BlueCross BlueShield of North Carolina

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RESET

Employer Group Application

This application should be completed to apply for Blue Cross and Blue Shield of North Carolina (Blue Cross NC) group coverage.

☐ **New Group** ☐ **Renewal —** As-is / Standard Changes ☐ **Renewal —** Plan / Other Changes

4 2 6 5 0 1
Prospect Number

0 7 — 0 1 — 2 6
Effective Date (Month, Day, Year)

SECTION 1 Group Information

1. Name of Group: **County of Chatham**

1 4 1 8 3 0 7 0
Group Number

5 6 — 6 0 0 0 2 8 4
Tax ID Number (EIN)

2a. Physical Address:

12 East Street
Address 1

Address 2

Pittsboro | **NC** | **27312**
City | State | Zip

Chatham
County

☐ **Billing Address is Same As Above**

2b. Billing Address (if different):

PO Box 1809
Address 1

Address 2

Pittsboro | **NC** | **27312**
City | State | Zip

Chatham
County

3a. Group Administrator / General User: **Julie Eckenrode**

julie.eckenrode@chathamcountync.gov
Email Address

9 1 9 — 5 4 5 — 8 3 7 0
Telephone Number

3b. Authorized Signer / Official: **Bryan Thompson**

bryan.thompson@chathamcountync.gov
Email Address

9 1 9 — 5 4 5 — 8 3 0 0
Telephone Number

9 2 1 1 1
4. Industry Type (NAICS Code)

SECTION 2 Group Eligibility

5. Is coverage being offered to all full-time employees?

☑ Yes ☐ No

6. The Group certifies that all individuals enrolling for coverage meet the following definition of eligible employee:

An eligible employee is an individual working 30 hours or more per week on a full-time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. Persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is a "statutory employee" as that term is defined under Internal Revenue Code Section 3121(d)(3) and works on a full-time basis for the Group may be considered eligible for small group coverage only. Documentation of "statutory employee" status is required.

☑ Yes ☐ No

7. Group certifies whether or not it meets the definition of a Small Employer as defined by the North Carolina Small Employer Group Health Insurance Reform Act.

North Carolina General Statute § 58-50-110(22b): a "Small employer" means, in connection with a nongrandfathered, nontransitional group health plan with respect to a calendar year and a plan year, an employer who meets the definition of small employer under 42 U.S.C. §18024(b)(2): An employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

☐ Yes, and is requesting an ACA plan or small group self-funded plan

☑ No

SECTION 3 Plan Administration

ORIENTATION / PROBATIONARY ELIGIBILITY PERIOD for New Hires ONLY:

8a. **Health, Dental, Vision:**

☑ 1st of the month following 30 days

☐ Next day following 30 days

☐ 1st of the month following 60 days

☐ Next day following 60 days

☐ Next day following 90 days

☐ 0 day, effective on date of hire (only for groups of 6+ eligible)

☐ 0 day, effective 1st of the month following the date of hire (only for groups of 6+ eligible)

☐ Self-funded Groups Only:
(51+): Other _____
(not greater than 90 days)

8b. **To be completed by NEW GROUPS ONLY:**

At the time of the Group's initial enrollment with Blue Cross NC, will all employees be enrolled as of the effective date of the group or should the probationary period apply?

☐ All

☐ Probationary Period

9. **Choose one of the following to be applicable to employees terminating coverage:**

☐ End of the contract month following employment termination

☑ Last day of employment (only available to groups of 6 or more eligible employees)

SECTION 3 Plan Administration (continued)

10a. **Domestic Partner Coverage Options** (check all that apply):

- [x] None
- [ ] Same Gender
- [ ] Opposite Gender

10b. **Self-Funded Groups Only (250+): Same Gender Spousal Coverage Options***:

Do you want to provide same gender spousal coverage?

- [x] Yes
- [ ] No

* If spouses are offered coverage, insured groups will automatically receive same gender spousal coverage.

Groups 51+:

Blue Cross NC standard eligibility allows for persons to be covered who are active, full-time employees, working 30 hours or more per week and their eligible dependents. Underwriting approval is required for any additional eligibility requests.

11a. **Pre 65 Retirees (Before Eligible Retiree Coverage):**

- [x] Yes
- [ ] No

11b. **Other Special Eligibility** (please specify): Elected officials County Commissioners

If you employ Elected Officials, do you want to provide Elected Official coverage?

- [x] Yes
- [ ] No

SECTION 4 Regulatory Mandates

12. **Important: The federal government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage.** Please provide the average number of employees at your company during the preceding calendar year using the following method. Include all temporary employees who receive a W-2 from you.

