BlueCross BlueShield of North Carolina

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Employer Group Application

☐ New Group	Prospect Number: 217063	☐ Renewal (As-is / Standard BCNC Changes) ☑ Renewal (Plan / Other Changes)	Effective Date: 07/01/2024

1. Name of Group:	Group Number:	Tax ID Number (EIN):
County of Chatham	14162068	56-6000284

2. Physical Address:

Address 1: 12 East Street Address 2: _____

City: Pittsboro State: NC Zip Code: 27312 County: Chatham

☐ **Billing Address is Same As Above**

Billing Address (if different):

Address 1: PO Box 1809 Address 2: _____

City: Pittsboro State: NC Zip Code: 27312 County: Chatham

3a. Group Administrator / General User:	Telephone Number:	E-Mail Address:
Courtney Jones	(919) 545-8370	courtney.jones@chathamcounty.gov
3b. Authorized Signer / Official:	**Telephone Number:**	**E-Mail Address:**
Dan LaMontagne	(919) 545-8531	dan.lamontagne@chathamcounty.gov

4. Industry Type (NAICS Code):

92111

5. **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.

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). Use 'None of the Above' for a Group Employer NOT wishing to restrict plan choices. If you have questions, contact your Agent or Blue Cross NC representative.

6. ☐ By checking this box, 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.
   - ☐ Religious Employer Group (Religious employer groups are exempt from the requirement to cover contraceptive services)
   - ☐ Fully-insured Employer Group (Fully-insured groups are required to cover contraceptive services under NCGS 58-3-178 and must choose a plan that includes state-mandated contraceptive coverage)
   - ☐ Self-funded Employer Group (Self-funded groups that choose to exclude contraceptive services)
   - ☐ Self-funded Employer Group (Self-funded groups that choose to cover contraceptive services under NCGS 58-3-178 and choose a state-mandated contraceptive plan)
   - ☑ None of the above. (By checking this box you will not receive a plan that excludes or limits coverage for contraceptive services.)

7. Is coverage being offered to all full-time employees? ☑ Yes ☐ No

8. 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, as written before the passage of North Carolina Session Law 2013-357, AND is requesting a transitional plan
   - ☐ Yes, as written after the passage of North Carolina Session Law 2013-357, AND is requesting an ACA plan or small group self-funded plan
   - ☑ No

9. 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

ORIENTATION / PROBATIONARY ELIGIBILITY PERIOD FOR NEW HIRES ONLY:

10a. **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)

10b. 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

11. **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)

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12a. **Domestic Partner Coverage Options** (check all that apply): ☑ None ☐ Same Gender ☐ Opposite Gender

12b. **Self-Funded Groups Only (250+): Same Gender Spousal Coverage Options*:**

Do you want to provide same gender spousal coverage? ☑ 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.

13a. **Pre 65 Retirees (Before Eligible Retiree Coverage):** ☑ Yes ☐ No

13b. **Other Special Eligibility** (please specify): _____

If you employ Elected Officials, do you want to provide Elected Official coverage? ☑ Yes ☐ No

Health, Dental, Vision

14. For Health Coverage: Number of Eligible Employees: _____ Number of Enrolled Employees: _____

15. Group Employer Contribution for health coverage (select one): ☑ Percentage Employees: 100 % ☐ Fixed Employees: $ _____

Dependents: varies by tier % Dependents: $ _____

16. For Dental Coverage: Number of Eligible Employees: _____ Number of Enrolled Employees: _____

Prior Group Dental Coverage: ☐ Yes ☐ No

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

18. Group Employer Contribution (percentage) for dental coverage: Employees: _____% Dependents: _____%

19. 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

20. For Vision Coverage: Number of Eligible Employees: _____ Number of Enrolled Employees: _____

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

22. Group Employer Contribution (percentage) for vision coverage: Employees: _____% Dependents: _____%

23a. **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. This average must include all individuals employed by your company, whether an employee was full-time, part-time, and/or seasonal. Only include temporary employees if they worked for your company (i.e., employees that receive a W-2).

Number of Employees*: _____

*** This number cannot be "0". For groups not in business the prior calendar year, enter the number of FTE employees you reasonably expect to employ on business days during the current calendar year.**

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23b. 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
☑ No

23c. If yes, how many total full-time equivalents are in the controlled group (all affiliated) commonly owned business?

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.)

24a. **Is your group health plan required to comply with federal COBRA continuation coverage requirements for this contract year?**

☑ **Yes**
☐ **No**

24b. **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.**

25. The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee health benefit plans sponsored by most employers. Governmental plans and church-sponsored plans (as defined by federal law) are exempt.

