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

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION FOR FREESTANDING DENTAL AND FREESTANDING VISION PRODUCTS (For Maryland Groups Not Subject to Small Group Reform)

This form should be completed for a new Group, or an existing Group selecting a new dental or vision product or making a jurisdictional change, if the Group does not have a health benefits program through CareFirst or another CareFirst affiliate. The Group is required to complete this Application in its entirety, in black ink, and sign and return it to the Group's CareFirst Sales Representative.

If the Group is an existing Group amending the 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 and return this Application to the Group's CareFirst 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

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: _____

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 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.

Annual Enrollment Certification: CareFirst 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 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:

Groups must enroll and maintain enrollment of 75% of all employees eligible for employer-sponsored coverage (or 100% if the employer pays the entire Individual Coverage premium). If at any time there are less than 75% enrolled, CareFirst reserves the right to rescind the proposal, 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.

For Groups with 50 or fewer eligible employees, 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 reserves the right to rescind the proposal, 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 with more than 50 eligible employees, 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 reserves the right to rescind the proposal, 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.

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

The following employees should be excluded from the above counts: 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.

At least two employees must be employed full-time and enrolled under the Group's coverage at all times. Enrolled Groups that drop to less than two full-time employees no longer meet the minimum enrollment requirements of this Group Contract and should contact their CareFirst Sales Representative to arrange for individual direct pay coverage if available.

If at any time total enrollment increases or decreases by 10% or more, CareFirst reserves the right to rescind the proposal, 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.

CareFirst 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. **(Seasonal employees, subcontractors, consultants or other persons issued 1099's by the Group are not eligible.)**

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

Note: No individual is eligible 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 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).

☐ YES ☐ NO Retirees who have retired prior to the effective date of this coverage. (Available only if covered under the Group's prior health coverage.)

☐ YES ☐ NO Retirees who retire on or after the effective date of this coverage.

☐ YES ☐ NO All employees who terminated employment due to disability prior to the effective date of this coverage for a period of not more than two years. If for a shorter period of time, state here _____. (Available only if covered under the Group's prior health coverage.)

☐ YES ☐ NO All employees who terminate employment due to disability after the effective date of this coverage for a period of not more than two years. If for a shorter period of time, state here _____. (Not available for community-rated Groups.)

☐ YES ☐ NO Domestic Partners of eligible employees or retirees.

☐ YES ☐ NO Other _____
(Specify; approval required)
CareFirst Approval: Initials_____ Date_____

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 or the Maryland Continuation of Coverage Provisions, 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 ____ months of employment (cannot exceed ninety (90) days following the date of employment)
☐ On the first of the month following ____ days of employment (cannot exceed ninety (90) days following the date of employment)
☐ Other _____ (cannot exceed ninety (90) days following the date of employment)
(Specify; approval required)
CareFirst Approval: Initials_____Date_____

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

AGE LIMITS FOR DEPENDENT CHILDREN

Groups with 50 or fewer enrolled employees:

Dependent children are covered until:

☐ End of the month of their 26th birthday.

Groups with more than 50 enrolled employees:

Dependent children are covered until:

Select One

☐ End of the month of their 26th birthday.
☐ End of the calendar year of their 26th birthday.
☐ On the date of their 26th birthday.
☐ Other _____
(Specify; approval by CareFirst required; age limit must be age 26 or over)
CareFirst Approval: Initials____ Date_____

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; and it is agreed and understood that the Group is not the agent or representative of CareFirst 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 participants enrolled through the Maryland Continuation of Coverage provisions, 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.

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 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: _____