A. Full-time Employee – anyone who worked an average of at least 30 hours per week or 130 hours per month. Add the total number of full-time employees employed each month and divide by twelve: 654

B. Full-time Equivalent - anyone who is not full time as described above. Total all the hours worked by non full-time employees and divide by 120: 16

C. Number of Employees* (add lines A and B): 670

* This number cannot be "0". For groups not in business the prior calendar year, on line A enter the number of Full-time Employees you reasonably expect to employ in the upcoming calendar year. For B provide a reasonable estimation based on expected part time employee need.

13a. Are you including any affiliated groups under your coverage that together make up a controlled group that is considered a single employer as defined under Section 414(b), (c), (m), or (o) of the Internal Revenue Code?

- [ ] Yes
- [x] No

13b. **If yes,** how many total full-time equivalents are in the controlled group (all affiliated) commonly owned business? Groups should use the total number of employees in an organizational structure (i.e., parent companies, subsidiaries, and sibling companies). Subsidiaries of foreign companies must count the number of employees of the organization worldwide.

SECTION 4 Regulatory Mandates (continued)

All employer-sponsored group health plans must offer COBRA continuation coverage unless the employer is exempt from COBRA. (An employer is exempt if the group (i) employed fewer than 20 employees including all full-time, part-time, and seasonal employees on at least 50% of its working days during the preceding calendar year; or (ii) is a church plan or governmental plan as defined under the Internal Revenue Code.)

14a. **Is your group health plan required to comply with federal COBRA continuation coverage requirements for this contract year?**

☑ Yes ☐ No

14b. **Fully Insured and Balanced Funded:** For the group health plans selected below (health / dental / vision only), will the group delegate COBRA administration (as outlined in the Group Contract) to Blue Cross NC's designee?

☐ Yes

☐ No, the group opts out of this service and will obtain its own COBRA administrator.

15. The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee health benefit plans sponsored by most employers. Will this coverage insure an Employee Welfare Benefit Plan that is regulated by ERISA?

☐ Yes

☑ No - Governmental and church-sponsored plans only

SECTION 5 Health, Dental, Vision

16a. **For Health Coverage:**

Number of Eligible Employees: 654 Number of Enrolled Employees: 652

16b. Employer's Premium Contribution for health coverage (select one):

☑ Percentage

Employees 100 %

Dependents 0 %

☐ Fixed

Employees $ _____

Dependents $ _____

17a. **For Dental Coverage:**

Number of Eligible Employees: NA Number of Enrolled Employees: _____

Prior Group Dental Coverage (Applicable only if adding NEW dental coverage): ☐ Yes ☐ No

17b. Will you offer dental coverage to: ☐ Employees only ☐ Employees and Retirees (only available to 51+)

17c. Employer's Premium Contribution (percentage) for dental coverage:

Employees: _____ % Dependents: _____ %

17d. **For Self-Insured Dental Coverage:** Blue Cross NC offers a dental product which is intended to qualify as an excepted benefit (benefits include dollar limits on essential health benefits, i.e., pediatric dental services). In order to ensure the dental product qualifies as an excepted benefit, participants must be able to select or decline dental coverage independent from health coverage. Failure to meet this requirement could implicate issues under the Patient Protection and Affordable Care Act.

Please indicate if your Dental is an excepted benefit under The Plan:

☐ Yes ☐ No

SECTION 5 Health, Dental, Vision (continued)

18a. **For Vision Coverage:**

Number of Eligible Employees: NA Number of Enrolled Employees: _____

18b. Will you offer vision coverage to: ☐ Employees only ☐ Employees and Retirees (only available to 51+)

18c. Employer's Premium Contribution (percentage) for vision coverage:

Employees: _____ % Dependents: _____ %

SECTION 6 Benefit Plan Selection

19. Are you pairing your benefit with a Flexible Spending Account (FSA)?

☑ Yes ☐ No

If yes, select your FSA Administrator Option: ☐ Blue Cross NC Fund Administrator HealthEquity ☑ Other Fund Administrator

If enrolling in Health Reimbursement Arrangement (HRA) with HealthEquity, please complete below:

20a. Are you selecting an HRA with HealthEquity? ☐ Yes ☐ No **If yes,** please answer 20b:

20b. Is the group an S Corporation? ☐ Yes ☐ No

If yes, please provide the name of the owner(s): _____

If yes, are the owners electing coverage? ☐ Yes ☐ No

This section must be fully completed to ensure accurate enrollment.

21. **The Group acknowledges that it agrees to pay Blue Cross NC the following rates for the benefits below.** If quotes displayed do not reflect the Group's final selection, please update quote information below. If additional space is needed, please use the box below.

