Group Application for Blue Cross and Blue Shield of North Carolina Coverage

☐ New Group	Prospect Number: 217063	■ Renewal Group	☐ Renewal (No Changes) ■ Renewal (With Changes)	Group Number: 062048	Effective Date: 07/01/2017

1. Name of Group: County of Chatham | Tax ID No (EIN): 56-6000284

2. Physical Address:

12 E. Street
ADDRESS 1 ADDRESS 2

Pittsboro	NC	27312	Chatham
CITY	STATE	ZIP CODE	COUNTY

Billing Address: (if different from above) P.O. Box 1809
ADDRESS 1 ADDRESS 2

Pittsboro	NC	27312
CITY	STATE	ZIP CODE

3. Group Administrator:	Telephone Number:	Fax Number:	Email Address:
Courtney Goldston	919-545-8370	919-542-8272	courtney.goldston@chathamnc.org

4. Divisions/Subsidiaries/Affiliates to be covered (attach list if necessary):

Name: N/A Relationship: _____

Address: _____ Nature of Business: _____

Group Name: _____ Group Number: _____ Email Address: _____

City: _____ State: _____ Zip Code: _____

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

5. Industry Type (NAICS Code): 92111

6. Group is, as defined under the Patient Protection and Affordable Care Act, 45 CFR §147.131, a(n)
   - ☐ religious employer
   - ☐ religious eligible organization (self-certification documentation is required or written notice to HHS) but not a closely held for-profit entity
   - ☐ a closely held for-profit entity as defined under federal law (26 CFR 54.9815-2713: 29 CFR 2590.715-2713: 45 CFR 147.130)
   - ■ none of the above

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 after the passage of North Carolina Session Law 2013-357, AND is requesting an ACA 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

Group Name: County of Chatham

ORIENTATION/PROBATIONARY PERIOD:

10. **Health, Dental Blue, Dental Blue Select, Blue 20/20:** Eligibility requirements to be applicable to future employees.
Note: "0 day orientation/probationary period" is only available for health coverage for groups of 6 or more eligible employees:

- [■] 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 1st of the month following the date of hire
- [ ] 0 day, effective on date of hire
- [ ] Self-funded Groups Only: Other _____ (not greater than 90 days)

At the time of initial enrollment, 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)

12a. **Domestic Partner Coverage Options** (check all that apply)**:**

[■] None [ ] Same Sex [ ] Opposite Sex

12b. **Self-Funded Groups Only: Same Sex Spousal Coverage Option*:**

Do you want to provide same sex spousal coverage? [■] Yes [ ] No

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

GROUPS 51+:

13. BCBSNC 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.

Pre 65 Retirees: (Before Eligible Retiree Coverage) [■] Yes [ ] No

Other Special Eligibility (please specify)**:**

MUNICIPALITIES AND COUNTY GOVERNMENT ONLY:

If you employ Elected Officials, do you want to provide Elected Official coverage? [■] Yes [ ] No

Medical/Health and Dental Blue/Dental Blue Select

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

15. Group Employer Contribution for health coverage (select one):

[■] Percentage [ ] Fixed

Employees: 100 % Dependents: varies % Employees $: _____ Dependents $: _____

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

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:** BCBSNC 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.**

20. 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. **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.** Only include temporary employees if they worked for your company (i.e., employees that receive a W-2).

Number of Employees

21. 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.)

Is your group health plan required to comply with federal COBRA continuation coverage requirements for this contract year? [■] **Yes** [ ] **No**

Insured ONLY: For the group health plans selected below (medical/dental only), will the group delegate COBRA administration (as outlined in the Group Contract) to BCBSNC's designee?

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

22. 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

If you checked yes, please identify a contact person for ERISA plan information.

Name and Title: Carolyn A. Miller

Address: 12 East St. Pittsboro, NC 27312 Phone: 919-548-8301

Group Name: County of Chatham

23. Under federal law, the Plan Administrator may be required to provide a notice to Plan Participants who do not read English but are literate in another language, advising them of where they can get information and assistance concerning their benefits and member rights. The notice must be in their primary language and appear in the summary plan description (member booklet). The following information is being requested to determine if such a notice will be necessary. It may also assist BCBSNC in meeting special customer service needs.

