☐ **Group Hospitalization and Medical Services, Inc.**
doing business as
CareFirst BlueCross BlueShield (CareFirst)
and
☐ **CareFirst BlueChoice, Inc. (CareFirst BlueChoice)**

1440 G Street, NW
Washington, DC 20005
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
Non-Grandfathered Small Groups
For Products offered outside of the SHOP Exchange

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.

Point-of-Service products are jointly offered products with in-network benefits provided under separate contract by CareFirst BlueChoice, Inc. (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 HMO benefits under the in-network plan or to receive traditional indemnity benefits under the out-of-network plan.

Point-of-Enrollment is jointly offered product(s) from CareFirst and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) (collectively referred to as the Company). With Point-of-Enrollment product(s), the Subscriber may select for himself/herself and his/her dependents a CareFirst or a CareFirst BlueChoice product offered by the Group each year. Except when a special enrollment provision may be applicable, the Subscriber is locked into the selected product until the next Annual Open Enrollment Period, at which time the Subscriber can elect to change to another product. There are two additional exceptions. If the Subscriber lives outside of the CareFirst BlueChoice Service Area, has chosen a CareFirst product and subsequently moves into the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst BlueChoice product within 60 days of residing in his/her new residence. This would only be applicable for a CareFirst BlueChoice product with a residency requirement. Additionally, if the Subscriber has chosen a CareFirst BlueChoice product with a residency requirement, and moves out of the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst product, or CareFirst BlueChoice product that does not have a residency requirement, within 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.

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

No retroactive effective dates for new groups or amendments will be permitted.

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

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 Company 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:

Small Employer:
The Group must meet all the requirements for a "Small Employer" as such is defined by Title 45, §144.103, of the Code of Federal Regulations, promulgated pursuant to the Patient Protection and Affordable Care Act of 2010, as amended. "Small Employer" includes a self-employed individual as defined by §38.2-3431 of the Code of Virginia.

If the Group's actual enrollment varies such that the Group is not eligible for coverage as a Small Employer, the Group will be required to apply for other coverage by completing a new application and 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 Small Employers.

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.

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

Medical coverage minimum enrollment requirements:

This must be the sole health plan offered by the Group to its employees.

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

If CareFirst BlueChoice coverage is selected, CareFirst BlueChoice must be the only HMO carrier offered by the Group to its employees.

If BlueChoice Advantage is selected, a maximum of 25% of eligible employees may live outside of the CareFirst BlueChoice Service Area.

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 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

(if prior to the effective date of the Group Contract), 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.

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

Minimum Enrollment Requirements do NOT apply to a Group that submits this Application between November 15th and December 15th of any calendar year.

Otherwise, all other Groups have to enroll and maintain the minimum enrollment requirements for medical coverage.

Dental and/or vision coverage minimum enrollment requirements:

When a Group selects employer-sponsored dental and/or vision benefit coverage, the Group must enroll and maintain enrollment of at least 75% of all eligible employees for the employer-sponsored dental and/or vision coverage. If at any time there are less than 75% enrolled in the employer-sponsored dental and/or vision products; the Company reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), 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.

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, the Company reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), 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 that select Voluntary vision benefit coverage, there are no minimum enrollment requirements for the Voluntary vision benefit coverage.

Exclusions from minimum enrollment requirements:

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, TRICARE, 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.

3. Those employees that obtain coverage through the Individual Exchange where the employer does not offer affordable coverage and minimum essential coverage as defined under the Affordable Care Act.

4. Those employees who neither live nor work in the CareFirst BlueChoice Service Area.

If the Group offers another medical health benefits program through the Company, the total Group enrollment in all such plans will be combined to determine enrollment.

Other requirements:

If at any time the Group fails to meet any minimum enrollment requirement stated in this Application for a group medical product; the Company reserves the right to rescind the proposal (if prior to the effective date of the applicable Group Contract), terminate the applicable Group Contract(s) for the product that does not meet a minimum enrollment requirement, or refuse to renew the applicable Group Contract(s) for the

product that does not meet a minimum enrollment requirement.

The Company reserves the right to increase a premium during the contract period as stated in the Group Contract. 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 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.

All former employees and their dependents whose eligibility for group coverage has been extended due to COBRA requirements or state continuation of coverage statute requirements are eligible to enroll.

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).

Specify below whether Domestic Partners of employees or retirees will be eligible to enroll, even if the Group does not currently have such individuals in the Group.

☐ YES ☐ NO Domestic Partners of subscribers.

EMPLOYEE EFFECTIVE DATES

Coverage for current employees who meet the requirements for eligibility under this application, 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 30 days of employment or eligibility.
☐ On the first of the month following 60 days of employment or eligibility.
☐ Other _____ (Specify. Date cannot exceed a total of ninety (90) days. This date must comply with federal and state law and regulation.)

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.

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.

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, COBRA participants, and their dependents, the Evidence of Coverage including all attachments, and all relevant notices furnished by the Company, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided the Company with information regarding the eligibility of employees (and their dependents) that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C).

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

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. 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)

_____
(Electronic Signature of Authorized Officer)

Title: _____ Date: _____

Broker (if applicable)

_____
(Printed Name of Broker)

_____
(Electronic Signature of Broker)

Email Address: _____

Broker ID#: _____ Date: _____

Effective Date of Group Contract: _____