☐ **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

Insurer(s) identified above is (are) responsible for the obligations in this Group Contract Application (selection of one or both of the above is required).

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 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 and return this Application to the Group's Sales Representative.

For the purposes of this Application, the term “Company” means the insurer or insurers identified above, which is dependent on the product or products selected by the Group. The Group’s attached rate sheet describes the benefits and corresponding rates for the coverage selected by the Group.

When the BlueChoice Opt-Out *Plus Open Access* product is purchased, check both company names in the heading at the top of the page. BlueChoice Opt-Out *Plus Open Access* is a jointly offered point-of-service product with in-network benefits provided under separate contract by CareFirst BlueChoice and out-of-network benefits provided under separate contract by CareFirst (collectively referred to in this Application as the Company). With this point-of-service product the Member may choose each time that services are sought to qualify for Health Maintenance Organization (HMO) benefits under the in-network plan or to receive traditional indemnity benefits under the out-of-network plan.

When the Point-of-Enrollment product is purchased, check both company names in the heading at the top of the page. Point-of-Enrollment is a jointly offered product from CareFirst and CareFirst BlueChoice (collectively referred to in this Application as the Company). With this point-of-enrollment product, the Subscriber may select for himself/herself and his/her Dependents a CareFirst or a CareFirst BlueChoice product offered by the Group each year. The Subscriber is locked into this product until the next annual enrollment period, at which time the Subscriber can elect to change to another product. However, if the Subscriber has chosen a CareFirst product and moves into the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst BlueChoice within sixty (60) days of residing in his/her new residence. If the Subscriber has chosen a CareFirst BlueChoice product, and moves out of the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst product within sixty (60) days of residing in his/her new residence. Any change caused by new residence will take effect on the first day of the month following notification to the Company of the change.

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

Company 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 Group health benefits coverage, the employer must contribute an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees.

To be eligible for 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: The Company 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 the Company an eligibility audit and/or census report annually.

Minimum Enrollment Requirements: The requirements in this section do not apply to Virginia small groups electing coverage under Virginia Essential or Standard Health Benefit Plans.

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

If Point of Enrollment or BlueChoice Opt-Out *Plus Open Access* is selected, this must be the sole health plan offered by the Group to its employees.

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 employer-sponsored dental and vision benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, the Company 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 Group cannot enroll in their HMO programs (other than CareFirst BlueChoice) more than 25% of the total number of employees enrolled in all health programs offered through the Group. The Group cannot continue to enroll new employees in their staff model HMO.

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, CHAMPUS, Medicare as primary under TEFRA, or their prior employer's plan under COBRA.

2. Those employees enrolled in other Company coverage or covered under any Company affiliate.

At least two employees must be employed full-time and enrolled under the Group's coverage at all times. (Note: Those employees with complementary to Medicare coverage do not count toward the two employee minimum enrollment requirement.) Enrolled Groups that drop to less than two full-time employees should contact their Company Sales Representative to arrange for individual direct pay coverage.

If at any time total enrollment increases or decreases by 10% or more, the Company 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.

The Company reserves the right to increase a premium during the contract period. The Group will be notified of a premium increase by mail forty-five (45) days prior to the effective date of the new premium. If, however, the proposed premium rate increase exceeds thirty-five percent (35%) of the annual premium charged, the Company will give the Group prior written notice of no less than sixty (60) days.

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.

Note: No individual is eligible under the Group's coverage both as a Subscriber and as a Dependent. If the Group employs both a husband and wife (or Domestic Partner, 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).

☐ 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. (Available only if covered under the Group's prior health 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)
Company 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, 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
☐ Other ____
(Specify; approval required)
Company 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 the end of the month of their 26th birthday. Dependent students may remain eligible after their 26th birthday as long as they are enrolled as full-time students in an accredited institution and have a student certification form on file with the Company until the end of the month of their graduation.

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.
- ☐ End of the month of their ____ birthday (must be over 26th).
- ☐ End of the calendar year of their ____ birthday (must be over 26th).
- ☐ On the date of their ____ birthday (must be over 26th).

Dependent students may remain eligible as long as they are enrolled as full-time students in an accredited institution and have a student certification on file with the Company until:

Select One (if applicable)

- ☐ End of the month of their graduation or the end of the month of their _____ birthday (must be over 26th), whichever occurs last.
- ☐ End of the month of their ____ birthday (must be over 26th).
- ☐ End of the calendar year of their ____ birthday (must be over 26th).
- ☐ On the date of their ____ birthday (must be over 26th).
- ☐ End of the calendar year of their graduation or on their ___ birthday (must be over 26th), whichever occurs last.
- ☐ End of the calendar year of their graduation or the end of the calendar year of their 26th birthday, whichever occurs last.

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 this 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 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 the Company 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 the Evidence of Coverage, including Attachments and all relevant notices furnished by the Company, and to forward such materials to these individuals.

This Group Contract Application is part of the Agreement between the Group and/or the Company.

IMPORTANT NOTE: The Group's rate sheet, which describes the benefits and corresponding rates for the Company coverage selected must be signed by the Group before coverage can be made effective. The Company 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: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

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: ________