For Groups 1-99: Are 25% or more of all plan participants literate only in the same foreign (non-English) language? ☐ Yes ☐ No

If **Yes,** what is the primary language (e.g., Spanish)? _____

For Groups 100+: Are 10% or more (or 500) of the plan participants whichever is less, literate only in the same foreign (non-English) language? ☐ Yes ☒ No

If **Yes,** what is the primary language (e.g., Spanish)? _____

24. The Group acknowledges that it agrees to pay BCBSNC the following rates for the benefits below.

Please check the benefit plan(s) you have selected for your group. If you will be contributing to an HSA during the benefit period, please verify benefit plans, annual contribution amounts, and the HSA administrator you will be contributing through.

Blue Options℠ (PPO) / Blue Care® (HMO) /Classic Blue® (CMM) / Blue Value℠ (POS) / Blue Select℠ (PPO) / Blue Local℠ for Carolinas HealthCare System* / Blue Local with Duke Medicine and WakeMed Dental Blue / Dental Blue Select / Blue 20/20**

If quote number/product name selected is not displayed, please enter quote number/product name under appropriate product.

* The group understands that the plan selected has a local provider network limited to the Blue Local Carolinas HealthCare System network. The group certifies that all covered employees live in one of the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln,Mecklenburg, Rowan, Stanly, and Union. The group acknowledges that not all BCBSNC contracted providers are in this plan's network. The group also acknowledges that if a covered employee uses a provider not in this plan's network, the employee may receive benefits at the out-of-network level.

** The group understands that the plan selected has a local provider network limited to the Blue Local with Duke Medicine and WakeMed network. The group certifies that all covered employees live in one of the following approved counties: Caswell, Chatham, Durham, Johnston, Orange, Person, and Wake. The group acknowledges that not all BCBSNC contracted providers are in this plan's network. The group also acknowledges that if a covered employee uses a provider not in this plan's network, the employee may receive benefits at the out-of-network level.

Quote Number: 5054147

Plan Name: _____

Quote number and rates for groups

Administrative Charges* $33.25
$100,000 SSL* $107.37
125% ASL* $8.06
Blue Options - Modified Quote # 5054147

25. Is the selected benefit plan being paired with a Health Reimbursement Account (HRA) administered by BCBSNC? ☐ Yes ☒ No

If yes, are the owners electing coverage? ☐ Yes ☐ No If yes, please provide the name of the owner(s) _____

If the selected benefit plan is being paired with an HRA, a fully completed HRA Addendum must be attached.

26. **SMALL GROUPS (1-50 Full-Time Equivalents)**

Please select your HSA Administrator Option: ☐ Integrated BCBSNC Fund Administrator (Health Equity) ☐ Other Fund Administrator

27. **LARGE GROUPS (51+ Eligible Employees if Grandfathered, Otherwise, 51+ Full-Time Equivalents)**

Blue Options HSA℠

This section must be completed to ensure accurate enrollment. Please write in quote information below, if existing quotes do not reflect the Group's final choices. Any change in the amounts you listed below could result in a change to the rate you were quoted. Please also verify if fees should be included in the premium or deducted from the employee's HSA account. (51+)

			ANNUAL FUND CONTRIBUTION AMOUNT (in dollars)								
	Quote Number	LOB	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family	Employee + 1 Other	HSA Administrator	Include in Premium	Deduct from Employee's HSA Account
☐											
☐											
☐											
☐											

28. **FSA**

Are you selecting the Flexible Spending Account (FSA) administered by BCBSNC for your employees? ☐ Yes ☒ No

If yes, check which element(s) of the FSA are being offered to your employees:

FSA with medical? ☐ Yes ☐ No
FSA dependent care? ☐ Yes ☐ No
FSA limited purpose (HSA only)? ☐ Yes ☐ No

Group Name: County of Chatham

29. **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 BCBSNC, hold it harmless against and reimburse it for any and all expenses paid or incurred by BCBSNC due to any act or omission of the Group or the employer inconsistent with the relevant Social Security laws, as amended.