Quote Number	Fund	Fund Administrator	Rates
PPO Copay **Qote #: 7007392**	☐ HSA ☑ N/A ☐ HRA	☐ HealthEquity ☐ Other	**Admin fee:** **SSL:** **ASL:**
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	
	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	

SECTION 6 Benefit Plan Selection (continued)

Please enter any additional selected quotes below (including Quote Number, Fund, Fund Administrator, and Rate):

22. **Please Read Carefully:** This question is designed to restrict plan choices offered by Blue Cross NC related to the Patient Protection and Affordable Care Act, 45 C.F.R. §147.132 and 45 C.F.R. §147.133. — exemptions for coverage of certain preventive benefits related to contraceptive services (also includes contraceptive drugs and devices). If you have questions, contact your Agent or Blue Cross NC representative.

By checking one of the boxes below, the group is claiming a religious or moral exemption under the Patient Protection and Affordable Care Act, 45 C.F.R. §147.132 and/or §147.133. Use 'Not Applicable' for a Group Employer NOT wishing to restrict plan choices.

- [x] Not Applicable
- [ ] Employer Group claiming religious exemption (exempt from requirement to cover contraceptive services)
- [ ] Fully Insured Employer Group claiming moral exemption *(Moral exemption is not recognized by NCGS 58-3-178. Group must choose a plan that includes state mandated contraceptive services.)*
- [ ] Self-Funded Employer Group claiming moral exemption (exempt from requirement to cover contraceptive services)

SECTION 7 Payment Options

23. **Renewing Groups:**
Please submit billing and payment preference changes via **BlueCrossNC.com/Employer** in the Billing and Payment application.

24. **New Groups ONLY:**

Initial Payment Method

- [ ] One-Time Draft: Provide banking information below. **Draft will be initiated immediately upon enrollment in the Blue Cross NC system, even if prior to effective date.**
- [ ] Paper Check (Not available for Balanced Funding groups)

25. **New Group Ongoing Payment Method**

- [ ] **AutoPay**
Provide banking information below. Monthly payments will be automatically initiated on the due date of 1st of each month via ACH withdrawal. Invoices available only at **BlueCrossNC.com/Employer**.

Invoice Notification Options:

- [ ] Recurring Bank Draft with no Email notification
- [ ] Recurring Bank Draft with Email notification sent approximately 5-days in advance of due date to the billing contact provided below

Invoice Notification Recipient Email Address: _____

- [ ] **Monthly Payment Online or Check**
Monthly payment can be initiated by the group via paper check, or one-time ACH at **BlueCrossNC.com/Employer** in the Billing and Payment application (paper check not available for Balanced Funding groups).

Invoice Notification Options:

- [ ] Email notifications sent approximately 20-days in advance of due date to the billing contact provided below

Invoice Notification Recipient Email Address: _____

- [ ] Paper invoice mailed to the group approximately 20-days in advance of due date (Not available for Balanced Funding groups)

SECTION 7 Payment Options (continued)

Required for One-Time Initial Payment Draft or AutoPay groups only:

Account Name (as printed on the check): _____

Bank Routing / Transit Number: | | | | | | | | | |

This number appears in the lower left-hand corner of your check.

Bank Account Number: | | | | | | | | | | | | | |

This number appears to the right of the transit number and is separated from the transit number by symbols/spaces. Your number may be shorter than the boxes provided above.

X _____

Signature to Authorize

Billing and payment preference changes can also be made at **BlueCrossNC.com/Employer** in the Billing and Payment application.

26. **Agent Fee Payments:**
In applying for this coverage, the self-funded groups (12+) and insured groups (51+) understand that they are responsible for reaching an agreement with the producer regarding agent fee payments. While Blue Cross NC is not responsible for producer agent fee, Blue Cross NC is available to help facilitate the process. A separate agreement where Blue Cross NC will bill the Group and accept producer agent fee payments from the Group on behalf of a producer is available.

SECTION 8 Statement of Understanding

Effective Date of Coverage:

Subject to the acceptance of this application by Blue Cross NC, at its home office and the payment of applicable fees, the effective date of coverage for the group health plan, pursuant to this application, shall be 12:01 AM Eastern time on the 1st day of July (month), 2026 (year).

Municipalities and County Government Only:

Group is a Municipality for a City, Town or Village as defined by NCGS 160A-1(2) or a County as defined by NCGS 153A-1(3) and NCGS 153A-10, we acknowledge the provisions of §153A-92(d) or §160A-162 (b) and (c) which prohibits the purchase of insurance benefits that provide abortion coverage greater than that provided by the State Health Plan for Teachers and State Employees under Article 3B of Chapter 135 of the General Statutes. We understand the implication of our benefit selection related to this classification should it not conform to those provisions. Blue Cross NC and its agents, if applicable, shall be held harmless for the benefit choices made on this application.

