility audit and/or census report annually.

EFFECTIVE DATES

Coverage for a new Eligible Employee will be effective on the first day of the month following the date of employment or eligibility, whichever is later, unless otherwise specified below:

☐ On the date of employment or eligibility, whichever is later.
☐ On the first day of the month following 30 days of employment or eligibility, whichever is later.
☐ On the first day of the month following 60 days of employment or eligibility, whichever is later.
☐ On the day following ____ days of employment or eligibility, whichever is later (day range cannot exceed a total of ninety (90) days).
☐ 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).

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers who are no longer eligible (and any enrolled Dependents) terminates on the last day of the month in which the Subscriber's employment or eligibility terminates.

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children enrolled by an Eligible Employee (other than an incapacitated Dependent Child) are covered until the last day of the month of their 26th birthday.

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.

PREMIUM RATE CHANGES

There may be a rate increase when approved by the Maryland Insurance Administration, as provided by law. CareFirst/CareFirst BlueChoice will not increase the Group's premium rate during the 12-month period beginning on the effective date of the Group Contract. CareFirst/CareFirst BlueChoice may increase the Group's premium more frequently if the increase is due solely to the enrollment of new Members.

CareFirst/CareFirst BlueChoice will provide notice of any change to premium rates by giving the Group at least sixty (60) days prior written notice. CareFirst/CareFirst BlueChoice will also prominently post notice of the premium rate change and justification for such on the CareFirst/CareFirst BlueChoice website.

GROUP STATEMENTS

The Group agrees that in submitting this Application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The Group is not the agent or representative of CareFirst/CareFirst BlueChoice for any purpose of this Application or any Group agreement issued pursuant to this Application.

The Group agrees to receive on behalf of its Subscribers and their Dependents and COBRA participants, if applicable, the Evidence of Coverage, the identification cards, and all relevant notices furnished by CareFirst/CareFirst BlueChoice and to forward such materials to these individuals at their last known address.

The Group agrees that it has provided CareFirst/CareFirst BlueChoice with information regarding the eligibility of Eligible Employees (and their Dependents) that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") and applicable state law.

This Group Contract Application is part of the applicable Group Contract(s) between the Group and CareFirst or CareFirst BlueChoice.

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 you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership 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: _____

Broker ID#: _____ Date: _____

Effective Date of Group Contract: _____