Blue 20/20 Vision

30. (a) Will the Employer pay any amount towards the vision premium? ☐ Yes ☐ No

(b) Employer (group) paid premium contribution percentage: For Employee: _____ % For Dependents: _____ %

(c) Is your group vision plan exempt from COBRA? ☐ Yes ☐ No

PLAN OPTIONS: (select) **Note: Premiums are based on a Per Employee Per Month fee**

Blue 20/20 Exam Only	Exam copay ☐ $0 ☐ $10 ☐ $20 ☐ $25	Employee Only $ _____ Employee + Spouse/Domestic Partner $ _____ Employee + Children $ _____ Employee + Family $ _____
Blue 20/20 Exam Plus	Exam copay ☐ $0 ☐ $10 ☐ $20 ☐ $25 Lens copay ☐ $10 ☐ $25 Frame allowance ☐ $100 ☐ $130 ☐ $150 Frame frequency ☐ 1 per 12 months ☐ 1 per 24 months	Employee Only $ _____ Employee + Spouse/Domestic Partner $ _____ Employee + Children $ _____ Employee + Family $ _____
Blue 20/20 Lens & Frame Only	Material allowance ☐ $200 ☐ $250 ☐ $300	Employee Only $ _____ Employee + Spouse/Domestic Partner $ _____ Employee + Children $ _____ Employee + Family $ _____

Payment Options:

33. **Authorization for Bank Draft**

New Groups:

☐ **Automatic Bank Draft** - withdraw the Group's initial and subsequent monthly premium payments (recurring payments). This authorization will remain in effect until an authorized representative of the Group revokes it in writing at least 10 days prior to the date the account is scheduled to be charged.

☐ **Monthly Payments Online** - withdraw the Group's initial premium payment (a one-time payment). The Group will log in to BCBSNC's Employer Services website for each additional month they would like drafted.

☐ **Paper Transactions** - A check is enclosed for the premium payment. Future monthly payments will be made by check upon receipt of a paper invoice.

Renewing Groups:
The automatic bank draft options shown above are available to renewal groups as well. Renewal groups may elect the desired options by logging in to BCBSNC's Employer Services website at ***bcbsnc.com/employers***.

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.

See authorization for bank draft under Statement of Understanding.

Group Name: County of Chatham

34. **Agent Fee Payments:**

In applying for this coverage, the self-funded groups (51+) and insured groups (100+) understand that they are responsible for reaching an agreement with the producer regarding agent fee payments. While BCBSNC is not responsible for producer agent fee, BCBSNC is available to help facilitate the process. A separate agreement where BCBSNC will bill the Group and accept producer agent fee payments from the Group on behalf of a producer is available.

35. **Effective Date of Coverage:**

Subject to the acceptance of this application by BCBSNC 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), 2017 (year).

36. **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 BCBSNC and BCBSNC's chosen HSA administrator. Acceptance of the offer by BCBSNC and the HSA administrator shall be signified by the earlier of the following events: BCBSNC's issuance of the Group Contract and the HSA administrator's issuance of its HSA Administrative Services Agreement (HSA/ASA) (collectively "the Contracts"), or issuance of identification cards to the Group's members. The Contracts issued by BCBSNC and the HSA administrator shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that the Contracts shall be binding upon the parties as issued, without the necessity of signature by the Group. In the event BCBSNC issues the Group Contract electronically, it may be accessed via ***bcbsnc.com/#employers***, or may be requested in writing by callin **1-800-446-8053**. A representative sample of the Contracts are available upon request. References to the HSA administrator and the HSA ASA in this document shall apply only if HSA services are being purchased by Group.

Small Group Disclosure (Required by NCGS 58-50-130(d), Title 11 NCAC 12.1304(g)):

By signing below, I attest to understanding that in connection with offering a health benefit plan, BCBSNC 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 BCBSNC 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 (BCBSNC) 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 BCBSNC. I agree that BCBSNC'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, BCBSNC 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 BCBSNC's Employer Services website ***(www.bcbsnc.com/employers)*** and I will not receive a paper invoice.

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

Email Address: _____

Print Name: _____ Title: _____

Agent Name: Bryan Bickley Date: 05/26/2017 MM/DD/YYYY

Agent Number: _____

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service at 1-888-206-4697; TTY and TDD, call 1-800-442-7028.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783 civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service 1-888-206-4697.

V. 8/2016

BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697（TTY： 1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. رقم هاتف الصم والبكم 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिदी बोलते ह हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。