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

GROUP CONTRACT APPLICATION

If you are a new group, or an existing group selecting a new product, or making a jurisdictional change, please complete this Application in its entirety, in black ink, and sign and return it to your Sales Representative.

If you are an existing group amending your current coverage or changing general information, please complete, in black ink, *only* the sections in which the information is changing, and sign and return this Application to your 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/CareFirst BlueChoice 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: _____

Chief Executive Officer/President

Name: _____ Telephone Number: _____

Title: _____

Type of Organization ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

Nature of Business: _____

Federal Tax Identification Number: _____

EMPLOYER CONTRIBUTION

To be eligible for Group coverage, the employer must contribute an amount equal to at least 50% of the cost of the Self-Only Coverage for enrolled employees.

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 and/or CareFirst BlueChoice, Inc. reserve 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 may be required to complete and return to CareFirst and/or CareFirst BlueChoice an Employee Status Certification annually.

Minimum Enrollment Requirements:

The Group must enroll and maintain enrollment (unless otherwise approved by CareFirst/CareFirst BlueChoice) as indicated below:

If the Group has fewer than 100 eligible employees, and CareFirst BlueChoice coverage is selected, CareFirst BlueChoice must be the only HMO carrier offered by the Group to its employees.

If this Group Contract covers dental benefits only, and the Group does not have a health benefits program through CareFirst or another CareFirst affiliate, the Group must have a minimum of ten (10) eligible employees enrolled at the time of the Group's initial effective date.

If this Group Contract covers vision or dental and vision benefits only, and the Group does not have a health benefits program through CareFirst or another CareFirst affiliate, the Group must have a minimum of two hundred (200) eligible employees enrolled under this contract at all times.

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 Self-Only premium). The ancillary products are dental and vision benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, 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.

The Group cannot enroll in their HMO programs (other than CareFirst BlueChoice, Inc.) 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:

- 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.
- Those employees enrolled in other CareFirst BlueChoice coverage or covered under any CareFirst affiliate.
- Those employees who neither live nor work in the CareFirst BlueChoice service area.

At least two employees must be employed full-time and enrolled under the Group's coverage at all times. (Note: Those employees either 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 CareFirst/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

If at any time total enrollment increases or decrease by 10% or more, CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal, revise the rates, terminate this Contract, or refuse to renew this 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/CareFirst BlueChoice will notify the Group for any rate adjustments allowed under the terms of this 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 set forth in the Certificate of Coverage or Group Enrollment Agreement, 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.

Please Note: No individual is eligible under your Group coverage both as an employee and dependent. Also, if your Group employs both a husband and wife, they may elect enrollment under two Self-Only coverages, one Two-Party Coverage or one Family Coverage, depending upon which types of coverage you have elected to offer. (They may not each have Two-Party or Family Coverage.)

Please specify which, if any, of the following additional categories of employees or retirees you wish to cover, even if you do not currently have such individuals in your 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, please indicate _____. **(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, please indicate _____. **(Not available for community-rated groups.)**

☐ YES ☐ NO Other _____
(Please specify; approval required)
CareFirst/CareFirst BlueChoice 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 or Group Enrollment Agreement becomes effective.

Coverage for new employees is effective as indicated below:

☐ 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 _____
(Please specify; approval required)
CareFirst/CareFirst BlueChoice Approval: Initials_____Date_____

AGE LIMITS FOR DEPENDENT CHILDREN

Groups with 50 or fewer eligible employees:

- Unmarried dependent children are covered under Family Coverage or Two-Party (Subscriber & Child) Coverage until the first of the month following their 23rd birthday.

- Unmarried dependent students may remain eligible under Family Coverage or Two-Party (Subscriber & Child) Coverage until the first of the month following graduation as long as they are enrolled as full-time students in an accredited institution and have a student certification form on file with CareFirst and/or CareFirst BlueChoice.

Groups with more than 50 eligible employees:

- Unmarried dependent children are covered under Family Coverage or Two-Party (Subscriber & Child) Coverage until the first of the month following their 19th birthday, (unless otherwise indicated in Attachment C, Eligibility Schedule), unless otherwise selected below.

  Select One

  ☐ First of the month following their ___ birthday.
  ☐ End of the calendar year following their ___ birthday.
  ☐ On the date of their ___ birthday.

- Unmarried dependent students may remain eligible under Family Coverage or Two-Party (Subscriber & Child) Coverage until the first of the month following graduation as long as they are enrolled as full-time students in an accredited institution and have a student certification form on file with CareFirst, unless otherwise selected below.

  Select One

  ☐ First of the month following their ___ birthday.
  ☐ End of the calendar year following their ___ birthday.
  ☐ On the date of their ___ birthday.
  ☐ On the date of their graduation.
  ☐ First of the month following graduation or until the first of the month following their ___ birthday.
  ☐ End of the calendar year following graduation or ___ birthday, whichever comes first.
  ☐ End of the calendar year following graduation.

- **Please 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, you may **not** select end of the month for dependent children and end of the year for dependent students.

DEDUCTIBLE CREDIT

If your Group had a previous indemnity group health plan, any Member who was covered on that plan will receive credit toward his/her major medical deductible for the amount previously satisfied under the prior plan. This credit toward the deductible is only applicable for the calendar year in which the change in group health plans occurs. The prior plan's Explanation of Benefits must be provided when the first claim is submitted. A separate dental deductible credit will also apply if your group had previous dental coverage and you are selecting CareFirst indemnity dental coverage.

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 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 Certificate of Coverage; or Group Enrollment Agreement.

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 CareFirst or CareFirst BlueChoice for any purpose of this Application or any Contract issued pursuant to this Application.

The Group agrees to receive on behalf of its eligible employees and their dependents and COBRA participants the Certificate of Coverage or Evidence of Coverage, including Attachments and all relevant notices furnished by CareFirst and CareFirst BlueChoice, and to forward such materials to these individuals.

It is agreed that, despite any language to the contrary, this Group Contract Application is part of the Agreement between the Group and/or CareFirst/CareFirst BlueChoice.

IMPORTANT NOTE: Your rate sheet, which describes the benefits and corresponding rates for the CareFirst or CareFirst BlueChoice coverage selected must be signed by the Group before coverage can be made effective. CareFirst and CareFirst BlueChoice reserve 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.

Following acceptance of this Application by CareFirst and/or CareFirst BlueChoice, a Group Contract or Group Enrollment Agreement will be issued for newly enrolled Groups and existing Groups selecting a new product or making a jurisdictional change. For other existing Groups, an Amendment, if required, will be issued in the form of this document or in the form of a separate Amendment.

Warning: It is a crime to provided false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, CareFirst/CareFirst BlueChoice may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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)

Broker ID#: _____ Date: _____

SUBJECT TO FINAL APPROVAL
ACCEPTED FOR GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. and/or CAREFIRST BLUECHOICE, INC.

By: _____ Effective Date of Group Contract: _____

Title: _____ By: _____
Director, Contract Administration

Rep. Code: _____

Date: _____ Date: _____