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

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 CareFirst/CareFirst BlueChoice). 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.

The Point-of-Enrollment product is a jointly offered product from CareFirst and CareFirst BlueChoice (collectively referred to in this Application as CareFirst/CareFirst BlueChoice). 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 unless the change request is a result of a change permitted as described in the Special Enrollment Period provisions of the Evidence of Coverage 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 product 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 CareFirst/CareFirst BlueChoice 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*

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: _____

E-mail Address: _____

Chief Executive Officer/President

Name: _____ Telephone Number: _____

Title: _____

E-mail Address: _____

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

Nature of Business: _____

Federal Tax Identification Number: _____

## *EMPLOYER CONTRIBUTION*

To be eligible for CareFirst/CareFirst BlueChoice 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 CareFirst/CareFirst BlueChoice 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 Preferred or Traditional Class dental benefit coverage, the Group must specify if the coverage will be:

- ☐ Employer-sponsored or
- ☐ Voluntary.

If the Group selects CareFirst BlueChoice freestanding (non-rider) dental HMO 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 and/or CareFirst BlueChoice, Inc. reserve 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 and/or CareFirst BlueChoice an eligibility audit and/or census report annually.

**Minimum Enrollment Requirements:**

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

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 CareFirst coverage or covered under any CareFirst 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 CareFirst/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

If at any time total enrollment increases or decreases by 10% or more, CareFirst/CareFirst BlueChoice 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/CareFirst BlueChoice 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.

Note: No individual is eligible under the Group's coverage both as a Subscriber and as a Dependent. If the Group employs both Spouses (or Domestic Partners, 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)
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 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)
CareFirst/CareFirst BlueChoice 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 CareFirst/CareFirst BlueChoice 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 CareFirst/CareFirst BlueChoice 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.

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;

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 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 CareFirst and CareFirst BlueChoice, and to forward such materials to these individuals.

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

**IMPORTANT NOTE: The Group's 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.**

Warning: It is a crime to provide 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)

E-mail Address: _____

Date: _____

Effective Date of Group Contract: _____