

POINT-OF-SERVICE OPTION ELECTION/WAIVER

CAREFIRST BLUECHOICE, INC.

550 12th Street, S.W.
Washington, D.C. 20065
(202) 479-8000

Name of Employee/Applicant: _____

Social Security Number: _____ Group Name: _____

Under the Maryland Small Employer Insurance Business Reform Law, small employers that offer a HMO benefit as their sole health benefits option, may include a point-of-service option for their employees. A point-of-service option allows you to obtain covered health care services from physicians and other providers outside the HMO network under certain circumstances. At this time, your employer has elected to give each employee the choice to accept or decline a point-of-service option as an add-on benefit to your CareFirst BlueChoice coverage. Your employer has the choice to pay for this point-of-service option, pay a portion of this option or require employees who have selected the option to pay for the entire cost of this additional coverage.

EMPLOYEE ELECTION/WAIVER

Please carefully read the information that has been provided to you describing the point-of-service option. **Check the applicable box** below to indicate your election or waiver of the point-of-service option. **Sign and date** this form and return it to your employer with your enrollment application.

- No**, I do not wish to add a point-of-service option to my HMO coverage. I understand that I will be covered under the HMO benefits as stipulated in the Group Contract.
- Yes**, I wish to add a point-of-service option to my coverage. I understand that I will be covered under the HMO benefits **and** a point-of-service option as stipulated in the Group Contract.

I further understand and agree that:

1. I must return this form, fully completed and signed, to my employer with my enrollment application. If this completed and signed form is **not** received by my employer as indicated above, my covered family members and I **will not receive** the point-of-service option;
2. If I elect to add the point-of-service option to my coverage, an additional rate will be charged. This additional rate will be deducted from my paycheck, unless otherwise arranged with my employer;
3. I will have an opportunity to change my election/waiver annually, prior to my group's anniversary date and that I will be given 30 days in which to make this change. However, if, in the future, my employer elects to decline the option for all employees, I understand that my waiver/election will be superseded by my employer's election. Thereafter, I will receive the benefits that my employer has elected for all employees.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

X _____
Signature of Employee/Applicant Date

DO NOT WRITE IN THIS SPACE			
Group Number	Identification Number	Service Code	Effective/Transaction Date