Will this coverage insure an Employee Welfare Benefit Plan that is regulated by ERISA?

☐ Yes*
☑ No

26. 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

This section must be fully completed to ensure accurate enrollment. Please check the benefit plan(s) selected for your group.

27a.
☐ Blue High Performance Network℠ (EPO)***
☐ Blue High Performance Network℠ (1-2-3 plan design) (EPO)***
☐ Blue High Performance Network℠ All Copay (EPO)
☐ Blue High Performance Network℠ All Copay (EPO) **Small Group Only*****
☐ Blue Options® 1-2-3℠ (PPO)
☐ Blue Options® All Copay (PPO)
☐ Blue Options® All Copay (PPO) **Small Group Only**
☐ Blue Options® HSA℠
☑ Blue Options® (PPO)
☐ Blue Care® (HMO)
☐ Classic Blue® (CMM)
☐ Dental Blue®
☐ Dental Blue® Select℠
☐ Dental Blue® Preferred℠
☐ Blue 20/20℠ Vision

27b. **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	☐ HSA ☐ N/A ☐ HRA	☐ HealthEquity ☐ Other	

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Quote Number	Fund	Fund Administrator	Rates
	☐ 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	

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

Admin charges = $44.61
$180,000 SSL = $121.38
125% ASL = $10.21

If enrolling in HRA with Health Equity, please complete below:

27c. Is the group a S-Corp? ☐ Yes ☑ No

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

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

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Small Group Fully-Insured:

*** The group understands that the plan selected has a national provider network limited to Blue High Performance Network. The group certifies that all covered employees live in one of the North Carolina approved High Performance Network (BlueHPN) Markets / Product Areas. The group acknowledges that not all Blue Cross NC contracted providers may be in this plan's network and the employees 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.

20+ Balance Funded / 51+ Self Funded Only / 51+ Fully-Insured:

*** The group understands that the plan selected has a national provider network limited to Blue High Performance Network. The group certifies that all covered employees live **(ASO 250 + ->)** or work in one of the approved High Performance Network (BlueHPN) Markets / Product Areas. The group acknowledges that not all Blue Cross NC contracted providers may be in this plan's network and the employees 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.

1000+ Self Funded Only:

*** The group understands that the plan selected has a national provider network limited to Blue High Performance Network. The group certifies that the covered employees live or work in one of the approved High Performance Network (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 HPN product area are not covered.

28. **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.

Payment Options:

29. **New Group Initial Payment Method**

☐ Paper Check. (Not available for Balanced Funding groups.)

☐ One-Time Draft: Provide banking information below. Draft will be initiated immediately upon enrollment in the BlueCross NC system, even if prior to effective date.

New Group Ongoing Payment Method

☐ Recurring Bank Draft: 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**. Please provide the BlueCross NC Originator ID to your bank: 1560894904.

☐ Email Invoice With Monthly Payment Online. Monthly payment initiated by the group via ACH at **BlueCrossNC.com/Employer** in the Billing and Payment application. Invoice notifications are emailed to the billing contact. Please provide the BlueCross NC Originator ID to your bank: 1560894904.

☐ Paper Transactions: Monthly payments will be made by check. Paper summary invoice mailed to the group. (Not available for Balanced Funding groups.)

Renewing Group Ongoing Payment Method

☑ Same as current.

☐ Change requested, effective upon renewal date:

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☐ Recurring Bank Draft: 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**. Please provide the BlueCross NC Originator ID to your bank: 1560894904.

☐ Email Invoice With Monthly Payment Online: Monthly payment initiated by the group via ACH at **BlueCrossNC.com/Employer** in the Billing and Payment application. Invoice notifications are emailed to the billing contact. Please provide the BlueCross NC Originator ID to your bank: 1560894904.

☐ Paper Transactions: Monthly payments will be made by check. Paper summary invoice mailed to the group. (Not available for Balanced Funding groups.)

Name of Bank Account Holder: _____

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.

Signature to Authorize: _____

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

30. **Agent Fee Payments:**
In applying for this coverage, the self-funded groups (20+) 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.

31. **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), **2024** (year).

32. **Statement of Understanding:**

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 **www.BlueCrossNC.com/Employer-Services**, or may be requested in writing by calling **1-800-446-8053**. 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.

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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:

I further 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 **(www.BlueCrossNC.com/Employer-Services)** and I will not receive a paper invoice.

Signature of Authorized Official: _____ Date: _____
MM / DD / YYYY

Print Name: _____ Title: _____

Agent Name: **Bryan Bickley** Date: **03/19/2024** Agent Number: **P0011226**
MM / DD / YYYY