Certification of Compliance with Federal and/or State Mandates:

Federal Social Security laws require employers to provide primary health care benefits under employer group health plans to certain individuals who are entitled to Medicare. The Group certifies and agrees that individuals eligible for Medicare, who are required to receive primary health care benefits under the Group's employee group health plan pursuant to federal Social Security laws, will be enrolled in a manner consistent with such laws. The Group hereby agrees to indemnify Blue Cross NC, hold it harmless against and reimburse it for any and all expenses paid or incurred by Blue Cross NC due to any act or omission of the Group or the employer inconsistent with the relevant Social Security laws, as amended.

For groups offering a Blue High Performance Network® (BlueHPN®) plan, please review the following information.

Small Group 1-50 Fully-Insured:

The group understands that the plan selected has a national provider network limited to BlueHPN. The group certifies that all covered employees live or work in one of the North Carolina BlueHPN Markets / Product Areas. The group acknowledges that not all Blue Cross NC contracted providers may be in this plan's network and the employee will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN product area are not covered.

12+ Balanced Funding / 100+ Self Funded / 51+ Fully-Insured:

The group understands that the plan selected has a national provider network limited to BlueHPN. The group certifies that the covered employees live or work in one of the BlueHPN Markets / Product Areas. The group acknowledges that not all Blue Cross NC contracted providers may be in this plan's network and the employee will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN product area are not covered.

SECTION 8 Statement of Understanding (continued)

Insured Groups Only (all sizes):

By signing below, I certify that I am the authorized signer on behalf of the Group and that all information provided is complete and accurate. I further understand that submission of this application and requisite fees constitutes an offer and a binding contract upon acceptance, as applicable, by Blue Cross NC. Acceptance of the offer by Blue Cross NC shall be signified by the earlier of the following events: Blue Cross NC's issuance of the Group Contract or issuance of identification cards to the Group's members. The Contract issued by Blue Cross NC shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that the Contract shall be binding upon the parties as issued, without the necessity of signature by the Group. In the event Blue Cross NC issues the Group Contract electronically, it may be accessed via **BlueCrossNC.com/Employer**, or may be requested in writing by calling **877-237-6275**. A representative sample of the Contract is available upon request.

Groups that select an HSA administered by Blue Cross NC's chosen HSA administrator:

I understand that submission of this application and requisite fees constitutes an offer and a binding contract upon acceptance, as applicable, by Blue Cross NC's chosen HSA administrator. The Contract provided by Blue Cross NC and the HSA administrator shall set out the terms of the agreement between the parties.

Fully Insured Small Group Disclosure (Required by NCGS 58-50-130(d)):

By signing below, I attest to understanding that in connection with offering a health benefit plan, Blue Cross NC guarantees the availability and renewability of coverage for small employers; provides 12-month initial and renewal rate guarantees unless benefits are changed; and that benefits available and premiums charged for health benefit plans offered to small employers are available upon request.

Self-Funded Groups:

By signing below, I certify that I am the authorized signer on behalf of the Group and that all information provided is complete and accurate. I understand that as a self-funded group the Group will enter into an Administrative Services Agreement (ASA) with Blue Cross NC for claims administration that requires a separate signature. If the Group is purchasing HRA/FSA Administration through an administrator, a separate contract may be required.

Groups who have selected Automatic Draft:

For your security, we process payments through a secure third-party vendor, ACI Payments, Inc. Blue Cross NC is not responsible for ACI Payments, Inc. processes including, for example the privacy policies that govern ACI Payments, Inc. Please see ACI Payments, Inc. Terms and Conditions at www.speedpay.com/terms for more information. By signing below, you accept the ACI Payments, Inc. Terms and Conditions.

By signing below, I certify that I am an authorized user of the bank account designated on this application ("Bank Account"). I hereby request and authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to charge the initial and/or subsequent premium payments, payments for health products, as I further certify, to the Bank Account payable to the order of Blue Cross NC. I agree that Blue Cross NC's rights in respect to the bank draft shall be the same as if it were a check drawn on the Bank Account and signed by me or another authorized user. I also authorize the financial institution to reduce the balance of the Bank Account by the amount of the bank draft. I agree that if such charges be dishonored, whether with or without cause and whether intentionally or inadvertently, Blue Cross NC shall have no liability whatsoever even though dishonor results in forfeiture of insurance. Finally, I understand that unless noted on this application all invoices will be available on the Blue Cross NC's Employer Services website **BlueCrossNC.com/Employer** and I will not receive a paper invoice.

X

Signature of Authorized Official

Date (Month, Day, Year)

Print Name

Title

Mark Browder

Agent Name

Date (Month, Day, Year)

P0055130

Agent Number