☐ **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 you are a new Group, or an existing Group selecting a new product, or making a jurisdictional change, 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, complete, in black ink, *only* the sections in which the information is changing, and sign and return this Application to your 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* product is purchased, make both selections above. BlueChoice Opt-Out *Plus* 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, make both selections above. 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: ______________________

Chief Executive Officer/President

Name: ______________________ Telephone Number: ____________

Title: ______________________

Type of Organization

☐ Sole Proprietorship ☐ Partnership
☐ Corporation ☐ Other ____________

Nature of Business: ______________________________

Federal Tax Identification Number: ______________________________

NOTICE TO VIRGINIA GROUPS

If your Group has 50 or fewer Eligible Employees, and your headquarters is in Virginia, you are subject to Virginia Small Employer (VASE) Reform laws. In Virginia, as a Small Employer, enrolling 2-50 eligible employees, you may elect coverage under an Essential or Standard Health Benefit Plan. Either of the plans may be purchased without the dental benefit if the Small Employer purchases separate dental coverage from a dental services plan. If you choose this coverage, contact your Sales Representative.

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: 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 Employee Status Certification 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* is selected, this must be the sole health plan 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, 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.

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:

- 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 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 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 Sales Representative to arrange for individual direct pay coverage.

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

The Company may change the applicable premium rates at any time by giving no less than thirty (30) days prior written notice to the Group. 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 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.

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.)

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 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 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:

☐ 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________

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:

  Select One

  ☐ First of the month following their nineteenth (19th) birthday.
  ☐ First of the month following their twenty-third (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 the Company, unless otherwise selected below.

  Select One

  ☐ First of the month following their twenty-fifth (25th) birthday.
  ☐ First of the month following graduation or until the first of the month following their twenty-fifth (25th) birthday, whichever occurs first.

The Virginia Essential and Standard Health Benefit Plans cover all unmarried dependent children under Family Coverage or Two-Party (Subscriber & Child) Coverage until the last day of the month following their eighteenth (18th) birthday, regardless of student status. This is the only selection available for these Plans

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 nineteenth (19th) birthday, (unless otherwise stated 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 the Company, unless otherwise selected below.

  Select One

  ☐ First of the month following their twenty-fifth (25th) birthday.
  ☐ 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, whichever occurs first.
  ☐ End of the calendar year following graduation or ___ birthday, whichever occurs first.
  ☐ End of the calendar year following graduation.

- **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 Company 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 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 Certificate of Coverage or Evidence of Coverage, including Attachments and all relevant notices furnished by the Company, 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 the Company.

IMPORTANT NOTE: Your 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.

Following acceptance of this Application by the Company, a Group Contract 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, the Company 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: __________________________
Title: __________________________
Rep. Code: __________________
Date: ______________________

Effective Date of Group Contract: ______________
By: ________________________________
Director, Contract Administration
Date: ______________________