# Group Hospitalization and Medical Services, Inc.

doing business as

**CareFirst BlueCross BlueShield (CareFirst)**

and

# CareFirst BlueChoice, Inc.

840 First Street, NE
Washington, DC 20065
202-479-8000

Independent licensees of the Blue Cross and Blue Shield Association

**Point-of-Enrollment**

## GROUP CONTRACT APPLICATION
## (For Maryland Groups Not Subject to Small Group Reform)

Point-of-Enrollment is a jointly offered product from CareFirst and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) (collectively referred to 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, 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 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 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.

If you are a new Group, or an existing Group selecting a new product or making a jurisdictional change you are required to 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, you are required to complete, in black ink, *only* the sections in which the information is changing, 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 CareFirst/CareFirst BlueChoice Group Coverage, the employer must contribute an amount equal to at least 50% of the cost of the Individual 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/CareFirst BlueChoice 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/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 stated below:

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 dental and vision benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, CareFirst/CareFirst BlueChoice 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 CareFirst/CareFirst BlueChoice 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 set forth in the Group Contract 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 or the Maryland Continuation of Coverage provisions.

Note: No individual is eligible under your Group coverage both as a Subscriber and as a Dependent. If your Group employs both a husband and wife (or Domestic Partner, if applicable), they may <u>not</u> both have Individual + Adult Coverage or Family Coverage.

Specify as many 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.

☐ 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)
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 or the Maryland Continuation of Coverage provisions, 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________

### *AGE LIMITS FOR DEPENDENT CHILDREN*

**Groups with 50 or fewer enrolled employees:**

Unmarried dependent children are covered until:

**Select One**

☐ End of the month of their 25th birthday.
☐ End of the month of their 25th birthday, or for dependent students over the age of 25, until the end of the month of their graduation from an institution or end of full-time student status, whichever occurs later. For students age 25 and over enrolled as a full-time student, a certification form must be on file with CareFirst/CareFirst BlueChoice.

**Groups with more than 50 enrolled employees:**

Unmarried dependent children are covered until:

**Select One**

☐ End of the month of their 25th birthday.
☐ End of the calendar year of their 25th birthday.
☐ On the date of their 25th birthday.
☐ End of the month of their ____ birthday (must be over 25th).
☐ End of the calendar year of their ____ birthday (must be over 25th).
☐ On the date of their ____ birthday (must be over 25th).
☐ Other_______________________________________________________
(Specify; approval by CareFirst/CareFirst BlueChoice required; age limit must be age 25 or over)
CareFirst/CareFirst BlueChoice Approval: Initials_____ Date______

Unmarried dependent students may remain eligible as long as they are enrolled as full-time students in an institution and students age 25 and over must have a student certification on file with CareFirst/CareFirst BlueChoice until:

**Select One**

- ☐ End of the month of their 25th birthday (no certification required).
- ☐ End of the calendar year of their 25th birthday (no certification required).
- ☐ On the date of their 25th birthday (no certification required).
- ☐ End of the month of their ____ birthday (must be over 25th).
- ☐ End of the calendar year of their ___ birthday (must be over 25th).
- ☐ On the date of their ____ birthday (must be over 25th).
- ☐ For dependent students over the age of 25, until end of month of their graduation from an institution or end of full-time student status, whichever occurs later.
- ☐ For dependent students over the age of 25, until the date of their graduation from an institution or end of full-time student status, whichever occurs later.
- ☐ For dependent students over the age of 25, until end of the calendar year of their graduation from an institution or end of full-time student status, whichever occurs later.
- ☐ End of the month of their graduation or until the end of the month of their ____ birthday (must be over 25th).
- ☐ End of the calendar year of their graduation or ____ birthday (must be over 25th), whichever occurs first.
- ☐ Other_______________________________________________________
  (Specify; approval by CareFirst/CareFirst BlueChoice required; age limit must be age 25 or over)
  CareFirst/CareFirst BlueChoice Approval: Initials_____ Date______

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 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 initial year in which your Group changes to a CareFirst indemnity group health plan. 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 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.
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 participants enrolled through the Maryland Continuation of Coverage provisions, and their dependents; and 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 receive on behalf of its eligible employees and their dependents and COBRA participants, and participants enrolled through the Maryland Continuation of Coverage provisions, the evidence of coverage, including all attachments, and all relevant notices furnished by CareFirst/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 CareFirst/CareFirst BlueChoice.

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

**If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a customer services representative before signing this Application.**

**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 CAREFIRST BLUECHOICE, INC.**

| | |
|---|---|
| By: ______________________________ | Effective Date of Group Contract: __________ |
| Title: _____________________________ | By: ____________________________________ |
| Rep. Code ____________________ | Title: ______________________________ |
| Date: _____________________________ | Date: ________________________________ |