☐ **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 the Group Contract(s) issued pursuant to this Application (selection of one or both of the above is required).

GROUP CONTRACT APPLICATION
For Direct Enrollment in Qualified Health Plans offered by CareFirst and/or CareFirst BlueChoice on the SHOP Exchange

This Application is being completed for a Group purchasing directly from CareFirst and/or CareFirst BlueChoice (collectively, "CareFirst/CareFirst BlueChoice") one or more Qualified Health Plans offered on the SHOP Exchange that the Group has selected below:

Plans Selected:

HMO Products Offered by CareFirst BlueChoice	**PPO Products Offered by CareFirst BlueCross BlueShield:**
☐ BlueChoice HMO Gold 1000 Med Ded 25 Dent Ded SE	☐ BluePreferred PPO Platinum Zero Med Ded 25 Dent Ded SE
☐ BlueChoice HMO HSA/HRA Silver 2900 Med Ded 25 Dent Ded SE	☐ BluePreferred PPO Gold 1250 Med Ded 25 Dent Ded SE
	☐ BluePreferred PPO HSA/HRA Silver 2900 Med Ded 25 Dent Ded SE

A new 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 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. This Application will not be accepted if any other changes are made.

GENERAL INFORMATION

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: _____

Federal Tax Identification Number: _____

CareFirst/CareFirst BlueChoice Group Number (if available): _____

DEFINITIONS

The terms below, when capitalized in this Application, are defined as follows:

Benefit Materials means (i) any enrollment or other coverage information or materials provided by CareFirst to the Group for delivery to employees, (ii) the Evidence of Coverage for a Qualified Health Plan, and (iii) any benefit summaries or other notices or materials relating to the Evidence of Coverage required by federal or state law or regulation to be provided by the Group or CareFirst to employees.

Group Contract means the agreement between the Group and CareFirst and/or CareFirst BlueChoice pursuant to which the HMO product, the PPO product and/or the Point-of-Service product is issued to the Group.

HMO product means a Qualified Health Plan with benefits provided only by CareFirst BlueChoice.

Point-of-Service product means a jointly offered Qualified Health Plan with in-network benefits provided under separate contract by CareFirst BlueChoice and out-of-network benefits provided under separate contract by CareFirst. 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.

PPO product means a Qualified Health Plan with benefits provided only by CareFirst.

Qualified Health Plan means an HMO product, a PPO product or a Point-of-Service product offered by CareFirst and/or CareFirst BlueChoice that has been certified by the SHOP Exchange as having met the standards established by the U.S. Department of Health and Human Services.

SHOP (Small Business Health Options Program) Exchange means the Virginia Health Benefits Exchange.

GROUP ELIGIBILITY REQUIREMENTS

It is understood and agreed that in order to be eligible to select an HMO product, a PPO product or the Point-of-Service product, and maintain such eligibility, the Group must meet the following requirements:

Qualified Employer
A Qualified Employer is an employer that is able to offer Qualified Health Plan(s) offered by the SHOP Exchange.

A Qualified Employer is:

A. A small employer that employs, on average, at least one (1) but not more than fifty (50) wage-earning employees on business days during the preceding calendar year and who will employ at least one (1) employee on the first day of the plan year;

B. Elects to offer, at a minimum, all full-time employees coverage in a Qualified Health Plan through the SHOP Exchange; and

C. Either:

1. Has its principal business address in the Commonwealth of Virginia and offers coverage to its full-time employees though the SHOP Exchange; or

2. Has its primary worksite in the Commonwealth of Virginia and offers coverage to each eligible employee through the SHOP Exchange.

If the Group becomes no longer eligible as a Qualified Employer, the Group will be required to apply for other CareFirst/CareFirst BlueChoice coverage by completing a new application and it will be charged different premium rates. A Group Sales Representative or broker can help you obtain additional detailed information about federal and state law requirements as it relates to Qualified Employers.

Offer Coverage to all Full-Time Employees
The Group is required to offer coverage to all of the Group's full-time employees.

Evidence of Eligibility
If applying for coverage as a self-employed individual, the self-employed individual must submit any applicable Internal Revenue Form or Forms and Schedule for the previous taxable year. These documents must be signed and submitted with the application to verify eligibility.

If you have any questions about the correct documentation to submit with your application, your Sales Representative can help you select the most appropriate documentation. Once we receive your application, we will notify you if additional documents or information is required.

GROUP MINIMUM PARTICIPATION REQUIREMENT

Groups not Subject to Minimum Participation Requirement
Groups are exempt from meeting the minimum participation requirement under the following circumstances:

Groups enrolling or renewing coverage during the annual open enrollment period between November 15 and December 15 of a calendar year may not be denied issuance or renewal of a CareFirst/CareFirst BlueChoice product for failure to meet minimum participation requirement.

Minimum Participation Requirement
For Groups other than those that meet the circumstances stated above, the Group is required to enroll and maintain enrollment in Qualified Health Plans offered on the SHOP Exchange no less than 70% of all its eligible employees (including all part time employees and retirees, if eligible as selected below).

Those employees who have coverage under another employer group health plan, a public insurance program such as Medicare or Medicaid, or a health plan for enlisted military personnel and dependents, such as TriCare, are excluded from this minimum participation calculation. Compliance with this minimum participation requirement will be calculated, pursuant to standards established by the SHOP Exchange, upon initial enrollment and at renewal.

If at any time the Group fails to meet the applicable minimum participation requirement stated in this Application for a Qualified Health Plan, CareFirst/CareFirst BlueChoice reserves the right, to the extent permitted by applicable law or by regulations or procedures adopted by the SHOP Exchange, to rescind the proposal and reject this Application (if prior to the effective date of the applicable Group Contract) or to refuse to renew the Group Contract(s).

The minimum participation requirement, and any exceptions to it, is subject to changes in applicable law or in requirements adopted or amended by the SHOP Exchange. Otherwise, all other Groups have to satisfy the minimum participation requirement stated in this Application or adopted by the SHOP Exchange.

EMPLOYEE ELIGIBILITY

All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week 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.

The Group, at its option, may offer coverage to part-time employees or to retirees who have retired in accordance with the provisions of the Group's retirement program, as amended from time to time.

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.

PAYMENT OF PREMIUMS

The Group agrees to make all premium payments due under the terms of the Group Contract(s) directly to CareFirst/CareFirst BlueChoice. CareFirst/CareFirst BlueChoice reserves the right to terminate the Group Contract(s) for failure to pay premiums when due after the applicable grace period.

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 their dependents. 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 inform CareFirst/CareFirst BlueChoice of any changes in the information provided in this Application. The Group may use this Application form to submit changes in information to CareFirst/CareFirst BlueChoice.

The Group agrees to receive on behalf of its eligible employees, and their dependents, all Benefit Materials furnished by the Company and to forward these Benefit Materials to its employees.

The Group acknowledges that, under federal and state law, discrimination on the basis of race, color, national origin, sex, age sexual orientation, gender identity, or disability is not permitted.

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

The Group and person signing below on behalf of the Group are submitting this Application under the penalty of perjury. This means that the Group and person signing below on behalf of the Group state that the Group has provided true answers to all of the questions in this Application to the best of their knowledge and understand that they may be subject to penalties under federal law if they intentionally provide false or untrue information.

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.

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: _____

Broker ID#: _____ Date: _____

Effective Date of Group Contract: _____